| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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<br><br>A complaint and follow up survey was completed on September 6, 2024. A complaint was substantiated (Intake #NC00220092) and a complaint was unsubstantiated (Intake #NC00221297). Deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents.<br><br>This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 1 current client, 1 former client and 1 deceased client. | V 000 | | |
| V 105 | 27G .0201 (A) (1-7) Governing Body Policies<br><br>10A NCAC 27G .0201 GOVERNING BODY POLICIES<br>(a) The governing body responsible for each facility or service shall develop and implement written policies for the following:<br>(1) delegation of management authority for the operation of the facility and services;<br>(2) criteria for admission;<br>(3) criteria for discharge;<br>(4) admission assessments, including:<br>(A) who will perform the assessment; and<br>(B) time frames for completing assessment.<br>(5) client record management, including:<br>(A) persons authorized to document;<br>(B) transporting records;<br>(C) safeguard of records against loss, tampering, defacement or use by unauthorized persons;<br>(D) assurance of record accessibility to authorized users at all times; and<br>(E) assurance of confidentiality of records.<br>(6) screenings, which shall include:<br>(A) an assessment of the individual's presenting | V 105 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 105 | Continued From page 1 | V 105 | | |

problem or need;
(B) an assessment of whether or not the facility can provide services to address the individual's needs; and
(C) the disposition, including referrals and recommendations;
(7) quality assurance and quality improvement activities, including:
(A) composition and activities of a quality assurance and quality improvement committee;
(B) written quality assurance and quality improvement plan;
(C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services;
(D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service;
(E) strategies for improving client care;
(F) review of staff qualifications and a determination made to grant treatment/habilitation privileges:
(G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death;
(H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 105 | Continued From page 2 | V 105 | | |

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to implement their written elopement and discharge policies. The findings are:

Finding A:

Review on 8/15/24 of the facility's record revealed:
- An elopement policy: "...2. Begin to look for the person on surrounding property (If you are alone call the local sheriff department to notify them you have a runaway and wait for another staff member to come before you leave the premises)..."

Attempted interviews on 8/14/24 & 8/20/24 with former client (FC) #5's guardian was unsuccessful because FC #5's guardian elected not to disclose any information without approval from her supervisor and didn't return any follow-up phone calls, but FC #5's guardian did verify on 8/14/24 that FC #5 eloped from the facility prior to being discharged.

Interview on 8/16/24 the House Manager reported:
- FC #5 eloped from the facility on multiple occasions, but couldn't recall the dates
- FC #5 crawled out of the window while she was administering the clients' medications
- She notified the Qualified Professional (QP)/Licensee of FC #5's elopement

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 105 | Continued From page 3<br>- She asked the QP/Licensee if she should drive around the neighborhood to look for FC #5 and call 911 and the QP/Licensee said "no..he (FC #5) was 18 (years old)"<br>- Was trained to do the following when clients eloped from the facility:<br>- Watch where the client went<br>- Go after the client and try to talk them into the car if there was more than one staff in the facility<br>- Notify the QP/Licensee and the police<br><br>Interview on 8/13/24 the QP/Licensee reported:<br>- FC #5 eloped from the facility but he couldn't recall the dates<br>- The House Manager "rode around the neighborhood" to look for FC #5 but was unsuccessful<br>- No one notified the police when FC #5 eloped, but he notified FC #5's Department of Social Service (DSS) guardian<br>- FC #5 was located at a local hospital and was returned back to the facility, but he couldn't recall any dates<br>- FC #5 eloped again about a month after first incident<br>- Didn't notify the police of FC #5's elopements because FC #5 was 18 years old at the time of his elopement<br><br>Finding B:<br><br>Review on 8/15/24 of the facility's record revealed:<br>- A discharge policy: "Prior to discharge, G.S. (General Statute) 122-61 requires: a) An individualized written discharge plan which contains recommendations for further services designed to enable the client to live as normally as possible..." | V 105 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 105 | Continued From page 4<br><br>Interview on 8/13/24 the QP/Licensee reported:<br>- FC #5 eloped from the facility and was admitted into the local hospital<br>- He notified FC #5's DSS guardian that FC #5 couldn't return to the facility after he was discharged from the hospital<br>- Was responsible for completing a client's discharge summary upon discharge<br>- Didn't complete a discharge summary because FC #5 was a crisis respite client and only received "temporary placement" in the facility | V 105 | | |
| V 108 | 27G .0202 (F-I) Personnel Requirements<br><br>10A NCAC 27G .0202 PERSONNEL REQUIREMENTS<br>(f) Continuing education shall be documented.<br>(g) Employee training programs shall be provided and, at a minimum, shall consist of the following:<br>(1) general organizational orientation;<br>(2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B;<br>(3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and<br>(4) training in infectious diseases and bloodborne pathogens.<br>(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 techniques such as those provided by Red Cross, the American Heart Association or their | V 108 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 108 | Continued From page 5<br>equivalence for relieving airway obstruction.<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure 3 of 3 audited staff (#1, #2 & House Manager) received training to meet the MH/DD/SA needs of the clients. The findings are:<br><br>Review on 8/13/24 of staff #1's personnel record revealed:<br>- Hired 7/31/23<br>- No documentation of diabetes management or insulin administration training<br><br>Review on 8/13/24 of staff #2's personnel record revealed:<br>- Hired 2/28/23<br>- No documentation of diabetes management and insulin administration training<br><br>Review on 8/13/24 of the House Manager's personnel record revealed:<br>- Hired 5/3/24<br>- No documentation of diabetes management and insulin administration training<br><br>Interview on 8/12/24 client #1 reported:<br>- Been a diabetic since 5 years old<br>- Wore a monitor that checked his blood sugar (BS) levels 24 hours a day | V 108 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 108 | Continued From page 6<br>- Injected insulin up to 6 times a day after meals<br><br>Attempted interviews on 9/4/24 with staff #1 was unsuccessful because staff #1 didn't return the phone calls.<br><br>Interview on 9/4/24 staff #2 reported:<br>- Client #1 was a diabetic<br>- Monitored client #1's BS readings and insulin injections<br>- Was trained in diabetes management and insulin administration during the medication administration training<br><br>Interviews on 8/13/24 & 8/15/24 the House Manager reported:<br>- Client #1 was diabetic<br>- Client #1 wore a Dexcom to monitor his BS levels<br>- She worried about the "lack of monitoring" of client #1's BS levels<br>- Had previous knowledge about diabetes and insulin administration, but hadn't received any training at the facility<br><br>Interviews on 8/13/24 & 8/15/24 the Qualified Professional/Licensee reported:<br>- Was responsible for coordinating staff trainings<br>- Staff wasn't trained in diabetes management or insulin administration<br>- Client #1 was the first client with diabetes in the facility<br>- Planned to coordinate with the facility's nurse to train staff in diabetes management and insulin administration | V 108 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 109 | Continued From page 7 | V 109 | | |
| V 109 | 27G .0203 Privileging/Training Professionals<br><br>10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS<br>(a) There shall be no privileging requirements for qualified professionals or associate professionals.<br>(b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served.<br>(c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.<br>(d) Competence shall be demonstrated by exhibiting core skills including:<br>(1) technical knowledge;<br>(2) cultural awareness;<br>(3) analytical skills;<br>(4) decision-making;<br>(5) interpersonal skills;<br>(6) communication skills; and<br>(7) clinical skills.<br>(e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS.<br>(f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional.<br>(g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. | V 109 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 109 | Continued From page 8<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure 1 of 1 audited Qualified Professional (QP/Licensee) demonstrated the knowledge, skills and abilities required by the population served. The findings are:<br><br>Review on 8/16/24 of the QP/Licensee personnel record revealed:<br>- Hired 5/3/13<br>- Signed CEO/Manager job description dated 12/12/08:<br>- "Managing day to day operations of the facility"<br>- "Provide supervision to clients to ensure a safe and therapeutic environment"<br>- "Will assist emotionally and behaviorally disturbed residents with routine, daily living activities in a healthcare home/facility"<br><br>Review on 8/15/24 of the facility's record revealed:<br>- An elopement policy: "...2. Begin to look for the person on surrounding property (If you are alone call the local sheriff department to notify them you have a runaway and wait for another staff member to come before you leave the premises)..."<br><br>Unable to interview former client (FC) #5 during the survey because FC #5 was discharged from the facility and contact information was not provided.<br><br>Attempted interviews on 8/14/24 & 8/20/24 with FC #5's guardian was unsuccessful because FC | V 109 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 109 | Continued From page 9 | V 109 | | |

