Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: MHL060-586 B. WING 08/07/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6807 IDLEWILD BROOK LANE IDLEWILD HOME CHARLOTTE, NC 28212 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX (X5)PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual and complaint survey was completed on 8/7/24. The complaints were unsubstantiated (NC00220088, NC00220094). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment Facilities For Children & Adolescents. This facility is licensed for 4 clients and has a current census of 4. The survey sample consisted of audits of 3 current clients. V 114 27G .0207 Emergency Plans and Supplies V 114 10A NCAC 27G .0207 EMERGENCY PLANS PCS will ensure disaster drills are held at least quarterly and repeated for each shift. AND SUPPLIES PCS will do an in-service on Fire and Disaster Drills requirements with staff. (a) Each facility shall develop a written fire plan Monitor by: Program Manager Clinical Director and QA/QI Director Complete date: 10/6/2024 and ongoing and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies. (d) Each facility shall have a first aid kit accessible for use.

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Marisil Burgos, MA QP

TITLE

NWHU11

(X6) DATE

QAQI Director 9/19/2024

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED MHL060-586 B. WING_ 08/07/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6807 IDLEWILD BROOK LANE IDLEWILD HOME CHARLOTTE, NC 28212 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 1 V 114 This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure fire and disaster drills were completed on each shift and quarterly. The findings are: Attempted review on 8/2/24, 8/5/24 and 8/7/24 of the facility's fire and disaster drills revealed: - On 8/2/24 requested fire and disaster drill documentation from Staff #2 and the Program Manager; - On 8/5/24 requested fire and disaster drill documentation from the Quality Assurance (QA)/ Quality Improvement (QI) Director: - No fire and disaster drill documentation were provided prior to survey exit on 8/7/24 at 3:55pm. Interview on 8/2/24 with Client #2 revealed: - Had not completed a fire or disaster drill in - Did not know where to go if there were a fire; - Did not know what to do if there were a disaster like a tornado Interview on 8/2/24 with Client #3 revealed: - Had no fire or disaster drill since she arrived on 7/23/24. Interview on 8/2/24 with Client #4 revealed: - Had not completed a fire or disaster drill since she arrived on 6/6/24; - Did not know where to go if there were a fire; - Did not know what to do if there were a disaster like a tornado. Interview on 8/7/24 with Staff #1 revealed: - Completed a fire drill on 8/6/24

- Had not "done one lately, haven't done one in Division of Health Service Regulation

	- Tricatti Service (Yegt	T				
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) D	ATE SURVEY
		DELTHIO ATION HOMBER.	A. BUILDING: _		CC	OMPLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E ZIP CODE		
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V 114	Continued From page	2	V 114			
	quite a while;"					
	- "To my knowledge th	ey are done monthlynot				
	certain if they are done	e regularly."				
		en sen sen en e				
	Interview on 8/7/24 wit					
	- Duties included fire d					
	- "Did a fire drill this me	onth, I think."				
1	Interview on 8/6/24 wit	h Stoff #2 counciled				
	- "[Program Manager]					
	-"I haven't done since I	I've been thereit's usually				
	done in the morning					
	Interview on 8/5/24 with	h the QA/QI Director				
	revealed:					
	- The fire and disaster	drills documentation were				
	located at the facility;					
		er stated they found the				
	book at the facility."					
	Interview on 8/2/24 and	8/7/24 with the Program				
	Manager revealed:	37724 With the Flogram				
	- On 8/2/24, had fire and	d disaster drills				
	documentation at the of	fice due to making copy				
	on yesterday for the Loc	cal Management				
[Entity/Managed Care O	rganization;				
	Found the fire and disa					1
		end and picked it up from				
	the facility to have on to					
	Stated she had the doo he office:	cumentation with her at				
1 22		nail fire and disaster drills				
	on 8/7/24;	iaii iiie aliu uisaster ūriiis				
	No documentation was	made available before				
	exit at 3:55pm on 8/7/24					
Ir	nterview on 8/7/24 with	Clinical Director				
-	evealed:					
		hether fire/disaster drills				
l h	ad been done or whether	er there was				

