

	IATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	(X3) DATE SURVEY COMPLETED	
-		MHL036-402	B. WING		11/15/2024
NEW HOP	PE NC 1, INC.	649 LOI DALLA:	ADDRESS, CITY, ST RAY FARM ROA S, NC 28034		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT 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 APPROPIDE DEFICIENCY)	D BE COMPLETE
V 118	on 11/15/24. The com (Intake #NC00222108) This facility is licensed category: 10A NCAC 2 Treatment Staff Secur Adolescents. This facility is licensed census of 4. The surve audits of 2current client 27G .0209 (C) Medicat 10A NCAC 27G .0209 IREQUIREMENTS (c) Medication administ (1) Prescription or nononly be administered to order of a person authorous (2) Medications shall be client's physician. (3) Medications, including administered only by licensed persons train that contains a medical drugs administered to prepare and (4) A Medication Administered to prepare and (5) A Medications and ecorded immediately a MAR is to include the form (6) instructions for administer (7) instructions for administer (8) instructions for administer (9) instructions for adm	for 6 and has a current by sample consisted of ts, 1 former client. ion Requirements MEDICATION ration: prescription drugs shall of a client on the written prized by law to prescribe be self-administered by prized in writing by the ensed persons, or by ned by a registered nurse, ally qualified person and d administer medications, istration Record (MAR) of to each client must be kept ministered shall be fiter administration. The llowing: quantity of the drug;	V 118	V118 CORRECTION: 1. Program supervisors respectively medication errors. 2. Therapist/Case Manager that all prescribed medication doctor's orders and were repharmacy PREVENTION: 1. All direct care staff will respectively refresher in meadministration that focuses importance of accurate, time complete recording. MONITORING 1. Program supervisor will periodic checks in addition monthly audits to compliance with meadministration requirement ensure proper use of	eviewed ecessary ation for ensured ons had filled by eceive a Effective dication 1/1/2025 on the ely, and ely, and ensure the ongoing ely, and ensure the ongoing dication ats to MAR, orrectly noting

Dr. malina

TITLE

(X6) DATE

4 THE REPORT OF THE PROPERTY OF THE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL036-402	B. WING	B. WING		1/15/2024	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
NEW HO	PE NC 1, INC.		NC 28034	i.b			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
	(E) name or initials of drug. (5) Client requests for checks shall be record file followed up by app with a physician. This Rule is not met a Based on record review interview, the facility fa affecting 1 of 2 current findings are: Review on 11/4/24 of C - Admission date 10/11 - Age 17; - Diagnoses Major Dep to severe stress unspe Explosive Disorder; - Physician's Orders da (Depression) 15 milligra by mouth daily; Budesc	medication changes or led and kept with the MAR cointment or consultation s evidenced by: w, observation, and iled to keep MARs current clients (Client #2). The Client #2's record revealed: //24; ressive Disorder, Reaction cified, Intermittent ated 10/4/24 Aripiprazole ams (mg), Take one tablet onide Formoterol	V 118				
	puffs into the lungs 2 tir - Physician's Order date	ed 10/14/24 Fluticasone 0 mcg, 1 spray into each					
	medication revealed: - Aripiprazole 15mg, Ta daily; - Budesonide Formotero						