#5's guardian elected not to disclose any information without approval from her supervisor and didn't return any follow-up phone calls, but FC #5's guardian did verify on 8/14/24 that FC #5 eloped from the facility prior to being discharged.

Interview on 8/16/24 the House Manager reported:
- FC #5 eloped from the facility on multiple occasions, but couldn't recall the dates
- FC #5 crawled out of the window while she was administering the clients' medications
- She notified the Qualified Professional (QP)/Licensee of FC #5's elopement
- She asked the QP/Licensee if she should drive around the neighborhood to look for FC #5 and call 911 and the QP/Licensee said "no..he (FC #5) was 18 (years old)"
- Was trained to do the following when clients eloped from the facility:
- Watch where the client went
- Go after the client and try to talk them into the car if there was more than one staff in the facility
- Notify the QP/Licensee and the police

Interviews on 8/13/24 & 9/4/24 the QP/Licensee reported:
- FC #5 eloped from the facility, but he couldn't recall when
- The House Manager "rode around the neighborhood" to look for FC #5, but she was unsuccessful
- Staff didn't call the police when FC #5 eloped, but he notified FC #5's Department of Social Service (DSS) guardian
- FC #5 was located at a local hospital and was returned back to the facility, but he couldn't recall any dates
- FC #5 eloped again about a month after first incident

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 109 | Continued From page 10<br>- Told the House manager to not call 911 anytime FC #5 eloped because FC #5 was 18 years old | V 109 | | |
| V 111 | 27G .0205 (A-B)<br>Assessment/Treatment/Habilitation Plan<br><br>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN<br>(a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to:<br>(1) the client's presenting problem;<br>(2) the client's needs and strengths;<br>(3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission;<br>(4) a pertinent social, family, and medical history; and<br>(5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs.<br>(b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. | V 111 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 111 | Continued From page 11 | V 111 | | |

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure an admission assessment for 1 of 2 former clients (FC #5) was completed prior to the delivery of services. The findings are:

Review on 8/13/24 of FC #5's record revealed:
- Admitted 10/6/23 & discharged 4/17/24
- Age 18
- No admission assessment documenting the following information:
- Presenting problems
- Needs and strengths
- Admitting diagnoses
- Social, family, or medical history
- Evaluations or assessments

Review on 9/6/24 of an email sent from the Qualified Professional (QP)/Licensee on 9/6/24 revealed:
- FC #5's diagnoses were Post Traumatic Stress Disorder w/ Dissociative Symptoms & Persistent Depressive Disorder (Dysthymia), with History of Intermittent Major Depressive Episodes, with Anxious Distress

Unable to interview FC #5 during the survey because FC #5 was discharged from the facility and contact information was not provided.