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: MHL060-586 B. WING 08/07/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6807 IDLEWILD BROOK LANE IDLEWILD HOME CHARLOTTE, NC 28212 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) V 114 Continued From page 3 V 114 documentation. - "Can't confirm it unless I get a copy of it. I send notification requesting it." V 118 27G .0209 (C) Medication Requirements V 118 10A NCAC 27G .0209 MEDICATION PCS will confirm Med order are signed by a person authorized by law to prescribe drugs before admission REQUIREMENTS PCS will ensure a Medication Administration Record (MAR) is kept current and ensure all medications administered are recorded immediately after administration. (c) Medication administration: PCS will train all staff on Medication Administration Record (MAR) and how to document immediately (1) Prescription or non-prescription drugs shall after medication administration. Monitor by: Program Manager, Clinical Director and QA/QI Director only be administered to a client on the written Complete date: 10/6/2024 and ongoing order of a person authorized by law to prescribe (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name: (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the

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drug.

with a physician.

(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation

PRINTED: 08/26/2024 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING MHL060-586 08/07/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6807 IDLEWILD BROOK LANE IDLEWILD HOME CHARLOTTE, NC 28212 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 118 Continued From page 4 V 118 This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure medications were administered on a written order of a physician, failed to ensure medications were available for administration and failed to ensure the MAR was kept current affecting 1 of 3 audited clients (#2). The findings are: Review on 8/5/24 of Client #2's record revealed: - Admission date 10/31/23: - Age 17: - Diagnoses Post Traumatic Stress Disorder, by history; Other Disorders of Psychological Development. - No signed physician orders for Ferrous Sulfate(iron) 325 (milligrams)mg, Take 1 tablet (tab) by mouth, Monday, Wednesday & Friday; Vitamin D3(supplement)5000 units, Take 1(Capsule) cap by mouth in the morning; Vraylar (antidepressant) 3mg, Take 1 cap every morning: Guanfacine (Attention Defcit Hyperactivity Disorder) 1mg, Take 1 tab daily in morning; Lamotrigine (Bipolar) 25mg, Take 2 tabs by mouth daily. Review on 8/2/24 of Client #2's August 1-2, 2024 MAR revealed: - No signatures on 8/1/24 and 8/2/24 for the

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mouth daily.

following medications: Ferrous Sulfate 325mg, Take 1 tab by mouth, Monday, Wednesday & Friday; Vitamin D3 5000 units, Take 1 cap by mouth in the morning; Vraylar 3mg, Take 1 cap every morning; Guanfacin 1mg, Take 1 tab daily in morning; Lamotrigine 25mg, Take 2 tabs by

