Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			B. WING		44/00/0004	
MHL051-173		b. WING		11/2	6/2024	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SAVIN G	RACE II		DAM ROAD NC 27576			
(X4) ID	<u> </u>			PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
V 000	INITIAL COMMENT	S	V 000			
	An annual and complaint survey was completed on 11/26/24. The complaint was unsubstantiated (intake #NC00224020). Deficiencies were cited.					
		sed for the following service C 27G .1700 Residential cure for Children or				
	This facility is licensed for 4 and has a current census of 2. The survey sample consisted of audits of 2 current clients and 1 former client.					
V 108	V 108 27G .0202 (F-I) Personnel Requirements		V 108			
	(g) Employee training provided and, at a refollowing: (1) general organiz (2) training on clier delineated in 10A N 10A NCAC 26B; (3) training to meet client as specified in plan; and (4) training in infect bloodborne pathogo (h) Except as permit .5602(b) of this Submember shall be a vitimes when a client	cation shall be documented.  Ing programs shall be ininimum, shall consist of the cational orientation; Intrights and confidentiality as CAC 27C, 27D, 27E, 27F and Interest the mh/dd/sa needs of the Interest the treatment/habilitation  It tous diseases and It t				
	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					

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

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION (X3) DATE S COMPLE		
MIII 054 472		B. WING		44/06/0004		
		MHL051-173			11/2	6/2024
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S DAM ROAD	STATE, ZIP CODE		
SAVIN G	RACE II	SELMA, N	_			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 108	the American Heart equivalence for reli (i) The governing to implement policies reporting, investiga	ige 1  Association or their eving airway obstruction. body shall develop and and procedures for identifying, ting and controlling infectious diseases of personnel and	V 108			
	Based on record re failed to ensure 2 of Professional and Q	et as evidenced by: view and interview the facility if 3 audited staff (Associate lualified Professional) had diopulmonary resuscitation s are:				
	- Hire date: 11/1/	personnel record revealed:				
	Review on 11/19/24 Professional's (QP) - Hire date: 11/1/ - First aid/CPR e	record revealed:				
	10/23/24-11/25/24   - The AP and the additional staff pres 10/24/24, 10/25/24	4 of staff schedules from revealed: e QP worked together with no sent 13 times: 10/23/24, , 10/29/24, 11/6/24, 11/7/24, 11/14/24, 11/15/24, 11/18/24,				
		11/25/24 the AP reported:				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
MHL051-173		B. WING		11/26/2024		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SAVIN G	RACE II	562 OLD [ SELMA, N	DAM ROAD IC 27576			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 108	Continued From pa	ge 2	V 108			
	did not know what t	I for training on 12/7/24, but training it was its me and [the QP]"				
	During interview on 11/20/24 the QP reported:  - She was responsible for scheduling staff trainings  - Did not realize that her and the AP's first aid/CPR was expired  During interviews on 11/25/24 and 11/26/24 the Chief Executive Officer reported:  - The AP and the QP did "often work together"  - Was not aware that the AP and the QP had expired first aid/CPR  - First aid/CPR was schedueld for 12/7/24, but she was trying to move it to 11/29/24 to get the AP and the QP back in compliance					
V 296	27G .1704 Residen Staffing	ntial Tx. Child/Adol - Min.	V 296			
	REQUIREMENTS  (a) A qualified profetelephone or page. able to reach the fatimes.  (b) The minimum required when child present and awake  (1) two direct one, two, three or for (2) three direct for five, six, seven adolescents; and	care staff shall be present for our children or adolescents; ct care staff shall be present or eight children or t care staff shall be present for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED			
	MHL051-173		B. WING		11/2	6/2024	
NAME OF 1		OTDEET AS	INDESS CITY O	STATE, ZIP CODE	-		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
SAVIN G	RACE II		DAM ROAD				
		SELMA, I	NC 27576				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 296	Continued From pa	ge 3	V 296				