Attempted interviews on 8/14/24 & 8/20/24 with FC #5's guardian was unsuccessful because FC #5's guardian elected not to disclose any information without approval from her supervisor and didn't return any follow-up phone calls.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 111 | Continued From page 12<br><br>Interview on 8/15/24 the House Manager reported:<br>- FC #5 was "placed" in the facility<br>- Didn't know FC #5's diagnoses<br>- Didn't have to document any notes on FC #5 because he was a respite client<br><br>Interviews on 8/12/24 & 8/20/24 the Qualified Professional (QP) #2 reported:<br>- FC #5 was a crisis respite client that received temporary placement in the facility<br>- The QP/Licensee was responsible for completing clients' admission assessments<br><br>Interviews on 8/12/24 & 8/13/24 the QP/Licensee reported:<br>- Was responsible for completing clients' admission assessments<br>- Didn't have a client record for FC #5, only a face sheet listing FC #5's birth date, admission date & picture<br>- FC #5 was a crisis respite client that was temporarily placed in the facility and had 45 days to discharge<br>- Thought he didn't need a client record for crisis respite clients<br>- The LME/MCO (Local Management Entity/Managed Care Organization) said that he could admit clients for respite services | V 111 | | |
| V 112 | 27G .0205 (C-D)<br>Assessment/Treatment/Habilitation Plan<br><br>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN<br>(c) The plan shall be developed based on the assessment, and in partnership with the client or | V 112 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 112 | Continued From page 13<br>legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.<br>(d) The plan shall include:<br>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;<br>(2) strategies;<br>(3) staff responsible;<br>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;<br>(5) basis for evaluation or assessment of outcome achievement; and<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to develop a plan that included goals and strategies to address the needs of 1 of 2 former clients (FC #5). The findings are:<br><br>Review on 8/13/24 of FC #5's record revealed:<br>- Admitted 10/6/23 & discharged 4/17/24<br>- Age 18<br>- No documentation of a treatment plan<br>- No documentation of goals or strategies to address elopement behavior | V 112 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 112 | Continued From page 14 | V 112 | | |

Review on 9/6/24 of an email sent from the Qualified Professional (QP)/Licensee on 9/6/24 revealed:
- FC #5's diagnoses were Post Traumatic Stress Disorder w/ Dissociative Symptoms & Persistent Depressive Disorder (Dysthymia), with History of Intermittent Major Depressive Episodes, with Anxious Distress

Unable to interview FC #5 during the survey because FC #5 was discharged from the facility and contact information was not provided.

Attempted interviews on 8/14/24 & 8/20/24 with FC #5's guardian was unsuccessful because FC #5's guardian elected not to disclose any information without approval from her supervisor and didn't return any follow-up phone calls, but FC #5's guardian did verify on 8/14/24 that FC #5 eloped from the facility prior to being discharged.

Interview on 8/15/24 the House Manager reported:
- FC #5 was "placed" in the facility
- Didn't know FC #5's diagnoses
- Didn't have to document any notes on FC #5 because he was a respite client
- FC #5 eloped from the facility on multiple occasions, but couldn't recall the dates

Interviews on 8/12/24 & 8/20/24 the Qualified Professional (QP) #2 reported:
- FC #5 was a crisis respite client that received temporary placement in the facility
- The QP/Licensee was responsible for completing clients' admission assessments

Interviews on 8/12/24 & 8/13/24 the QP/Licensee reported:

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 112 | Continued From page 15<br>- FC #5 eloped from the facility on different occasions, but he couldn't recall the dates<br>- Was responsible for completing the clients' treatment plans<br>- Didn't have a client record for FC #5, only a face sheet listing FC #5's birth date, admission date & picture<br>- FC #5 was a crisis respite client that was temporarily placed in the facility and had 45 days to discharge<br>- Thought he didn't need a client record for crisis respite clients<br>- Didn't complete an admission assessment for FC #5 because he was a crisis respite client<br>- The LME/MCO (Local Management Entity/Managed Care Organization) said that he could admit clients for respite services | V 112 | | |
| V 113 | 27G .0206 Client Records<br><br>10A NCAC 27G .0206 CLIENT RECORDS<br>(a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to:<br>(1) an identification face sheet which includes:<br>(A) name (last, first, middle, maiden);<br>(B) client record number;<br>(C) date of birth;<br>(D) race, gender and marital status;<br>(E) admission date;<br>(F) discharge date;<br>(2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV;<br>(3) documentation of the screening and assessment;<br>(4) treatment/habilitation or service plan;<br>(5) emergency information for each client which shall include the name, address and telephone | V 113 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 16<br>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;<br>(6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician;<br>(7) documentation of services provided;<br>(8) documentation of progress toward outcomes;<br>(9) if applicable:<br>(A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM);<br>(B) medication orders;<br>(C) orders and copies of lab tests; and<br>(D) documentation of medication and administration errors and adverse drug reactions.<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to maintain client records for 1 of 2 former clients (FC #5). The findings are:<br><br>Review on 8/13/24 of FC #5's record revealed:<br>- Admitted 10/6/23 & discharged 4/17/24<br>- Age 18<br>- No documentation of the following information:<br>- Screening and assessment<br>- Treatment plan | V 113 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 17<br>- Emergency contact information<br>- Signed consent granting permission to seek emergency care<br>- Documentation of services provided & documented progress toward outcomes<br><br>Review on 9/6/24 of an email sent from the Qualified Professional (QP)/Licensee on 9/6/24 revealed:<br>- FC #5's diagnoses were Post Traumatic Stress Disorder w/ Dissociative Symptoms & Persistent Depressive Disorder (Dysthymia), with History of Intermittent Major Depressive Episodes, with Anxious Distress<br><br>Unable to interview FC #5 during the survey because FC #5 was discharged from the facility and contact information was not provided.<br><br>Attempted interviews on 8/14/24 & 8/20/24 with FC #5's guardian was unsuccessful because FC #5's guardian elected not to disclose any information without approval from her supervisor and didn't return any follow-up phone calls.<br><br>Interviews on 8/15/24 the House Manager reported:<br>- FC #5 was "placed" in the facility<br>- Didn't know FC #5's diagnoses<br>- Didn't have to document any notes on FC #5 because he was a respite client<br>- FC #5 eloped from the facility on multiple occasions, but couldn't recall the dates<br><br>Interviews on 8/12/24 & 8/20/24 the Qualified Professional (QP) #2 reported:<br>- The QP/Licensee was responsible for maintaining the clients' records<br>- Was responsible for reviewing and authorizing clients' progress notes | V 113 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 18<br>- There were no progress notes for FC #5 because FC #5 was a crisis respite client that received temporary placement in the facility<br><br>Interviews on 8/12/24 & 8/13/24 the QP/Licensee reported:<br>- Responsible for maintaining client records<br>- Didn't have a client record for FC #5, only a face sheet listing FC #5's birth date, admission date & picture<br>- FC #5 was a crisis respite client that was temporarily placed in the facility and had 45 days to discharge<br>- Thought he didn't need a client record for crisis respite clients<br>- The LME/MCO (Local Management Entity/Managed Care Organization) said that he could admit clients for crisis respite | V 113 | | |
| V 118 | 27G .0209 (C) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(c) Medication administration:<br>(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.<br>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.<br>(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.<br>(4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be | V 118 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 19<br>recorded immediately after administration. The MAR is to include the following:<br>(A) client's name;<br>(B) name, strength, and quantity of the drug;<br>(C) instructions for administering the drug;<br>(D) date and time the drug is administered; and<br>(E) name or initials of person administering the drug.<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure the MAR was kept current for 1 of 3 audited client (#1). The findings are:<br><br>Review on 8/13/24 of client #1's record revealed:<br>- Admitted 5/14/24<br>- Age 17<br>- Diagnoses of Type 1 Diabetes, Major Depressive Disorder, Posttraumatic Stress Disorder (PTSD) & Cannabis Use Disorder<br>- Physician order dated 7/29/24 for the following:<br>- Dexcom G7 Sensor & Receiver use as directed to monitor glucose levels (Diabetes)<br>- Glucagon 1mg inject 0.2 mL (milliliter) under the skin as needed (Severe Hypoglycemia)<br>- Insulin Lispro Injection Pen inject subcutaneously as directed up to max daily dose (MDD) of 50 units (Diabetes)<br>- Insulin Lispro Injection Pen inject | V 118 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 20<br>subcutaneously as directed up to MDD of 75 units<br>- Lantus Solostar U (units)-100 Insulin use as directed up to MDD 50 units (Diabetes)<br><br>Review on 8/13/24 of client #1's medication bin revealed the following medications:<br>- Glucagon 1mg inject 0.2 mL<br>- Insulin Lispro Injection Pen<br>- Lantus Solostar U-100<br><br>Review on 8/13/24 of client #1's June, July & August 2024 MARs revealed:<br>- No documentation of blood sugar (BS) readings<br>- No instructions or documentation of administration for the following medications:<br>- Glucagon 1mg inject 0.2 mL<br>- Insulin Lispro Injection Pen<br>- Lantus Solostar U-100<br><br>Review on 8/16/24 of client #1's BS log revealed:<br>- Daily BS readings from 6/1/24-6/10/24<br>- No documentation of BS readings from 6/11/24-8/13/24<br><br>Observation and interview at 8/16/24 at 12:45pm client #1 reported:<br>- Client #1 retrieved two BS logs that contained BS readings from June 1-10, 2024<br>- He no longer documented his BS readings in the BS log after he received his Dexcom<br>- The Dexcom checked his BS readings throughout the day and it stored his BS readings for 90 days<br>- He told staff the BS readings from his Dexcom daily and when he administered his daily insulin<br>- The BS readings in the Dexcom was reviewed during his appointments with his Primary Care Provider | V 118 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 21<br><br>Interview on 8/14/24 client #1's guardian reported:<br>- Client #1 monitored his BS levels and administered his own insulin<br>- Felt client #1 was capable of monitoring his BS levels and administer his insulin<br><br>Attempted interviews on 9/4/24 with staff #1 was unsuccessful because staff #1 didn't return the phone calls.<br><br>Interview on 9/4/24 staff #2 reported:<br>- Client #1 was a diabetic and was "independent" in monitoring his BS levels<br>- Client #1 administered his insulin<br>- Client #1 documented his BS readings in a BS log<br>- Was told that client #1 "knew what he was doing"<br><br>Interviews on 8/13/24 & 8/15/24 the House Manager reported:<br>- Client #1 was a diabetic and was prescribed insulin<br>- Was worried about the "lack of monitoring of his BS" in the facility<br>- Client #1 checked his BS levels and administered his own insulin before meals<br>- Didn't have anything to document client #1's BS readings or insulin administration<br>- Staff didn't document client #1's BS readings or insulin administration on his MAR<br>- When client #1 was admitted into the facility she told him to write his BS readings down in a BS log, "but he (client #1) half did it"<br>- Was "familiar" with client #1's Dexcom, but she didn't document the BS readings down<br>- Client #1 "been doing it (monitoring BS readings and insulin administration) all himself" | V 118 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 22<br>- No one showed her how to administer insulin<br>- She asked client #1's guardian, but he never gave her an answer<br><br>Interview on 8/20/24 the QP #2 reported:<br>- Was responsible for overseeing the clients' medications and MARs<br>- Was out on medical leave in June 2024 and she just returned back to work<br>- Trained staff on monitoring client #1's BS levels<br>- Showed staff how to read client #1's glucometer<br>- Client #1 was supposed to show staff his Dexcom readings and staff was supposed to document those readings in client #1's BS log<br>- Client #1's MAR didn't have client #1's insulin medication listed because "staff didn't do it (administer insulin)"<br>- Client #1 administered his own insulin because client #1 knew how to administer his own insulin<br>- Client #1's guardian told them that client #1 can administer his own insulin<br>- "He's pretty much managing his own meds (medications)"<br>- Staff was supposed to check with client #1 to ensure he took his insulin<br><br>Interviews on 8/13/24 & 8/16/24 the QP/Licensee reported:<br>- The QP #2 was responsible for overseeing the clients' medications and MARs<br>- Was unaware client #1's diabetic medications and BS readings weren't documented on the MARs<br>- Was unaware staff weren't documenting client #1's BS readings and insulin administration<br>- Client #1 monitored his own BS levels and administered his own insulin | V 118 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 23<br>- Purchased client #1 BS logs to document his BS readings<br>- Thought client #1 was still documenting his BS readings in the BS logs | V 118 | | |
