STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-268	A. BUILDING: _____ B. WING _____	R 01/28/2025

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BELMONT HOUSE	927 FLOYD LANE GASTONIA, NC 28052

(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 An annual and follow up survey was completed on 01/28/2025. 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 4 and has a current census of 3. The survey sample consisted of audits of 3 current clients.	V 000		
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. (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.	V 114		

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V 114	Continued From page 1 This Rule is not met as evidenced by: Based on interview and record review, the facility failed to complete fire and disaster drills at least quarterly for each shift and failed to simulate emergency conditions. The findings are: Review on 01/27/2025 of the facility's fire and disaster drills from 01/01/2024-12/31/2024 revealed: 1st quarter (January-March 2024): -Fire and disaster drills were completed on the same day and at the same time; 01/18/2024 at 5:00pm - 5:04 pm, 02/21/24 at 5:00pm - 5:03pm, and 03/29/2024 at 5:02pm - 5:05pm. 2nd quarter (April-June 2024): -No 1st shift (8 am-3 pm) and 3rd shift (11 pm- 8 am) fire drills and no 1st, 2nd (3 pm-11 pm) and 3rd shift disaster drills. 3rd quarter (July-September 2024): -No 1st shift and 3rd shift fire drills and no 1st, 2nd, and 3rd shift disaster drills. 4th quarter (October-December 2024): -No 1st shift and 3rd shift fire drills, and no 1st, 2nd, and 3rd shift disaster drills. Interview on 01/27/2025 with Client #1 revealed: -Went outside to the mailbox for fire drills. -Went into the bathroom for tornado drills. Interview on 01/27/2025 with Client #2 revealed: -Went to the mailbox across the street for fire drills. -Went into the bathroom and got into the bathtub for tornado drills.	V 114		

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V 114	Continued From page 2 Interview on 01/27/2025 with Client #3 revealed: -"We go outside and go to the mailbox at the road." -Had not practiced a tornado drill. Interview on 01/27/2025 with Staff #1 revealed: -The facility had 5 shifts; 1st shift was 8 am-3 pm, 2nd shift was 3 pm-11 pm, 3rd shift was 11pm- 8 am, Weekend was 8am-8pm and 8pm-8am. Drills was not conducted on the weekend shift. -"We run fire and disaster drills at the same time." -"We can make sure we document it (fire and disaster drills) separately moving forward." -"I will make sure that all drills (fire and disaster) are performed at the precise times according to the shifts; first, second, third." -"Tornado drills have been run but have not been documented." -Would ensure fire and disaster drills were completed at least quarterly for each shift in the future. Interview on 01/28/2025 with the Qualified Professional (QP) revealed: -"I am not sure about that (missing fire and disaster drills). I could not find the book (fire and disaster drill logbook). The book was missing for a while. I will make sure that the drills (fire and disaster) are separated and ensure that the book does not go missing moving forward." Interview on 01/28/2025 with the Executive Administrator revealed: -"All drills (fire and disaster drills) should be ran on all shifts; first, second, third, and the weekend moving forward. The QP will be assigned that duty and will ensure that all drills be ran correctly."	V 114		

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V 118	Continued From page 3	V 118		
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. This Rule is not met as evidenced by:	V 118		

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V 118	Continued From page 4 Based on record reviews and interviews, the facility failed to ensure MARs were kept current for 1 of 3 clients (Client #1). The findings are: Review on 01/27/2025 of Client #1's record revealed: -Date of Admission: 07/23/2024. -14 years old. -Diagnoses: Attention Deficit Hyperactivity Disorder (ADHD); Oppositional Defiant Disorder; Adjustment Disorder. -Physician's orders included: -Melatonin 1 milligram (mg) 1-3 tablets by mouth (PO) 30 minutes before bedtime each night (Sleep) dated 11/18/2024. -Focalin Extended Release (XR) 20 mg 2 capsules PO in the morning (ADHD) dated 01/23/2025. Review on 01/27/2025 and 01/28/2025 of Client #1's MARs dated 11/01/2024 through 01/27/2025 revealed: -Melatonin 5 mg (instead of 1 mg) 1 tablet PO was initialed as having been administered for a total of 26 days from 01/01/2025-01/26/2025 with no documentation of the frequency. -Melatonin 1 mg 1-3 tablets PO was initialed as having been administered for a total of 61 days from 11/01/2024-12/31/2024 with no documentation of the frequency, or the number of tablets administered. -Focalin XR 20 mg 2 capsules was initialed as having been administered for a total of 3 days from 01/24/2025-1/27/2025 with no documentation of the route (instructions for administering the medication), or the frequency. Interview on 01/27/2025 and 01/28/2025 with Staff #1 revealed: -Transcribed physician's orders onto clients'	V 118		

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V 118	Continued From page 5 MARs each month. -Sometimes the local pharmacy had to have the physician's orders adjusted to match the available medication strength. -Did not realized the MARs were missing full administration instructions until he was made aware by Division Health Service Regulation Surveyors on 01/27/2025. -"I am not solely responsible for it (medication oversight)." -Would ensure compliance of medication administration protocol moving forward. Interview on 01/28/2025 with Staff #2 revealed: -Prior to administering medications, staff were required to compare medication labels to the MARs to "check it all matches." Interview on 01/28/2025 with Staff #3 revealed: -"No issues with medications that I am aware of." Interview on 01/28/2025 with the Qualified Professional revealed: -Staff #1 provided oversight for clients' medications and MARs. -"I am responsible for making sure all the (medication administration) requirements are met. I have not looked at the November and December (2024) MARs yet." Interview on 01/28/2025 with the Executive Administrator revealed: -"I am going to hire a Registered Nurse (RN) to come in monthly to check the MARs." -"I hope to have her (RN) hired by the end of February 2025."	V 118		
V 366	27G .0603 Incident Response Requirements	V 366		