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ŀ		T		OTTE, NC 28212				
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	V 118	Continued From page	5	V 118				
		revealed: - Ferrous Sulfate 325m - Vraylar 3mg, Guanfac						
		1, 2024- July 31, 2024 medications were admi - The following medicat daily from May 1, 2024 Sulfate 325mg, Take 1 Wednesday & Friday; Vake 1 cap by mouth in Take 1 cap every morni Take 1 tab daily in morn Take 2 tabs by mouth d Observation on 8/7/24 crevealed:	lient #2's MARs from May revealed the following inistered daily: tions were administered - July 31, 2024:Ferrous tab by mouth, Monday, //tamin D3 5000 units, the morning; Vraylar 3mg, ing; Guanfacine 1mg, ning; Lamotrigine 25mg, laily; of Client #2's medication froms were filled on 8/2/24: to every morning; 1 tab daily in morning;					
	f	for a few days;" - "I don't know the name medicines I haven't take	ered "some medications es so I can't tell you which en."					
		nterview on 8/2/24 with "There was no MAR croput the MAR this morning "She (Client #2) received on't know why they (staward or fill out the form; All staff is responsible for filled out each month.	eated for Augustfilled g" on 8/2/24; ed her medications, I					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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V 120	revealed: - Was in charge of the - Reviewed the MARs week;" - Unaware that the MA created until 8/2/24 for - Stated Client #2 had that were sent electror - Did not have physicia physician for Client #2 - Client #2's medicatio pharmacy on 8/2/24. 27G .0209 (E) Medicat 10A NCAC 27G .0209 REQUIREMENTS (e) Medication Storage (1) All medication shall (A) in a securely locked well-lighted, ventilated and 86 degrees Fahrer (B) in a refrigerator, if in degrees and 46 degree refrigerator is used for it shall be kept in a separ or container; (C) separately for each (D) separately for exter (E) in a secure manner for a client to self-medic (2) Each facility that ma controlled substances is registered under the No	medications; "once or twice out of the AR for August was not Client #2; rewritten physician orders nically to the pharmacy; an orders signed by a at the facility; ns were picked up from the ion Requirements MEDICATION ; be stored: d cabinet in a clean, room between 59 degrees wheit; equired, between 36 is Fahrenheit. If the food items, medications ate, locked compartment client; nal and internal use; if approved by a physician cate. intains stocks of hall be currently rth Carolina Controlled 0, Article 5, including any	PCS will recei Monitor by: P	re that all Medication stored in a securely locked cabin we additional training on Medication storage. ogram Manager, Clinical Director and QA/QI Director e: 10/6/2024 and ongoing	et at the fac	lity.

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	(X3) DATE	E SURVEY
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10 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 10 1- 1	, 110ML	CHARLO	OTTE, NC 28212			
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V 120	120 Continued From page 7		V 120			
	This Rule is not met a					
	Based on record review	w, observation and				
	interview the facility fa	iled to ensure medications				
		ked container for 2 of 3				
	audited clients (#2, #3					
	dadited ellerites (#2, #0). The infolligs are.				
	Review on 8/5/24 of Client #2's record revealed:					
	- Admission date 10/31	1/23;				1
	- Age 17;					
Ì	- Diagnoses Post Traur	matic Stress Disorder, by				
	history; Other Disorder	s of Psychological				
	Development.					
	I and a second					1
	Review on 8/5/24 of CI	ient #3's record revealed:				
	- Admission date 7/23/2					1
		24,				
	- Age 17;					
	 Diagnoses Opposition 					
	Attention Deficit Hypera					
	Combined Type; Major					
	Single Recurrent Mode	rate.				
	Observation on 8/7/24 a	at approximately 12:38pm				
	during a tour of the facil	lity revealed:				
	The 3-drawer file cabin					
		vere stored was not locked				
	and 2 of the drawers we					
		in individual black boxes				
						1
1	out the locks were not lo	ocked on the boxes.				
	nterview on 8/7/24 with					
	The file cabinet did not				1	
-	There were keys for th	e individual mediation				
	oxes but the boxes we					
1.0	ock.					
	E 6000190					
1	nterview on 8/7/24 with	Staff #2 revealed:				
1.1	TION ON ON THE T WILL!	Juli HE TOVOCIOU.			1	

PRINTED: 08/26/2024 Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ B. WING MHL060-586 08/07/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6807 IDLEWILD BROOK LANE IDLEWILD HOME CHARLOTTE, NC 28212 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 120 Continued From page 8 V 120 - "We are getting something new ...a whole new cabinet, I don't have the key for that." Interview on 8/7/24 with the Program Manager - "The grey cabinet behind the desk has a top lock and a bottom lock:" - The locks worked on the file cabinet: - The locks locked on the clients medication boxes. V 366 27G .0603 Incident Response Requirements V 366 PCS staff will be re-trained on the internal incident reporting expectations. 10A NCAC 27G .0603 INCIDENT PCS staff will be re-educated on what is defined as an incident and the expectation RESPONSE REQUIREMENTS FOR for the completion and submission of incident reports. CATEGORY A AND B PROVIDERS Monitor by: Clinical Director and QA/QI Director (a) Category A and B providers shall develop and Complete date: 10/6/2024 and ongoing implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: attending to the health and safety needs of individuals involved in the incident; determining the cause of the incident; (2) developing and implementing corrective (3)measures according to provider specified timeframes not to exceed 45 days; developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; assigning person(s) to be responsible for implementation of the corrections and