| V 120 | 27G .0209 (E) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(e) Medication Storage:<br>(1) All medication shall be stored:<br>(A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit;<br>(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;<br>(C) separately for each client;<br>(D) separately for external and internal use;<br>(E) in a secure manner if approved by a physician for a client to self-medicate.<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review & interview, the facility failed to ensure all medications were stored for 1 of 3 audited clients (#1). The findings are: | V 120 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 24<br><br>Review on 8/13/24 of client #1's record revealed:<br>- Admitted 5/14/24<br>- Age 17<br>- Diagnoses of Type 1 Diabetes, Major Depressive Disorder, Posttraumatic Stress Disorder (PTSD) & Cannabis Use Disorder<br>- Physician order dated 7/29/24 for Lantus Solostar units-100 Insulin use as directed up to MDD 50 units (Diabetes)<br><br>Observations at 1:52pm on 8/13/24 & 3:20pm on 9/4/24 revealed:<br>- Client #1 retrieved his insulin injection pen out of his pant pocket<br><br>Interviews on 8/13/24 & 9/4/24 client #1 reported:<br>- Diagnosed with diabetes at 5 years old<br>- Monitored his blood sugar (BS) levels and injected his own insulin<br>- Always kept his insulin pen on him in his pocket<br>- He administered the insulin after his meals or if his BS was elevated throughout the day<br>- Planned to get physician's order to carry his insulin pen on him<br><br>Interview on 8/14/24 client #1's guardian reported:<br>- Client #1 administered his own insulin<br>- Client #1 was not supposed to carry his daily insulin pen, only his "emergency (insulin) pen" for hyperglycemia<br>- Wasn't aware client #1 carried his daily insulin pen<br>- Felt client #1 was capable of monitoring his BS levels and administer his insulin<br><br>Interview on 8/15/24 the House Manager reported:<br>- Client #1 kept his insulin pen with him all the | V 120 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 25<br>time<br>- Client #1 administered his own insulin before meals<br>- No one showed her how to administer insulin<br>- She asked client #1's guardian but he never gave her an answer<br>- Knew medications should be stored and locked<br><br>Interview on 8/20/24 the Qualified Professional (QP) #2 reported:<br>- Was responsible for overseeing clients' medications<br>- Medications were supposed to be stored and locked<br>- Knew client #1 carried his insulin pen around with him daily<br>- Was told by client #1's guardian that client #1 could carry his insulin pen<br><br>Interview on 8/13/24 the QP/Licensee reported:<br>- Client #1 had diabetes and carried his insulin pen on him daily<br>- Medications were supposed to be stored and locked in the facility<br>- Client #1 carried his insulin pen because he needed his insulin at school | V 120 | | |
| V 132 | G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection<br><br>G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY<br>(g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: | V 132 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 132 | Continued From page 26<br>a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.<br>b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.<br>c. Misappropriation of the property of a healthcare facility.<br>d. Diversion of drugs belonging to a health care facility or to a patient or client.<br>e. Fraud against a health care facility or against a patient or client for whom the employee is providing services).<br>Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to provide evidence that all alleged acts were investigated and failed to notify Health Care Personnel Registry (HCPR) of the allegations within 5 working days for 2 of 3 audited staff (#3 & House Manager). The findings are:<br><br>Finding A.<br><br>Review on 8/16/24 of the House Manager's personnel record revealed:<br>- Hired 5/3/13<br>- Title: Paraprofessional | V 132 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 132 | Continued From page 27<br><br>Review on 8/28/24 of Former Client (FC) #5's hospital medical records dated 4/11/24 revealed:<br>- "Patient (FC #5) reports to me that this morning the group home employee [House Manager] came into his room accusing him of using her card to order off [online store] and trying to take her car, he states she was holding a pot in her hand and then hit him multiple times with the pot. States that she hit his head, left chest, and left leg several times. He states she also punched him with a fist to this right arm..."<br><br>Review on 8/12/24 & 9/3/24 of the facility's records revealed:<br>- No documentation of an investigation for alleged abuse by the House Manager towards FC #5<br><br>Unable to interview FC #5 during the survey because FC #5 was discharged from the facility and contact information was not provided.<br><br>Attempted interviews on 8/14/24 & 8/20/24 with FC #5's guardian was unsuccessful because FC #5's guardian elected not to disclose any information without approval from her supervisor and didn't return any follow-up phone calls.<br><br>Interview on 9/3/24 client #2 reported:<br>- FC #5 used the House Manager's phone for a virtual therapy session<br>- FC #5 purchased $1,000 worth of items from an online store that was on the House Manager's phone<br>- The House Manager saw the purchase and asked him what had happened<br>- He got mad and confronted FC #5 about the purchase<br>- He punched FC #5 in the arm for stealing from the House Manager | V 132 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 132 | Continued From page 28<br>- The House Manager never went into FC #5's bedroom<br>- Never saw the House Manager with a pot<br>- The House Manager didn't hit FC #5 with a pot<br>- The next day FC #5 eloped from the facility, but he came back<br><br>Interviews on 8/15/24 & 9/3/24 the House Manager reported:<br>- She pressed charges on FC #5 because he went into an online store on her phone and charged items to her bank card<br>- She called the police when she saw the charges, but she couldn't recall the exact date<br>- The next day FC #5 eloped from the facility<br>- The Qualified Professional (QP)/Licensee called her and asked if she hit FC #5<br>- She never touched FC #5 and FC #5 was known to fabricate stories<br><br>Interview 9/4/24 the QP/Licensee reported:<br>- He conducted an investigation for the House Manager's allegation of abuse, but he didn't type a report<br>- He spoke with client #2 and the House Manager<br>- Client #2 said "he (FC #5) was lying" and the House Manager denied the allegation<br>- Was responsible for notifying the HCPR<br>- Didn't notify the HCPR of the allegation of abuse because he felt FC #5 was just retaliating because the House Manager pressed charges against him<br><br>Finding B.<br><br>Review on 8/16/24 of staff #3's personnel record revealed:<br>- Hired 5/11/23 & terminated 8/23/24 | V 132 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 132 | Continued From page 29<br>- Title: Paraprofessional<br><br>Review on 9/3/24 of the facility's records revealed:<br>- Incident report dated 8/23/24: "Staff [staff #3's first initial & last name] called the client (client #3) a "f*ggot"<br><br>Interview on 9/3/24 client #1 reported:<br>- Staff #3 called client #3 a "f*ggot" and the clients reported it to the QP/Licensee<br>- Staff #3 was no longer working in the facility<br><br>Interview on 9/3/24 client #2 reported:<br>- Staff #3 and client #3 were "fussing" a couple of weeks ago<br>- Staff #3 called client #3 a "f*ggot"<br>- The clients reported staff #3 when the QP/Licensee arrived at the facility that night<br>- The QP/Licensee fired staff #3 the same night<br><br>Interview on 9/3/24 client #3 reported:<br>- He and staff #3 got into an argument<br>- Staff #3 called him a "f*ggot" and it made him mad<br>- He reported staff #3 to the QP/Licensee and the QP/Licensee fired staff #3<br><br>Interview on 9/3/24 client #4 reported:<br>- Staff #3 called client #3 a "f*ggot," but "[QP/Licensee] took care of that"<br>- Staff #3 no longer worked in the facility<br><br>Interview on 9/3/24 the QP/Licensee reported:<br>- Conducted an investigation regarding staff #3 calling client #3 a "f*ggot" around 8/22/24 or 8/23/24<br>- Staff #3 admitted to calling client #3 a "f*ggot"<br>- He immediately fired staff #3 for the | V 132 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 132 | Continued From page 30<br>derogatory comment<br>- Was responsible for notifying the HCPR, but he didn't notify them of the allegation | V 132 | | |
| V 179 | 27G .1301 Residential Tx - Scope<br><br>10A NCAC 27G .1301 SCOPE<br>(a) The rules of this Section apply only to a residential treatment facility that provides residential treatment, level II, program type service.<br>(b) A residential treatment facility providing residential treatment, level III service, shall be licensed as set forth in 10A NCAC 27G .1700.<br>(c) A residential treatment facility for children and adolescents is a free-standing residential facility which provides a structured living environment within a system of care approach for children or adolescents who have a primary diagnosis of mental illness or emotional disturbance and who may also have other disabilities.<br>(d) Services shall be designed to address the functioning level of the child or adolescent and include training in self-control, communication skills, social skills, and recreational skills. Children or adolescents may receive services in a day treatment facility, have a job placement, or attend school.<br>(e) Services shall be designed to support the child or adolescent in gaining the skills necessary to return to the natural, or therapeutic home setting.<br>(f) The residential treatment facility shall coordinate with other individuals and agencies within the client's system of care. | V 179 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 179 | Continued From page 31 | V 179 | | |