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED FOR A CONTROL OF THE PROPERTY OF THE PROPE	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		, , , , , , , , , , , , , , , , , , , ,	(X3) DATE SURVEY COMPLETED		
NEW HOPE NC 1, INC. SUMMARY STATEMENT OF DEFICIENCIES DALLAS, NC 28034			MHL036-402	B. WING		11/1	11/15/2024	
NEW HOPE NC 1, INC. CAJ ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES DALLAS, NC 28034	NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
DALLAS, NC 28034 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 118 Continued From page 2 daily; Fluticasone Propionate 50mcg, 1 spray into each nostril daily as needed for allergies. Review on 11/5/24 of Client #2's MARs from October 11, 2024- November 5, 2024 revealed: No signature on 10/21/24 for the following medications to indicate the medications were administered: Aripiprazole 15mg, Take one tablet by mouth daily; Budesonide Formoterol (Symbicort) 160-4,5mcg, Inhale 2 puffs into the lungs 2 times daily; Fluticasone Propionate 50mcg, 1 spray into each nostril daily as needed for allergies. Interview on 11/5/24 with Client #2 revealed: Missed morning medications one day but could not remember the date. Interview on 11/6/24 with Staff #1 revealed: - Administered medications after received medication administration training. Interview on 11/6/24 with Staff #2 revealed: - The Qualified Professional, Residential Director	NEW HOI	PENC 1 INC						
PREFIX TAG REGULATORY OR LSC (IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC (IDENTIFY INFORMATION) PREFIX TA	NEW 1101							
daily; - Fluticasone Propionate 50mcg, 1 spray into each nostril daily as needed for allergies. Review on 11/5/24 of Client #2's MARs from October 11, 2024- November 5, 2024 revealed: - No signature on 10/21/24 for the following medications to indicate the medications were administered: Aripiprazole 15mg, Take one tablet by mouth daily; Budesonide Formoterol (Symbicort) 160-4.5mcg, Inhale 2 puffs into the lungs 2 times daily; Fluticasone Propionate 50mcg, 1 spray into each nostril daily as needed for allergies. Interview on 11/5/24 with Client #2 revealed: - Missed morning medications one day but could not remember the date. Interview on 11/6/24 with Staff #1 revealed: - Administered medications after received medication administration training. Interview on 11/6/24 with Staff #2 revealed: - The Qualified Professional, Residential Director	PREFIX	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROFINE DEFICIENCY)		OULD BE	(X5) COMPLETE DATE	
- Fluticasone Propionate 50mcg, 1 spray into each nostril daily as needed for allergies. Review on 11/5/24 of Client #2's MARs from October 11, 2024- November 5, 2024 revealed: - No signature on 10/21/24 for the following medications to indicate the medications were administered: Aripiprazole 15mg, Take one tablet by mouth daily; Budesonide Formoterol (Symbicort) 160-4.5mcg, Inhale 2 puffs into the lungs 2 times daily; Fluticasone Propionate 50mcg, 1 spray into each nostril daily as needed for allergies. Interview on 11/5/24 with Client #2 revealed: - Missed morning medications one day but could not remember the date. Interview on 11/6/24 with Staff #1 revealed: - Administered medications after received medication administration training. Interview on 11/6/24 with Staff #2 revealed: - The Qualified Professional, Residential Director	V 118	Continued From page	2	V 118				
MARs; - The Team Lead overseen the medications and MARs for each shift. Interview on 11/5/24 with the Qualified Professional: - The Therapist/Case Manager was in charge of the MARs. Interview on 11/6/24 with the Therapist/Case Manager revealed: - Supervisors were in charge of the MARs;		daily; - Fluticasone Propional each nostril daily as not reach nostril daily; Budes (Symbicort) 160-4.5 mouth daily; Budes (Symbicort) 160-4.5 mouth daily; Budes (Symbicort) 160-4.5 mouth daily; Flutings 2 times daily; Flutings 2 time	ate 50mcg, 1 spray into eeded for allergies. Client #2's MARs from vember 5, 2024 revealed: 1/24 for the following ethe medications were zole 15mg, Take one tablet onide Formoterol eg, Inhale 2 puffs into the uticasone Propionate ach nostril daily as needed with Client #2 revealed: ications one day but could exticute to after received ion training. If th Staff #1 revealed: sional, Residential Director charge of medications and the the Qualified flanager was in charge of the the Therapist/Case	V 118				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION 3:	(X3) DATE SURVEY COMPLETED		
		MHL036-402	B. WING		11.	/15/2024
	PROVIDER OR SUPPLIER PE NC 1, INC.	649 LORA DALLAS,	DRESS, CITY, S AY FARM ROA NC 28034	TATE, ZIP CODE AD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT 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 APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
	C.S. §131E-256 HEAL REGISTRY (d2) Before hiring heal health care facility or shealth care facility or shealth care facility sha Personnel Registry an of access in the appropriate of access in the access in the appropriate of access in the access in t	s evidenced by: v and interview, the facility alth Care Personnel accessed prior to an offer 3 audited staff (Staff #1, are: taff #1's personnel's taff #3's personnel's ounselor; 3.	V 131	V131 CORRECTION: 1. The Employee Experience an Talent Recruiter will conduct HCPR shortly after an offer acceptance. 2. PREVENTION: 1. The Employee Experience an Talent Manager has assigned task of running the report to recruiter who will be respons completing the report once to offer has been accepted. MONITORING 1. The Performance and Quality Improvement Department will conduct regular internal review personnel records to ensure compliance.	d I the the sible for he	Effective 11/21/2024 Effective 11/21/2024 Ongoing/ Quarterly