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164; and

preventive measures;

adhering to confidentiality requirements

maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in

set forth in G.S. 75, Article 2A, 10A NCAC 26B. 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and

DIVISION	of health Service Regu	liation			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Paragraph (a) of this is shall address incident regulations in 42 CFR (c) In addition to their Paragraph (a) of this is providers, excluding IC develop and implement their response to a lew while the provider is door while the client is on The policies shall requibe: (1) immediately by: (1) immediately by: (A) obtaining the (B) making a phoragoral	Rule, ICF/MR providers is as required by the federal Part 483 Subpart I. requirements set forth in Rule, Category A and B CF/MR providers, shall into written policies governing rel III incident that occurs relivering a billable service in the provider's premises. The provider to respond securing the client record client record; a copy's completeness; and the copy to an internal record to the incident. The reall consist of individuals in the incident and who are the client's direct care or a loversight of the client's the incident. The internal reliable to the incident and who are the client's direct care or a loversight of the client's the incident. The internal reliable to the client record t	V 366	DEFICIENCY)	
4	LME in whose catchment area the provider is located and to the LME where the client resides, if different; and				

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DIVISION	of Health Service Regu	lation			
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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IDLEWILD	HOME	CHARLO	TTE, NC 28212		
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	owner within three moderical report shall be see catchment area the property of the client of the catchment area the property of the catchment area the property of the catchment and shall make the catchment and shall make the catchment of the c	written report signed by the onths of the incident. The not to the LME in whose ovider is located and to the resides, if different. The ill address the issues all review team, shall ments pertinent to the ke recommendations for ence of future incidents. If for the report are not months of the incident, the wider an extension of up to to the final report; and notifying the following: consible for the catchment are provided pursuant to the creek client resides, if agency with responsibility dating the client's ent from the reporting	V 366		
1	This Rule is not met as Based on record review facility failed to impleme governing their respons The findings are:	and interviews, the ent written policies			

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1		NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION	(X3) DAT	E SURVEY	
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	(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
	TAG		SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE	
					DEFICIENCY)			
	11,000	2						-
	V 366	Continued From page	11	V 366				
		Review on 8/5/24 of th	ne facility's incident reports					
		from May 1, 2021- Au						
			ysis (RCA) for Client #1's					
			owards client #2. Client #2					
			d stitches on forehead and					
			ical hospital on 5/26/24;					
		- No incident reports o						
		Ferrous Sulfate 325mg, Vitamin D3 5000 units, Vraylar 3mg, Guanfacine 1mg; Lamotrigine 25mg were unavailable on 8/1/24;						
		- No incident reports of						-
			, Vitamin D3 5000 units,					
			ne 1mg; Lamotrigine 25mg					1
		were unavailable on 8/						-
		Train and talled on or	Sear I done 1 4					-
		Interview on 8/7/24 with	h the Program Manager					-
		revealed:	in and mogram manager					-
			ncident report for Client					I
			ing available in the home.					1
		,, = 0 0 0 0	ing available in the norms.					ı
		Interview on 8/7/24 with	the Clinical Director					l
		revealed:						
			oorts along with the Quality					I
		Assurance/Quality Impr						Name of Street
	1		ports once learned of the					l
		incident;	partia arrea fournad ar una					The same
			ining this weekI don't go					l
		to the house like I do a	-		*			
	\/ 367	27G .0604 Incident Rep	acting Requirements	V 367				
	V 307	27G .0604 Incident Rep	porting Requirements	V 367				
		10A NCAC 27G .0604	INCIDENT					
	1		INCIDENT	PCS staff will	ensure all level II and level III incidents are reported v	vithin to th	e LME	
	1	REPORTING REQUIRE CATEGORY A AND B P			r the catchment area where services are provided wi		urs of becoming	
	4			level II and III	cident. QA Director will be responsible for reporting incidents to the LME within 72 hours of becoming aw	all	incident	
		(a) Category A and B p			rogram Manager, Clinical Director and OA/OI Director		incident.	
	4		t deaths, that occur during	E 5	e: 10/6/2024 and ongoing			
		the provision of billable			0.00			
		consumer is on the prov	viders premises or level III					
				1	f .	1		

