STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-872	A. BUILDING: _____ B. WING _____	C 11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MR BILL'S PLACE	8612 NATIONS FORD ROAD CHARLOTTE, NC 28217

(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 A complaint survey was completed on November 27, 2024. The complaint was unsubstantiated (intake #NC00222947). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children and Adolescents. This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits 1 current client.	V 000		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (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: 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. 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. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against	V 132		

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V 132	Continued From page 1	V 132		

a patient or client for whom the employee is providing services).
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.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to report allegations of abuse and harm including injuries of an unknown source to the Health Care Personnel Registry (HCPR), failed to provide evidence that all alleged acts were investigated and failed to report within 5 working days of the initial notification, the results of the investigation to the Department. The findings are:

Review on 11/25/24 of the North Carolina Incident Response Improvement System (IRIS) from 10/1/24 to 11/25/24 revealed:
-On 10/7/24 the House Manager reported Client #1 "attacked" Staff #2.
-No report submitted that Staff #2 allegedly pushed Client # 1 with her fist on 10/7/24.
-No report submitted that Staff #2 allegedly called Client #1 "a little b***h." on 10/7/24.
-No report submitted that Staff #2 allegedly told Client #2 she (Staff #1) was "going to get her grandchild to beat Client #2's a**" on 10/7/24.

Interview on 11/7/24 with Client #1 revealed:
-On 10/7/24 she was upset because her ride for school was late and she wanted breakfast.
-Staff #2 had an "attitude" with her because she asked for breakfast.
-She poured a cup of water on Staff #2's head.

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V 132	Continued From page 2 -"She (Staff #2) hit me in the head and face area and we (Client #1 snd Staff #2) got into a fight." -Staff #2 said, "I have grandkids your age and I'm going to get one of them to beat your a**." -Staff #2 called her a "b***h". -Told her Department of Social Service (DSS) Legal Guardian that Staff #2 hit her in the head and face area, called her a "b***h, and threatened to have her (Staff #2) grandchildren "beat her a**." -Told the House Manager that Staff #2 hit her in the head and face area and called her a "b***h." Interview on 11/18/24 with the House Manager revealed: -Submitted the IRIS report for Client #1 "attacking" Staff #2 on 10/7/24. -Client #1 mentioned that Staff #2 hit her "days later." -Client #1's DSS Legal Guardian reported the allegation (Staff #2 hit Client #1 in the head and face area) to DSS. -Did not update IRIS or submit a new IRIS report to reflect the allegations made by Client #1 (Staff #2 hit Client #1 in the head and face area). Interview on 11/27/24 with the Executive Director revealed: -She did not know about Staff #2 allegedly hitting Client #1 until DSS started their investigation on 10/11/24. -"[Staff #2] was suspended while I looked into it (Staff #2 hitting and cursing at Client #1)." -Did not update IRIS or submit a new IRIS report. -Did not notify HCPR. -Did not know she had to report the allegation to HCPR. -Will submit a report of the incident to HCPR.	V 132		

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V 367	Continued From page 3	V 367		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously	V 367		

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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 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

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V 367	Continued From page 5 meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview the facility failed to submit level II incident reports to the Local Management Entity/Managed Care Organization within 72 hours. The findings are: Review on 11/25/24 of the North Carolina Incident Response Improvement System (IRIS) from 10/1/24 to 11/25/24 revealed: -On 10/7/24 the House Manager reported Client #1 "attacked" Staff #2. -No report submitted that Staff #2 allegedly pushed Client # 1 with her fist on 10/7/24. -No report submitted that Staff #2 allegedly called Client #1 "a little b***h." on 10/7/24. -No report submitted that Staff #2 allegedly told Client #2 she (Staff #1) was "going to get her grandchild to beat Client #2's a**" on 10/7/24. Interview on 11/7/24 with Client #1 revealed: -On 10/7/24 she was upset because her ride for school was late and she wanted breakfast. -Staff #2 had an "attitude" with her because she asked for breakfast. -She poured a cup of water on Staff #2's head. -"She (Staff #2) hit me in the head and face area and we (Client #1 snd Staff #2) got into a fight." -Staff #2 said, "I have grandkids your age and I'm going to get one of them to beat your a**."	V 367		

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V 367	Continued From page 6 -Staff #2 called her a "b***h". -Told her Department of Social Service (DSS) Legal Guardian that Staff #2 hit her in the head and face area, called her a "b***h, and threatened to have her (Staff #2) grandchildren "beat her a**." -Told the House Manager that Staff #2 hit her in the head and face area and called her a "b***h." Interview on 11/18/24 with the House Manager revealed: -Submitted the IRIS report for Client #1 "attacking" Staff #2 on 10/7/24. -Client #1 mentioned that Staff #2 hit her "days later." -Client #1's DSS Legal Guardian reported the allegation (Staff #2 hit Client #1 in the head and face area) to DSS. -Did not update IRIS or submit a new IRIS report to reflect the allegations made by Client #1 (Staff #2 hit Client #1 in the head and face area). Interview on 11/27/24 with the Executive Director revealed: -She did not know about Staff #2 allegedly hitting Client #1 until DSS started their investigation on 10/11/24. -"[Staff #2] was suspended while I looked into it (Staff #2 hitting and cursing at Client #1)." -Did not update IRIS or submit a new IRIS report. -Did not know the allegation had to be submitted to IRIS because it was alleged "days later." -Would submit an IRIS report.	V 367		