	Interview on 11/15/24 w Director of North Carolii - Was not aware the HC the hire date of the emp	na revealed: PR was completed after				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	(X2) MULTIPLE CONSTRUCTION (X			
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3:	COMPLETED	
		MHL036-402	B. WING		11/	15/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
NEW HO	PE NC 1, INC.	649 LORA	AY FARM ROA	AD		
		DALLAS,	NC 28034			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 131	Continued From page	4	V 131	V366		
				CORRECTION:		
	- HUPR Checks would	be completed before hire.		The state of the s		
V 366	27C 0602 Incident De		1/ 000	Program Director reviewed in reporting procedures and an arms.		
V 300	27G .0603 Incident Re	esponse Requirements	V 366	reporting procedures and pro		
	10A NCAC 27G .06	03 INCIDENT		with program supervisors on		
	RESPONSE REQUIR			11/6/2024 to ensure complia	ince	11/6/2024
	CATEGORY A AND B	PROVIDERS		with reporting timelines		11/6/2024
		providers shall develop and		2. The Incident Reporting Policy	will be	
	implement written police			review by supervisor at the n	ext	
	shall require the provide	or III incidents. The policies		staff meeting.		
		he health and safety needs		PREVENTION:		((
	of individuals involved	in the incident;		Program Supervisor will facili	tato	01/09/2025
		the cause of the incident;		A STATE OF THE STA	late	
		nd implementing corrective		incident reporting refresher		
	measures according to			quarterly to ensure staff are a		
	timeframes not to exce			of incident reporting procedu	ires	Ongoing
	(4) developing a	nd implementing measures ents according to provider		and expectations are met.		O'ligoling
	specified timeframes no			MONITORING:		
		rson(s) to be responsible		1. Program Supervisors will review	ew all	
	for implementation of the			incidents to ensure that all		
	preventive measures;			components of the report have	10	1
	(6) adhering to co	onfidentiality requirements		been completed to include	/6	1
		icle 2A, 10A NCAC 26B, and 45 CFR Parts 160 and			C	Ongoing
	164; and	and 45 CFR Parts 160 and		prevention/mitigation and		
		ocumentation regarding		notification of legal guardians		- 1
	Subparagraphs (a)(1) th	rough (a)(6) of this Rule.		and other authorities required	yd b	- 1
	(b) In addition to the re	quirements set forth in		law		- 1
	Paragraph (a) of this Ru	ule, ICF/MR providers				
	shall address incidents	as required by the federal				
	regulations in 42 CFR F	rant 483 Subpart I.				
	(c) In addition to the rec Paragraph (a) of this Ru	quirements set forth in				
	providers, excluding ICI	F/MR providers shall				- 1
	develop and implement	written policies governing				
	their response to a level	I III incident that occurs				- 1
1	while the provider is del	ivering a billable service				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	S:			LETED
		MHL036-402	B. WING			11/	15/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	ΓΑΤΕ,	ZIP CODE		
NEWWO	DE NO 4 1110		AY FARM ROA				
NEW HO	PE NC 1, INC.		NC 28034				
(X4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		_			
PREFIX TAG	(EACH DEFICIENCY	'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 366	Continued From page	5	V 366	2.	Residential Director will mon	itor	Ongoing
					adherence to the incident re		
		n the provider's premises.				Jorting	
		ire the provider to respond			guidelines		
	by: (1) immediately	securing the client record		3.	The Performance and Quality	1	Ongoing/
	by:	securing the chefit record			Improvement Department w	ill	Quarterly
		client record;			conduct regular internal revie		
	(B) making a ph				personnel records to ensure		
		e copy's completeness; and					
		he copy to an internal			compliance.		
	review team;						
	(2) convening a	meeting of an internal					
		hours of the incident. The					
		nall consist of individuals					
		in the incident and who					
		or the client's direct care or					1
	with direct professiona	l oversight of the client's					1
		the incident. The internal					1
	follows:	plete all of the activities as					1
		py of the client record to					
		d causes of the incident					
		ations for minimizing the					- 1
	occurrence of future in	cidents:					
		information needed;					
		preliminary findings of fact					
	within five working days	s of the incident. The					
	preliminary findings of						1
	LME in whose catchme	ent area the provider is					- 1
		where the client resides,					1
	if different; and						ı
	(D) issue a final w	ritten report signed by the					- 1
		ths of the incident. The					
	final report shall be sen						
	LME where the client are	vider is located and to the					- 1
	LME where the client re final written report shall	address the issues					
	identified by the interna						
	include all public docum	nents partinent to the					1
	incident, and shall make	e recommendations for					
		5 1000 mineridations for					- 1