Division	of Health Service Regu	lation			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL060-586	B. WING		08/07/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE	
		6807 IDL	EWILD BROOK	K LANE	
IDLEWILD	HOME	CHARLO	TTE, NC 2821	2	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD : CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
	to whom the provider 90 days prior to the in responsible for the car services are provided becoming aware of the be submitted on a form Secretary. The report in person, facsimile or means. The report sh information: (1) reporting providentification information (2) client identification information (3) type of incidentification information (4) description of (5) status of the cause of the incident; as (6) other individuor responding. (b) Category A and B missing or incomplete shall submit an update report recipients by the day whenever: (1) the provider of information provided in erroneous, misleading (2) the provider of required on the incident unavailable. (c) Category A and B pupon request by the LN obtained regarding the (1) hospital recominformation; (2) reports by oth control of the provider's of the provider's the provider's control of the provider's the provider's control of th	deaths involving the clients rendered any service within cident to the LME techment area where within 72 hours of a incident. The report shall m provided by the may be submitted via mail, encrypted electronic all include the following ovider contact and on; cation information; ent; if incident; effort to determine the and uals or authorities notified providers shall explain any information. The provider d report to all required a end of the next business has reason to believe that the report may be or otherwise unreliable; or obtains information at form that was previously providers shall submit, ME, other information incident, including: reds including confidential her authorities; and response to the incident.	V 367		
	(d) Category A and B providers shall send a copy				

PRINTED: 08/26/2024 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DESCRIPTION AND PLAN OF CORRECTION DISTRICTION NUMBER	DIVISION	of Health Service Regu	lation			
IDLEWILD HOME SITREETADDRESS, CITY, STATE, 2IP CODE \$807 IDLEWILD BROOK LANE CHARLOTTE, NC 28212 [PARTIX TAG SUMMARY STATEMENT OF DEFICIENCIES PARTIX TAG PARTIX TAG						
DLEWILD HOME SUMMARY STATEMENT OF DEFICIENCIES CHARLOTTE, NO. 28212			MHL060-586	B. WING		08/07/2024
DLEWILD HOME SUMMARY STATEMENT OF DEFICIENCIES	NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	
(PA) ID SUMMARY STATEMENT OF DEPICIENCIES ID PREFIX PROVIDERS PLAN OF CORRECTION PREFIX PAGE OF THE APPROPRIATE PAGE OF THE APPROPRIATE PAGE OF THE APPROPRIATE DEFICIENCY MUST BE PRECIDED BY PULL. TAG PREFIX TAG PROPRIATE DEFICIENCY) V 367 Continued From page 13 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. Larges of client death within seven days of use of seclusion or restraint, the provider 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 are electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level III or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level III and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rible and Subparagraphs (1)	IDLEWILD	HOME	6807 IDL	EWILD BROOK	LANE	
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) V 367 Continued From page 13 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 sedusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(13). (e) Category A and 8 providers shall send a report quarterly to the LME responsible for the catchment area where services are provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1)	102277123	TOME	CHARLO	TTE, NC 28212	2	
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 2EC 0.0300 and 10A NCAC 2EC 10J04(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1)	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLETE
		of all level III incident in Mental Health, Develor Substance Abuse Sembecoming aware of the providers shall send a incidents involving a control Health Service Regular becoming aware of the client death within sever restraint, the provide immediately, as required 0.300 and 10A NCAC (e) Category A and B report quarterly to the locatchment area where The report shall be substituted summary inform (1) medication endefinition of a level II on (2) restrictive into the definition of a level (3) searches of a (4) seizures of client (5) the total number of the course of a statement in been no reportable incidents have occurred (6) a statement in been no reportable incidents have occurred meet any of the criteria (a) and (d) of this Rule in the control incidents have occurred (a) and (d) of this Rule in the control incidents have occurred (a) and (d) of this Rule in the criteria (a) and (d) of this Rule in the control incidents have occurred (a) and (d) of this Rule in the criteria (a) and (d) of this Rule in the criteria (a) and (d) of this Rule in the criteria (a) and (d) of this Rule in the criteria (a) and (d) of this Rule in the criteria (a) and (d) of this Rule in the criteria (a) and (d) of this Rule in the criteria (a) and (d) of this Rule in the criteria (a) and (d) of this Rule in the criteria (a) and (d) of this Rule in the criteria (a) and (d) of this Rule in the criteria (a) and (d) of this Rule in the criteria (a) and (d) of this Rule in the criteria (a) and (d) of the criteria (d) a	reports to the Division of pmental Disabilities and vices within 72 hours of a incident. Category A copy of all level III lient death to the Division of a incident. In cases of an days of use of seclusion are shall report the death and by 10A NCAC 26C 27E .0104(e)(18). Providers shall send a LME responsible for the services are provided. In a service of a provided and the downward of the services are provided. In the service of the services are provided and the section of the services are provided. In the service of the servi	V 367		

