STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601585	A. BUILDING: _____ B. WING _____	01/29/2025

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MHVII	710 BRAXFIELD DRIVE CHARLOTTE, NC 28217

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 1/29/25. The complaint was unsubstantiated (Intake #NC00224682). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 3 and has a current census of 3. The survey sample consisted of audits of 2 current clients, 1 former client.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to develop and implement goals and strategies in the client's treatment plan affecting 1 of 3 audited clients (Former Client (FC) #3). The findings are: Review on 1/23/25 of FC #3's record revealed: - Admission date 10/18/24; - Age 11; - Diagnoses Intermittent Explosive Disorder, Intellectual Disability, Mild; - No documentation of a current treatment plan; - Discharge date 11/24/24. Interview on 1/29/25 with the Owner revealed: - "I thought the facility the client is coming from was responsible for creating the treatment plan."	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan 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.	V 114		

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V 114	Continued From page 2 (b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (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. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to have completed fire and disaster drills held at least quarterly and repeated on each shift. The findings are: Review on 1/22/25 of the facility's fire and disaster drill log from June 2024-December 2024 revealed: 2nd quarter (April-June 2024): - No 1st (7am-3pm), 2nd (3pm-11pm) and 3rd (11pm-7am) shift disaster drills. 3rd quarter (July-September 2024): - No 3rd shift fire drills and no 1st, 2nd and 3rd shift disaster drills. 4th quarter (October-December 2024): - No 3rd shift fire drills and no 1st, 2nd and 3rd shift disaster drills.	V 114		

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V 114	Continued From page 3 Interview on 1/16/25 with Client #1 revealed: - "Been here for a couple of months;" - Denied completing fire and disaster drills since being admitted into the facility; - Did not know where to go if there was a fire or a disaster. Interview on 1/16/25 with Client #2 revealed: - "Been here for a couple of months;" - Denied completing fire and disaster drills; - "I don't know where to go", if there was a fire or disaster drill. Interview on with Staff #1 revealed: - Officially started working at the facility in September 2024; - Worked 2nd shift (3pm-11pm); - Completed fire and disaster drills, "I have not done one myself, but I know they are done on different shifts;" - Denied a fire or disaster drill being completed while on shift. Interview on with staff #2 revealed: - Started at the facility on August 1, 2024; - Worked all shifts but mainly 3rd shift (11pm-7am); - Completed fire and disaster drills Interview on 1/23/25 with the Qualified Professional revealed: - All staff were responsible for making sure fire and disaster drills were completed; - Fire and Disaster drills were completed on the 16th of each month. Interview on 1/29/25 with the Owner revealed: - Fire and Disaster drills have to be completed every 6 months; - Planned to start completing fire and disaster	V 114		

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V 114	Continued From page 4 drills quarterly on each shift.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (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 drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		

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V 118	Continued From page 5 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 and maintain an accurate MAR affecting 1 of 3 audit clients (Client #1). The findings are: Review on 1/21/25 of Client #1's record revealed: - Admission date 12/4/24; - Age 9; - Diagnoses Attention Deficit Hyperactivity Disorder, combined Type; Major Depressive Disorder, Recurrent, Mild; Generalized Anxiety Disorder; - Physician's order dated 1/2/25 Risperidone 2 milligram (mg), Take 1 tablet by mouth at bedtime; Sertraline 50mg, Take 1 tablet by mouth at bedtime; Guanfacine ER 2mg, Take 1 tablet by mouth at bedtime; Atomoxetine 40mg, Take 1 tablet by mouth in the morning. Observations on 1/21/25 at approximately 12:48pm of Client #1's mediations revealed: - Risperidone 2mg, Sertraline 50mg, Guanfacine ER 2mg, Atomoxetine 40mg were available. Review on 1/22/25 of Client #1's MAR for December 4, 2024-January 21, 2025 revealed the following medications were not administered: - December 2024: - Risperidone 2mg- 12/10, 12/11, 12/13 - Sertraline 50mg- 12/10, 12/1, 12/13 - Guanfacine ER 2mg- 12/10, 12/11, 12/13, 12/14 - Atomoxetine 40mg- 12/10. Interview on 1/16/25 with Client #1 revealed: - Received medications daily.	V 118		

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V 118	Continued From page 6 Interview on 1/29/25 with the Owner revealed: - Client #1 received medications; - Reviewed the MAR and seen the circles on the MAR showing the medications were not administered; - There was no explanation for why Client #1 did not receive medications. Due to failure to accurately document medication administration, it could not be determined if client #1 received his medication as ordered by the physician.	V 118		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and	V 366		

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V 366	Continued From page 7 (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the	V 366		

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V 366	Continued From page 8 LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interviews the facility	V 366		

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V 366	Continued From page 9 failed to implement policies governing their response to Level I incidents. The findings are: Review on 1/21/25 of the facility's incident reports from October 1, 2024-January 22, 2025 revealed: -No Incident Reports or Risk/Cause/Analysis (RCA) for: - Client #1's Risperidone 2mg was not administered on 12/10/24; - Client #1's Risperidone 2mg was not administered on 12/11/24; - Client #1's Risperidone 2mg was not administered on 12/13/24; - Client #1's Sertraline 50mg was not administered on 12/10/24; - Client #1's Sertraline 50mg was not administered on 12/11/24; - Client #1's Sertraline 50mg was not administered on 12/13/24; - Client #1's Guanfacine ER 2mg was not administered on 12/10/24; - Client #1's Guanfacine ER 2mg was not administered on 12/11/24; - Client #1's Guanfacine ER 2mg was not administered on 12/13/24; - Client #1's Guanfacine ER 2mg was not administered on 12/14/24; - Client #1's Atomoxetine 40mg was not administered on 12/10/24. Interview on 1/29/25 with the Owner revealed: - There were no incident reports due to no knowledge of Client #1 not receiving medications.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS	V 367		

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V 367	Continued From page 10 (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 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	V 367		

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V 367	Continued From page 11	V 367		

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 meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.