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED			
		MHL036-402	B. WING		11/1	11/15/2024	
37.000000000.0774963 100.	PROVIDER OR SUPPLIER PE NC 1, INC.		Y FARM ROA	TATE, ZIP CODE			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	BE	(X5) COMPLETE DATE	
V 366	minimizing the occurred all documents needed available within three LME may give the prothree months to submit (3) immediately (A) the LME resparea where the services Rule .0604; (B) the LME who different; (C) the provider for maintaining and up treatment plan, if differ provider; (D) the Department (E) the client's leapplicable; and	ence of future incidents. If I for the report are not months of the incident, the vider an extension of up to it the final report; and notifying the following: consible for the catchment es are provided pursuant to ere the client resides, if agency with responsibility dating the client's ent from the reporting	V 366				
	This Rule is not met as Based on record review failed to implement writ their response to level I findings are:	and interview, the facility ten policies governing					
	from August 1, 2024- O - No Incident Reports of (RCA) for: - Client #2's Aripiprazol by mouth daily was not - Client #2's Budesonide	e facility's incident reports ctober 31, 2024 revealed: Risk/Cause/Analysis e 15mg, Take one tablet administered on 10/21/24; e Formoterol (Symbicort) uffs into the lungs 2 times					

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-402	B. WING		11/	15/2024
	NAME OF PROVIDER OR SUPPLIER STREET 649 LOI DALLA:			TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT 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 APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 366	daily was not administ - Client 2's Fluticasone spray into each nostril allergies was not adm Interview on 11/6/24 w - Unaware an incident completed for a medic being administered me - Staff completed incid Qualified Professional Manager reviewed the Interview on 11/6/24 w Professional revealed: - Supervisors were res incident reports were of manner; - Unaware Client #2 wa medications on 10/21/2 - Reviewed incidents re were completed in a tir Interview on 11/5/24 wi of North Carolina revea - Unaware incident rep	ered on 10/21/24; e Propionate 50mcg, 1 daily as needed for inistered on 10/21/24. with Staff #1 revealed: report needed to be ation error of a client not edication. ent reports and the and Therapist/Case incident reports. with the Qualified ponsible for making sure completed and in a timely as not administered 24; eports to make sure they nely manner. th the Residential Director aled: orts were not completed dministered medications; dent Response and	V 366			
	the provision of billable	4 INCIDENT EMENTS FOR PROVIDERS roviders shall report all t deaths, that occur during	V 367			

Division of Health Service Regulation

PRINTED: 12/04/2024 FORM APPROVED

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE:	SURVEY
ANDIEN	OF CONNECTION	IDENTIFICATION NUMBER:	A. BUILDING	3:	COMP	LETED
					1	
)	MHL036-402	B. WING		11/	15/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
NEW HO	PE NC 1, INC.	649 LOR	AY FARM ROA	AD		
ALW NO	LIVO I, INC.	DALLAS	NC 28034			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J.	0.5
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 367	Continued From page	8	V 367	V367		
	incidents and level II d	eaths involving the clients		CORRECTION:		
	to whom the provider r	endered any service within		Program Director reviewed in reporting procedures and are	ncident	
	90 days prior to the inc	cident to the LME		reporting procedures and pro	otooolo	11/6/2024
	responsible for the cat	chment area where				
	services are provided	within 72 hours of		with program supervisors on		
	becoming aware of the	incident. The report shall		11/6/2024 to ensure complia	ance	
	be submitted on a form	provided by the		with reporting timelines		
8	Secretary. The report	may be submitted via mail,		2. The Incident Reporting Policy	will be	01/09/2024
	in person, facsimile or	encrypted electronic all include the following		review by supervisor at the n		01/03/2021
	information:	an include the following		staff meeting.	CAC	
		vider contact and		PREVENTION:		
	identification information	on;		A STATE OF THE STATE OF T		
		cation information;		1. Program Supervisor will facili	tate	Ongoing
	(3) type of incide			incident reporting refresher		
	(4) description of			quarterly to ensure staff are a	aware	
		effort to determine the		of incident reporting procedu	ıres	
	cause of the incident; a (6) other individu	als or authorities notified		and expectations are met.		
	or responding.	als or authorities notified		MONITORING:		
		roviders shall explain any				
	missing or incomplete i	nformation. The provider		Program Supervisors will revi	ew all	Ongoing
	shall submit an updated	report to all required		incidents to ensure that all		
	report recipients by the	end of the next business		components of the report have	ve	1
	day whenever:			been completed to include		- 1
	(1) the provider h	as reason to believe that		prevention/mitigation and		1
	information provided in	the report may be		notification of legal guardians	LME	1
		or otherwise unreliable; or btains information		and other authorities required	10 % A	- 1
		form that was previously		law	J Dy	- 1
	unavailable.	Tom that was proviously				- 1
	(c) Category A and B pr			Residential Director will moni	(ngoing
	upon request by the LM			adherence to the incident rep	orting	
	obtained regarding the i			guidelines		
		ds including confidential		3. The Performance and Quality		
	information; (2) reports by othe	or outh orition, and		Improvement Department wil	1 0	ngoing/
		er authorities; and response to the incident.		conduct regular internal review	'	luarterly
		oviders shall send a copy			WS OI	55.0
	, , , , , , , , , , , , , , , , , , ,	oriali coria a copy		personnel records to ensure		
ision of Health	Service Regulation			compliance.		i i