Division	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 2 2	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL060-586	B, WING		08/07/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
IDLEWILD	HOME		EWILD BROOK TTE, NC 28212	LANE		
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
	failed to ensure that in submitted to the Local (LME)/Managed Care responsible for the cat services were provided becoming aware of the current clients (#1,#2). Review on 8/5/24 of C - Admission date 6/29/- Age 16; - Diagnoses Attention Disorder, Oppositional Traumatic Stress Disorder, Oppositional Traumatic Stress Disorder, Age 17; - Diagnoses Post Traumistory; Other Disorder Development. Review on 8/5/24 of the from May 1, 2024 - Aug - There were no incider 2024 - August 2, 2024 from 16 - Client #1's aggressive #2. Client #2 was treated liquid stitches and bite in Client #2's Ferrous Substitution of the submitted from S	as evidenced by: w and interviews the facility reident reports were I Management Entity Organization (MCO) rehment areas where d within 72 hours of e incident affecting 2 of 3 . The findings are: lient #1's record revealed: '23; Deficit Hyperactivity Defiant Disorder, Post refer. lient #2's record revealed: 1/23; matic Stress Disorder, by s of Psychological e facility's incident reports ust 2, 2024 revealed: nt reports from May 1, or the following: e behavior towards Client ed at the local hospital for marks on 5/26/24, ulfate 325mg, Vitamin D3 g, Guanfacine 1mg; e unavailable on 8/1/24; ulfate 325mg, Vitamin D3	V 367	DEFICIENCY)		
	Lamoungine 25mg were	unavallable on 0/2/24,				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMP		
			A. BUILDING	3:			
		MHL060-586	B. WING	B. WING		08/07/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ID I FIAM I	2.110.115		EWILD BROO				
IDLEWILI	D HOME	CHARLO	TTE, NC 2821	2			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD : CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETE DATE	
V 367	Continued From page	15	V 367				
	Review on 8/5/24 of In Improvement System August 2, 2024 reveal were not reported with - Client #2 broke the of the security system. Provider did not submit IRIS. - Client #2 had suicidate the local hospital on 7 submit report until 7/10 Interview on 8/7/24 with revealed: - Complete incident reasonable and a suicident reasonable incident reincident;	ncident Response (IRIS) from May 1, 2024- led the following incidents hin the required time: door frame lock, damaging Property damage charges ent #2 on 7/3/24. The it report until 7/8/24 into al ideation and evaluated at //6/24. The provider did not 0/24 into IRIS. the Clinical Director ports along with the Quality provement Director; eports once learned of the aining this week! don't go					
	10A NCAC 27G .0303 EXTERIOR REQUIRE (c) Each facility and its	MENTS grounds shall be lean, attractive and orderly	PCS will e Monitor b	maintain the facility in a safe, clean, attractive a nsure all the items listed on POC are fixed by 10 y: House Manager, HR Director, Clinical Directo date: 10/6/2024and ongoing	0/6/2024		
	was not maintained in a and orderly manner. Th	and interviews the facility a safe, clean, attractive ne findings are:					
	Observations on 8/7/24 12:35pm of facility's inte - Client #4's bedroom d	erior revealed:					