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V 367	Continued From page 12 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure that incident reports were submitted to the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment areas where services were provided within 72 hours of becoming aware of the incident affecting 1 of 3 audit clients (Client #1). The findings are: Review on 1/22/25 of the facility's incident reports from October 1, 2024- January 25, 2025 revealed: - There were no incident reports from October 1, 2024- January 22, 2025 for the following: - Client #1's Risperidone 2mg was not administered on 12/10/24; - Client #1's Risperidone 2mg was not administered on 12/11/24; - Client #1's Risperidone 2mg was not administered on 12/13/24; - Client #1's Sertraline 50mg was not administered on 12/10/24; - Client #1's Sertraline 50mg was not administered on 12/11/24; - Client #1's Sertraline 50mg was not administered on 12/13/24; - Client #1's Guanfacine ER 2mg was not administered on 12/10/24; - Client #1's Guanfacine ER 2mg was not administered on 12/11/24; - Client #1's Guanfacine ER 2mg was not administered on 12/13/24; - Client #1's Guanfacine ER 2mg was not	V 367		

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V 367	Continued From page 13 administered on 12/14/24; - Client #1's Atomoxetine 40mg was not administered on 12/10/24. Interview on 1/29/25 with the Owner revealed: - There were no incident reports due to no knowledge of Client #1 not receiving medications.	V 367		
V 539	27F .0102 Client Rights - Living Environment 10A NCAC 27F .0102 LIVING ENVIRONMENT (a) Each client shall be provided: (1) an atmosphere conducive to uninterrupted sleep during scheduled sleeping hours, consistent with the types of services being provided and the type of clients being served; and (2) accessible areas for personal privacy, for at least limited periods of time, unless determined inappropriate by the treatment or habilitation team. (b) Each client shall be free to suitably decorate his room, or his portion of a multi-resident room, with respect to choice, normalization principles, and with respect for the physical structure. Any restrictions on this freedom shall be carried out in accordance with governing body policy. This Rule is not met as evidenced by: Based on observations, record review and interviews the facility failed to provide accessible area for personal privacy for 2 of 3 audit clients (Client #1, Client #2). The findings are: Observations on 1/16/25 at approximately 6:40pm and 1/29/25 at approximately 3:15pm of	V 539		

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(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 539	Continued From page 14 Client #1's and Client #2's bedroom revealed: - No bedroom door Review on 1/21/25 of Client #1's record revealed: - Admission date 12/4/24; - Age 9; - Diagnoses Attention Deficit Hyperactivity Disorder, combined Type; Major Depressive Disorder, Recurrent, Mild; Generalized Anxiety Disorder. Review on 1/21/25 of Client #2's record revealed: - Admission date 12/23/24; - Age 16; - Diagnoses Paranoid Schizophrenia. Review on 1/27/25 of the Division Health Service Regulations record for licensure revealed: - Picture of bedroom #3 with the door on the hinges of bedroom #3. Interview on 1/16/25 with Client #1 revealed: - There was no door when admitted into the facility. Interview on 1/16/25 with Client #2 revealed: - There was no door when admitted into the facility. Interview on 1/27/25 with DHSR licensure revealed: - Completed a walk through of the facility; - Did not approve for the facility to remove the doors to the bedrooms; Interview on 1/29/25 with the Owner revealed: -There were no doors on the bedroom when the facility was inspected; - Due to safety concerns for clients the doors were removed.	V 539		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601585	A. BUILDING: _____ B. WING _____	01/29/2025

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V 762	27G .0304(d)(1) Client Bedrooms 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements: (1) Client bedrooms shall have at least 100 square feet for single occupancy and 160 square feet when two clients occupy the bedroom. This Rule is not met as evidenced by: Based on record review, observation and interviews, client bedrooms failed to meet the 160 square foot minimum for double occupancy rooms. The findings are: Observations on 1/16/25 at approximately 6:39pm revealed: - Three bedroom home; - Master bedroom was for staff use; - Bedroom #2 single client room with twin bed and rug; - Bedroom #3 two twin beds and 6 cube shelves. Review on 1/23/25 of the Division Health Service Regulations (DHSR) licensure file revealed: - Floor plan with Master bedroom with 2 clients; - Bedroom #2 with 1 client; - Bedroom #3 for staff use. Interview on 1/28/25 with DHSR construction via email revealed: - The facility was approved for the Master bedroom to have two clients and bedroom #3	V 762		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 762	Continued From page 16 utilize by the staff. Interview on 1/29/25 with the Owner revealed: - Was given approval to switch the Master bedroom and bedroom #3 due to an issue in the Master bedroom; - Had an email from construction approving the switch of the two bedrooms.	V 762		