PRINTED: 12/04/2024 FORM APPROVED

1						
ŀ						
OTATELLE	TOPPERIOR					
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10. 10. 10.	CONSTRUCTION	(X3) DATE SUR	VEY
		SELLI ISKITON NOMBER.	A. BUILDING:		COMPLETE	ED
		MHL036-402	B. WING		11/15/2	2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STATI	E ZIP CODE		
			FARM ROAD	L, 211 OODE		
NEW HOP	PE NC 1, INC.	DALLAS, N				
(VALID	CLIBARADYOT					
(X4) ID PREFIX	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION		(X5)
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETE DATE
				DEFICIENCY)		
ivision of Hea TATE FORM	alth Service Regulation					
AIFFORM		No.	922547			

Division of Health Service Regulation

GGMT11

If continuation sheet 10 of 13

Division of Health Service Regulation Continued From page 9 V 367 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: 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; the total number of level II and level III incidents that occurred; and 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. STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: MHL036-402 B. WING 11/15/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 649 LORAY FARM ROAD NEW HOPE NC 1, INC. DALLAS, NC 28034 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Division of Health Service Regulation

STATE FORM

GGMT11

Division of H	lealth Service Reg	ulation			FORM APPROVED
V 367 C TI Bi fa su (L re se be cu Re frc -T 20 - C by - C	nis Rule is not me ased on record reviled to ensure that ubmitted to the Loc ME)/Managed Carvices were provide coming aware of the review on 11/1/24 of the review of the rev	t as evidenced by: riew and interview, the facility incident reports were cal Management Entity re Organization (MCO) catchment areas where ded within 72 hours of the incident affecting 1 of 2 findings are: If the facility's incident reports -October 31, 2024 revealed: ent reports from August 1, 024 for: zole 15mg, Take one tablet not administered on 10/21/24; hide Formoterol (Symbicort)	V 367		FORM APPROVED
da - C spi	ily was not adminis lient 2's Fluticasor ray into each nostr	2 puffs into the lungs 2 times stered on 10/21/24; ne Propionate 50mcg, 1 ril daily as needed for ninistered on 10/21/24.			
- U cor bei - S Qu	naware an incider mpleted for a medi ng administered n taff completed inci alified Professiona	with Staff #1 revealed: It report needed to be cation error of a client not nedication. Ident reports and the all and Therapist/Case e incident reports.			
Pro - Si inci ma - Ui me	dent reports were nner; naware Client #2 v dications on 10/21	d: esponsible for making sure completed and in a timely vas not administered /24;			
STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL036-402	B. WING		11/15/2024
NAME OF PROVID	ER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	
NEW HOPE NO	1, INC.	649 LORA DALLAS, I	Y FARM ROAD NC 28034		
(X4) ID PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE

STATE FORM

GGMT11

PRINTED: 12/04/2024 FORM APPROVED

Division	of Health Service Regulation		
V 367	Continued From page 11	V 367	
	- Reviewed incidents reports to make sure they were completed in a timely manner.		
	Interview on 11/5/24 with the Residential Director of North Carolina revealed: - Unaware incident reports were not completed when a client was not administered medications; - Planned to review Incident Response and Reporting Manual with staff.		
			l l