	during child or adole follows:  (1) two direct and one shall be aw children or adolesce (2) two direct and both shall be aw children or adolesce (3) three direct of which two shall be asleep for nine, ten adolescents.  (d) In addition to the care staff set forth it Rule, more direct cathe facility based or individual needs as plan.  (e) Each facility shased or individual needs as plan.  (e) Each facility shased or individual needs as specified.  This Rule is not me Based on observation interview the facility staff were present for the same present f	care staff shall be present wake for five through eight ents; and ct care staff shall be present e awake and the third may be eleven or twelve children or e minimum number of direct in Paragraphs (a)-(c) of this are staff shall be required in the child or adolescent's specified in the treatment all be responsible for ensuring ren or adolescents when they acility in accordance with the individual strengths and in the treatment plan.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
MHL051-173		B. WING		11/26/2024		
NAME OF PROVID	ER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SAVIN GRACE	II	562 OLD [ SELMA, N	DAM ROAD IC 27576			
	EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
Revi - // - I Diso Diso Depr Read Revi - // - I Diso Revi - // - I Diso Revi - // - I mixe relate Obse 11/19 - // addit // facili 2:25 - S Revi Nove	Admitted: 6/5/2 Age: 14 years of Diagnoses: Disorder (DMDD), Arder (ADHD) or dessive Disorder to the control of	client #1's record revealed: 4 bild ruptive Mood Dysregulation Attention Deficit Hyperactivity by by bild by bild ruptive Mood Dysregulation Attention Deficit Hyperactivity by by bild by bild by continuous con	V 296	DELIGIENCI)		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
MHL051-173		B. WING		11/26/2024		
						0/202-i
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SAVIN G	RACE II		DAM ROAD			
OATHIT O	10.02 11	SELMA, N	IC 27576			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DAIL
				,		
V 296	Continued From pa	ge 5	V 296			
	10:20nm	8:00am (3rd)				
	- Weekend shifts					
	- 8:00am - 8:					
		:00am (2nd)				
		1/25/24, only one staff was				
		at the facility during times				
	when clients were p					
		weekday 1st shift				
		weekday 2nd shift				
		weekday 3rd shift				
		weekend 1st shift				
	2 411100 011	Wookend Tot erint				
	Interview on 11/19/24 client #1 reported:					
		re 2 clients in the home, there				
		2 on certain occasions"				
		was "typically only 1 (staff) at				
	night"	<i>y</i> ,				
	J					
	Interview on 11/19/2	24 client #2 reported:				
	- There was typic	cally "1 or 2 staff here"				
	- "Not that often	that its just 1"				
	- She was at the	facility with staff #1 today				
	because she had be	een picked up early from				
	school					
		/24 and 11/21/24 staff #1				
	reported:					
		working at the facility since				
	July 2024	and the state of				
	- She "typically" \					
		ient #2 was sick and needed				
		n school so she arrived to the				
	facility early to stay					
		ed working at the facility, she				
	worked with other s					
		onth and a half," she had				
	been working alone					
		hy staffing had changed				
		w many were going to be on				
	shift" until she arrive	ed at the facility				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL051-173	B. WING		11/26/	/2024
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
SAVIN GRACE II		OAM ROAD			
	SELMA, N MENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
· · · · · · · · · · · · · · · · · · ·	JST BE PRECEDED BY FULL DENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)		COMPLETE DATE
V 296 Continued From page	6	V 296			
- "Sometimes it wou with 3 clients" in the fac	uld be just one staff even cility				
- She was responsible schedules - "Normally 2 staff the lift there is only one working" - There were 2 staff  Interviews on 11/19/24 reported: - Staff #1 was alone on 11/19/24 "due to em #2 needed to be picked lift. The QP was responsible they were "suppose scheduled" - "Staffing issues ha maybe about 2 weeks we just had 2 people leboth left pretty abruptly bind." - "Sometimes we on house (facility) and a bafford to have that mar "We just hired 3 minight (shift) and anothe be full-time so that will	at the facility since 11/1/22 ble for creating the staff here" e client, there will be 2 at the facility overnight and 11/26/24 the CEO e at the facility with client #2 nergency" because client d up from school onsible for staff scheduling ed to always have 2 staff ave just recently started, ago. Hasn't been too long. leave 2 or 3 weeks ago and y and that really put us in a haly have 1 client in the bunch of staff and I can't my staff with one client." hore people2 to go on er to go on day. They will all help a lot." e going through orientation				

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