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V 366	Continued From page 6 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 (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	V 366		

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V 366	Continued From page 7	V 366		

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 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

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V 366	Continued From page 8 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 reviews and interviews, the facility failed to implement written policies governing their response to Level II incidents. The findings are: Review on 01/27/2025 of the facility's incident reports from 11/01/2024 - 01/17/2025 revealed: -Staff #2 and Staff #5 utilized a restrictive intervention on Client #2 on 01/11/2025. Reviews on 01/27/2025 and 01/28/2025 of the Incident Response Improvement System (IRIS) from 11/01/2024 - 01/17/2025 revealed: -No response to Level 2 for Client #2's restrictive intervention incident dated 01/11/2025. Review on 01/27/2025 of the facility's records	V 366		

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V 366	Continued From page 9 revealed: No documentation support the above recorded incident had been evaluated to: -Determined the cause of the incident. -Assigned person to be responsible for implementation of the corrective and/or preventive measures. Interview on 01/28/2025 with Staff #1 revealed: -Could not identify who was responsible for determining the cause of the incident and assigning person to be responsible for implementation of the corrective and/or preventive measures for Client #2's restrictive intervention incident dated 01/11/2025. Interview on 01/28/2025 with the Qualified Professional revealed: -Could not identify who was responsible for determining the cause of the incident and assigning person to be responsible for implementation of the corrective and/or preventive measures for Client #2's restrictive intervention incident dated 01/11/2025. Interview on 01/28/2025 with the Executive Administrator revealed: -"Operation of the home (facility) is a team effort." -"I reviewed the incident report (dated 01/11/2025) and determined that an IRIS report was not needed." -"The Risk Cause Analysis will be documented the right way moving forward." -Would implement improvements to the agency's incident reporting system.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT	V 367		

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V 367	Continued From page 10 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 unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information	V 367		

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V 367	Continued From page 11 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 meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.	V 367		

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V 367	Continued From page 12	V 367		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to report all level II incidents in the Incident Response Improvement System (IRIS) and notify the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment area where services as required. The findings are:

Review on 01/27/2025 of the facility's incident reports from 11/01/2024 - 01/17/2025 revealed:
-Staff #2 and Staff #5 utilized a restrictive intervention on Client #2 on 01/11/2025.

Reviews on 01/27/2025 and 01/28/2025 of the IRIS from 11/01/2024 - 01/17/2025 revealed:
-No level II IRIS report and LME/MCO notification for Client #2's physical restraint incident dated 01/11/2025.

Interview on 01/28/2025 with Staff #1 revealed:
-Client #2 was placed in a physical restraint on 01/11/2025.
-"I notified [Executive Administrator] about the restraint."
-Was not responsible for entering the incident in IRIS.

Interview on 01/28/2025 with the Qualified Professional (QP) revealed:
-Was not aware of the 01/11/2025 incident, so the incident was not entered into IRIS.

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V 367	Continued From page 13 Interview on 01/28/2025 with the Executive Administrator revealed: -"I reviewed the incident report (dated 01/11/2025) and determined that an IRIS report was not needed." -"I have a meeting planned Friday (01/31/2025) to meet with all QPs to discuss what to put in IRIS and how to improve our incident reporting system."	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observations and interviews, the facility was not maintained in a clean, attractive, and orderly manner. The findings are: Observation on 01/27/2025 at approximately 10:45 am of the facility revealed: Client #2's bathroom: -Wooden floor strip with dark black spots covered the entire base of the shower from end to end. -Numerous dark black spots on the right interior lining of the shower. -Golf ball sized unfinished drywall repair area around the perimeter of the left end of the shower rod. -Soccer ball sized unfinished drywall repair area around the perimeter of the right end of the shower rod. -Football sized unfinished drywall repair area near	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-268	A. BUILDING: _____ B. WING _____	R 01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT HOUSE	927 FLOYD LANE GASTONIA, NC 28052

(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 736	Continued From page 14 the shower head. Overhead bathroom Light/Exhaust fan: -Covered in dust. Client #2's Bedroom ceiling fan: -No light cover. Hallway: -Air intake vent covered in dust. -Doorbell alarm box covered in dust. -Laundry doorframe covered in dust. Client #3's bedroom: -1 white plastic blind had approximately 9 broken slats. Interview on 01/27/2025 with Client #3 revealed: -"Blinds are broken because when I first got there (11/18/2024), I was frustrated, and I broke them." Interview on 01/27/2025 with Staff #1 revealed: -"Work orders have been placed for the flooring, areas of the bathroom and trim, light fixtures and things like that." -"Last work order, I think the last I remember was the bathrooms for the floor and the sink but [Executive Administrator] will have information at the office for that." Interview on 01/28/2025 with the Executive Administrator revealed: -"I replaced the blinds yesterday (01/27/2025)." -"Dusting is something that the second and third shift (staff) do. That is their duties." -"I will contact the landlord so that repairs are complete." This deficiency constitutes a re-cited deficiency	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-268	A. BUILDING: _____ B. WING _____	R 01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELMONT HOUSE	**927 FLOYD LANE GASTONIA, NC 28052**

(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 736	Continued From page 15 and must be corrected within 30 days.	V 736		