Division	of Health Service Regu	lation				
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	MHL060-586		B. WING		08/07/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E. ZIP CODE		
TANINE OF T	TO THE TOTAL OF TH		EWILD BROOK L			
IDLEWILD	HOME		OTTE, NC 28212			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 736	Continued From page	16	V 736			
	approximately 12 inch - Basement/Downstain - Return vent in ba inner rim and had no o - Filter (14x20x1) w - Broken metal disp the basement wall (ou room) with metal strip 1/2 in width, 1.5 to 2 in Observation on 8/7/24 of the facility's exterior - Gutters were filled w seedlings; - Back deck and patio rotted wood; - Stairs to deck had m wood on handrail appr side and 10-12 in on le - Extended deck near had rotted wood and 2 diameter; - Tire was on the right ground; - Broken chair was lea the deck stairs - Broken/cracked conc lengths and dimension - Concrete was unever perimeter where it was - Yard debris consisted - Plastic chair, - Piece of metal (a - Water hose, - Piece of wire, - Broken bricks/pa - Metal tube	res long and 6 inches wide; rs; sement was rusted around cover; was crumpled and ill-fitted; tenser holder was nailed to atside the door of Client #3's extended approximately in length. At approximately 1:05pm revealed: ith debris and growing tree were in disrepair with issing handrail and rotted roximately 2.5 in on right eff side; attached to cement pation tholes approximately 2-4 in side of the facility on the ned against the outside of rete on patio of varied is; in and sank around the cracked/split; of:	V /36			
	following: - Uncovered electric	cal box with loose wires,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION MILDBO-5366 STREET ADDRESS, CITY, STATE, 2IP CODE SHOTING OF PROVIDER OR SUPPLIER SOUTH HOLD BROOK LANE CHARLOTTE, NC 28212 CHARLOTTE, NC 28212 V 736 Continued From page 17 - broken industrial office copier; - broken industrial office copier; - broken industrial office copier; - broken piece of siding; - A missing waterspoul was on the back comer of the facility near the deck. Interview on 8/2/24 with Client #4 revealed: - "I don't like bassements. I try not to come down here. I don't like hat vent (return) has ever had a cover on it." Interview on 8/7/24 with the Clinical Director revealed: - "I don't with the Volicial Director revealed: - "I don't go to the house like I do a Lavel 3 this is good feedback, uncomfortable, but good feedback."	Division of Health Service Regulation							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE S807 IDLEWILD BROOK LANE CHARLOTTE, NC 28212 (24) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 17 - broken industrial office copier; - broken glece of siding; - A missing waterspout was on the back corner of the facility near the deck. Interview on 3/2/24 with Client #4 revealed: - "Last Friday (7/26/24) I blacked out and when I came conscious I hit the door." - "My door has been like that for a few weeks now. I did it when I got really mad." Interview on 8/7/24 with Staff #1 revealed: - "I don't like basements. I try not to come down here. I don't like nothing where there is bugs." - "I don't think that vent (return) has ever had a cover on it." Interview on 8/7/24 with the Clinical Director revealed: - "I don't go to the house like I do a Level 3 this is good feedback, uncomfortable, but good								
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CHARLOTTE, NC 28212	NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
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Division of Health Service Regulation

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