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to operate within the scope of their level II program affecting 1 of 1 former client (FC #5). The findings are:

Review on 8/13/24 of FC #5's record revealed:
- Admitted 10/6/23 & discharged 4/17/24
- Age 18

Review on 9/6/24 of an email sent from the Qualified Professional (QP)/Licensee on 9/6/24 revealed:
- FC #5's diagnoses were Post Traumatic Stress Disorder w/ Dissociative Symptoms & Persistent Depressive Disorder (Dysthymia), with History of Intermittent Major Depressive Episodes, with Anxious Distress

Unable to interview FC #5 during the survey because FC #5 was discharged from the facility and contact information was not provided.

Attempted interviews on 8/14/24 & 8/20/24 with FC #5's guardian was unsuccessful because FC #5's guardian elected not to disclose any information without approval from her supervisor and didn't return any follow-up phone calls.

Interview on 8/15/24 the House Manager reported:
- FC #5 was a crisis respite client
- Staff didn't have to write progress notes on him because he was crisis respite

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 179 | Continued From page 32<br><br>Interview on 8/12/24 the Qualified Professional #2 reported:<br>- FC #5 was a crisis respite client<br>- Was in the facility temporarily until placement was found<br><br>Interviews on 8/12/24, 8/13/24 & 9/3/24 the QP/Licensee reported:<br>- Wasn't licensed for respite programs<br>- FC #5 was a crisis respite client<br>- FC #5's Local Management Entities/Managed Care Organization told him that he could admit clients to receive respite services until placement was found<br>- Thought he could admit respite clients as long as he didn't go over the number of beds he was licence for | V 179 | | |
| V 366 | 27G .0603 Incident Response Requirements<br><br>10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS<br>(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:<br>(1) attending to the health and safety needs of individuals involved in the incident;<br>(2) determining the cause of the incident;<br>(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;<br>(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;<br>(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; | V 366 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 33 | V 366 | | |

(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 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;

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 34<br>(B) gather other information needed;<br>(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<br>(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 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<br>(3) immediately notifying the following:<br>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;<br>(B) the LME where the client resides, if different;<br>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;<br>(D) the Department;<br>(E) the client's legal guardian, as applicable; and<br>(F) any other authorities required by law. | V 366 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 35<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to issue a written preliminary finding of fact to the Local Management Entity/Managed Care Organization (LME/MCO) within five working days of the incidents. The findings are:<br><br>Review on 8/12/24 of the facility's records revealed:<br>- No documentation of an investigation for the following level II incidents:<br>- The House Manager contacted the police and pressed charges against FC #5 for an unauthorized purchase on her bank card. After FC # was confronted about purchase, he eloped from the facility and alleged that he was abused by the House Manager<br>- Clients #1 & #2 use of an illegal substance which resulted in Emergency Services (EMS) being called to the facility to aid client #2<br>- FC #7's elopement<br><br>Review on 9/3/24 of the facility's records revealed:<br>- Incident report dated 8/23/24: "Staff [staff #3's first initial & last name] called the client (client #3) a "f*ggot"<br><br>Interview 9/4/24 the Qualified Professional/Licensee reported:<br>- Was responsible for conducting investigtions and notifying the LME/MCO<br>- Was responsible for submitting the preliminary findings of fact to the LME/MCO<br>He conducted an investigation for the House Manager's allegation of abuse, but he didn't type a report or submit the findings to the LME/MCO | V 366 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 36<br>because FC #5 was a crisis respite client<br>- He conducted an investigation for staff #3, but he didn't submit the investigation to the LME/MCO<br>- He didn't conduct an investigation or submit an IRIS for FC #7's elopment or client #2 smoking a THC vape<br><br>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. | V 366 | | |
| V 367 | 27G .0604 Incident Reporting Requirements<br><br>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS<br>(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:<br>(1) reporting provider contact and identification information;<br>(2) client identification information;<br>(3) type of incident;<br>(4) description of incident;<br>(5) status of the effort to determine the cause of the incident; and<br>(6) other individuals or authorities notified | V 367 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 37 | V 367 | | |

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. 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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 38<br>definition of a level II or level III incident;<br>(2) restrictive interventions that do not meet the definition of a level II or level III incident;<br>(3) searches of a client or his living area;<br>(4) seizures of client property or property in the possession of a client;<br>(5) the total number of level II and level III incidents that occurred; and<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to report all level II incidents in the Incident Response Improvement System (IRIS) and notify the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours of becoming aware of the incident for 3 of 4 clients (#1, #2 & #3) and 2 of 2 former clients (FC #5 & #7). The findings are:<br><br>Review on 8/12/24 & 9/3/24 of IRIS system revealed:<br>- No IRIS reports for the following level II incidents:<br>- A. The House Manager contacted the police and pressed charges against FC #5 for an unauthorized purchase on her bank card. After FC # was confronted about purchase, he eloped | V 367 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 39 | V 367 | | |

from the facility and alleged that he was abused by the House Manager
- B. Allegation of abuse by staff #3 towards client #3
- C. Clients #1 & #2's use of an illegal substance which resulted in Emergency Services (EMS) being called to the facility to aid client #2
- D. FC #7's elopement

Finding A.

Review on 8/13/24 of FC #5's record revealed:
- Admitted 10/6/23 & discharged 4/17/24
- Age 18

Review on 9/6/24 of an email sent from the Qualified Professional (QP)/Licensee on 9/6/24 revealed:
- FC #5's diagnoses were Post Traumatic Stress Disorder (PTSD) w/ Dissociative Symptoms & Persistent Depressive Disorder (Dysthymia), with History of Intermittent Major Depressive Episodes, with Anxious Distress

Review on 8/20/24 of a police report dated 4/9/24 revealed:
- "Caller (House Manager) stated a male (FC #5) purchased items on her phone on [online store] when he was using it for a zoom call with his therapist. Caller stated she did not want to pursue charges but only wanted me to talk to this individual (FC #5). I spoke to this individual..."

Review on 8/28/24 of FC #5's hospital medical records dated 4/11/24 revealed:
- "Patient (FC #5) reports to me that this morning the group home employee [House Manager] came into his room accusing him of using her card to order off [online store] and trying to take her car, he states she was holding a

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 40 | V 367 | | |

pot in her hand and then hit him multiple times with the pot. States that she hit his head, left chest, and left leg several times. He states she also punched him with a fist to this right arm..."

Unable to interview FC #5 during the survey because FC #5 was discharged from the facility and contact information was not provided.

Attempted interviews on 8/14/24 & 8/20/24 with FC #5's guardian was unsuccessful because FC #5's guardian elected not to disclose any information without approval from her supervisor and didn't return any follow-up phone calls, but FC #5's guardian did verify on 8/14/24 that FC #5 eloped from the facility prior to being discharged.

Interview on 9/3/24 client #2 reported:
- FC #5 used the House Manager's phone for a virtual therapy session
- FC #5 purchased $1,000 worth of items from an online store that was on the House Manager's phone
- The House Manager saw the purchased and asked him what had happened
- He got mad and confronted FC #5 about the purchase
- He punched FC #5 in the arm for stealing from the House Manager
- The House Manager never went into FC #5's bedroom
- Never saw the House Manager with a pot
- The House Manager didn't hit FC #5 with a pot
- The next day FC #5 eloped from the facility, but he came back

Interviews on 8/15/24 & 9/3/24 the House Manager reported:
- She pressed charges on FC #5 because he

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 41 | V 367 | | |

went into her online store on her phone and charged items
- She called the police when she saw the charges, but she couldn't recall the exact date
- The next day FC #5 eloped from the facility
- FC #5 was located at a local hospital
- The Qualified Professional (QP)/Licensee called her and asked if she hit FC #5
- She never touched FC #5 and FC #5 was known to fabricate stories
- Wrote an incident report regarding the theft and elopement and gave it to the QP/Licensee

Interviews on 8/12/24 the QP #2 reported:
- The facility called the police when FC #5 eloped from the facility, but she couldn't recall the exact date

Finding B.

Review on 8/13/24 of client #3's record revealed:
- Admitted 7/3/24
- Age 12
- Diagnoses of Oppositional Defiant Disorder & Attention Deficit Hyperactivity Disorder (ADHD) Combined Type

Review on 8/12/24 & 9/3/24 of the facility's records revealed:
- Incident report dated 8/23/24: "Staff [staff #3's first initial & last name] called the client (client #3) a "f*ggot"

Interview on 9/3/24 client #1 reported:
- Staff #3 called client #3 a "f*ggot" and the clients reported it to the QP/Licensee
- Staff #3 was no longer working in the facility

Interview on 9/3/24 client #2 reported:
- Staff #3 and client #3 were fussing a couple

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 42 | V 367 | | |

of weeks ago
- Staff #3 called client #3 a "f*ggot"
- All of the clients reported staff #3 when the QP/Licensee arrived at the facility that night
- The QP/Licensee fired staff #3 the same night

Interview on 9/3/24 client #3 reported:
- He and staff #3 got into an argument
- Staff #3 called him a "f*ggot" and it made him mad
- He reported staff #3 to the QP/Licensee and the QP/Licensee fired staff #3

Interview on 9/3/24 client #4 reported:
- Staff #3 called client #3 a "f*ggot," but "[QP/Licensee] took care of that"
- Staff #3 no longer worked in the facility

Interview on 9/3/24 the QP/Licensee reported:
- Conducted an investigation regarding staff #3 calling client #3 a "f*ggot" around 8/22/24 or 8/23/24
- Staff #3 admitted to calling client #3 a "f*ggot"
- He immediately fired staff #3 for the derogatory comment
- Was responsible for submitting IRIS reports and notifying the LME/MCO, but he didn't

Finding C.

Review on 8/13/24 of client #1's record revealed:
- Admitted 5/14/24
- Age 17
- Diagnoses of Type 1 Diabetes, Major Depressive Disorder, Posttraumatic Stress Disorder (PTSD) & Cannabis Use Disorder

Review on 8/13/24 of client #2's record revealed:
- Admitted 4/27/23

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 43<br>- Age 15<br>- Diagnoses of PTSD & Adjustment Disorder<br><br>Attempt on 8/23/24 to review client #2's EMS Runsheet but was unsuccessful because client #2 was not transported to the hospital; therefore, there was no record found for the incident.<br><br>Interview on 8/12/24 client #1 reported:<br>- He brought a tetrahydrocannabinol (THC) vape into the facility about 3-4 months ago<br>- He got the THC vape pen from school<br>- He and client #2 smoked the THC vape and client #2 got sick<br>- He didn't say anything about it to staff, but staff saw client #2 acting weird<br>- Staff called the QP #2 and EMS<br>- EMS came and checked on client #2<br>- Client #2 wasn't transported to the hospital<br><br>Interview on 8/12/24 client #2 reported:<br>- Client #1 brought THC in the facility<br>- He smoked the THC vape with client #1<br>- "I thought I was dying"<br>- His heart started slowing down, he threw up and passed out three times<br>- Staff were in the facility but they didn't know about the THC vape<br>- Staff saw him sick and called the QP #2 and House Manager<br>- EMS was called and he was evaluated<br>- He admitted to smoking the THC vape after EMS arrived<br>- EMS told him that he was allergic to THC, but he was not transported to the hospital<br><br>Interview on 8/12/24 the QP #2 reported:<br>- Knew clients had used drugs in the facility but couldn't recall when<br>- Wasn't at the facility the day client #1 & #2 | V 367 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 44 | V 367 | | |

smoked the THC pen
- She received a call from client #2 and he said that he wasn't feeling good
- The House Manager arrived to the facility and EMS was outside attending to client #2
- Was told that client #2 had smoked a THC vape
- Couldn't recall if an investigation or IRIS report was completed
- The QP/Licensee was responsible for conducting investigations and submitting IRIS reports

Finding D.

Review on 9/3/24 of FC #7's record revealed:
- Admitted 9/11/23 and discharge date was unknown
- Age 13
- Diagnoses of Oppositional Defiant Disorder, General Anxiety Disorder, Disruptive Mood Dysregulation Disorder & ADHD

Review on 8/20/24 of a police report dated 9/13/23 revealed:
- "12 YR (year) old male b/m (black male) [FC #7] upset with workers at group home and he is out by the stop sign at the road wearing all black...[FC #7] was back at the residence upon my arrival..."

Interview on 8/12/24, 8/29/24, & 9/4/24 the QP/Licensee reported:
- FC #5 eloped from the facility "around April (2024)" but he couldn't recall the exact date
- He contacted FC #5's Department of Social Services Guardian when FC #5 eloped
- FC #5 was located at a local hospital
- While in the hospital, FC #5 alleged that the House Manager assaulted him in April (2024)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 45<br>- FC #5 eloped again a month later and he discharged him from the facility<br>- He conducted an investigation for the House Manager's allegation of abuse, but he didn't type a report<br>- He spoke with client #2 and the House Manager<br>- Client #2 said "he (FC #5) was lying" and the House Manager denied the allegation<br>- FC #5 was "trying to retaliate for [House Manager] pressing charges on him"<br>- Client #1 brought a vape in the facility<br>- Clients #1 and #2 "probably snuck out and done something like that (smoke THC vape)"<br>- Thought client #1 had access to a cellphone and called someone to drop off the THC vape at the facility<br>- Couldn't remember when the incident occurred and didn't know all of the details concerning the incident<br>- Was told about an incident when staff believed that client #2 "may have gotten something (drugs) from the park<br>- Staff called EMS to check on client #2 because staff said client #2 wasn't acting right, but "that was a while back"<br>- FC #7 was in the facility for a short time<br>- Couldn't recall FC #7's elopement on 9/13/24<br>- He didn't conduct an investigation or submit an IRIS for FC #7 or client#2's level II incidents<br>- Was responsible for submitting level II IRIS reports and notifying the LME/MCO, but he didn't because FC #5 was a crisis respite client<br><br>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. | V 367 | | |
| V 736 | 27G .0303(c) Facility and Grounds Maintenance | V 736 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 46<br>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the facility was not maintained in an attractive and clean manner. The findings are:<br><br>Observation at 2:18pm on 9/3/24 revealed:<br>- Interior:<br>- Client #2 & 4's bedroom:<br>- Bedroom door had a crack approximately 3 inches long<br>- An unpainted patched area approximately 4 inches wide located on the wall near the bedroom door<br>- An unpainted patched area approximately 3 inches wide located on the wall near the bedroom window<br>- Client #1's bedroom wall had a whole approximately the size of a soccer ball located behind the bedroom door<br>- Exterior:<br>- Large black SUV with two flat tires in the facility's driveway<br><br>Interview on 2/29/24 the Qualified Professional/Licensee reported:<br>- Was responsible for overseeing the repairs in the facility<br>- Clients damaged the blinds by pulling on them<br>- The holes in the walls came from a previous client<br>- Planned to have the walls repaired and painted when he received an anticipated grant | V 736 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL051-170 | A. BUILDING: _____ B. WING _____ | R-C 09/06/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHILDREN UNDER CONSTR TREATMENT CEN | 42 JEWEL LANE FOUR OAKS, NC 27524 |

| (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 47<br>-<br>This deficiency has been cited 6 times since the original cite on 4/12/19 and must be corrected within 30 days. | V 736 | | |