STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL090-218	A. BUILDING: _____ B. WING _____	R 03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENDON COTTAGE	1915 HASTY ROAD, SUITE D MARSHVILLE, NC 28103

(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 and follow up survey was completed on 3-31-25. The complaint was unsubstantiated (#NC00228709). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G Residential Treatment for Children or Adolescents. This facility is licensed for 12 and currently has a census of 6. The survey sample consisted of 1 former client.	V 000		
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 (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.	V 366		

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V 366	Continued From page 1 (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 LME in whose catchment area the provider is located and to the LME where the client resides,	V 366		

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V 366	Continued From page 2 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 failed to implement written policies for level I incidents. The findings are:	V 366		

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V 366	Continued From page 3 Review on 3-31-25 of Level I incident reports revealed: -One level 1 incident report dated 3-27-25 of Former Client #1 leaving the facility and returning on his own. -No level I incident report dated for the incident on 3-16-25 Review on 3-31-25 of Former Client #1's record revealed: -Admitted 10-26-23. -16 years old. -Diagnoses include: Attention Deficit Disorder, Post Traumatic Stress Disorder, and Oppositional Defiant Disorder. Interview on 3-27-25 with local store owner revealed: -Former Client #1 (FC#1) came into the store on 3-16-25 when she was working by herself. -FC#1 told her that someone had spilled a drink in back of the store and walked with her to the back of the store to show her. -She cleaned up the spill, but FC#1 disappeared. -After she had finished cleaning, she didn't see FC#1 anymore. -She didn't get a chance to watch the video until 3-17-25. -She then saw FC#1 on video, going behind the counter and trying to get into the cigar case, but it was locked. -FC#1 then took at least one pack of cigarettes and a lighter, hung around the front of the store for several minutes and left. Interview on 3-27-25 with Former Client #1 revealed: -Other clients in the facility were threatening	V 366		

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V 366	Continued From page 4	V 366		

to "jump" him if he didn't go get them some cigars from the store.

-Staff was "doing other things" when he eloped from the facility.

-When he got to the store, he took a soda bottle and poured it on the store floor and when the store staff was cleaning it up he took the cigarettes and left.

-He was gone from the facility approximately 35 minutes.

-Staff saw him run into the woods, but didn't know he had left the property.

-He didn't remember the date or the time that this incident happened.

-The clients often play outside behind the facility.

-The staff are always supervising the clients and they are never left alone.

Interview on 3-27-25 with Staff #1 revealed:

-On 3-16-25 the facility had a kickball tournament so some clients were on the football field with staff.

-The football field can be accessed by going through the woods.

-FC#1 was supposed to be going up to the field.

-She knew that he was "out of supervision" (meaning staff didn't know where he was).

Interview on 3-27-25 with the facility supervisor revealed:

-He was told that FC#1 was walking around the facility and they had lost site of him.

-They thought he might have left the campus, but could not confirm that.

-Several people had phoned him about FC#1 being out of supervision so he was aware of the situation,

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V 366	Continued From page 5 Interview on 3-27-25 with the Director revealed: -Staff knew that FC#1 had run into the woods. -Staff was not sure that he had left the campus. -Staff did notify the supervisor and told him about the situation. -FC#1 left and came back to the facility on his own. -An incident report should have been completed.	V 366		
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	V 367		

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V 367	Continued From page 6 (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 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:	V 367		

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V 367	Continued From page 7 (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. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to report all Level II incidents to the Local Management Entity within 72 hours of becoming aware of the incident. The findings are: Review on 3-27-25 of the North Carolina Incident Response Improvement System (IRIS) revealed: -No level II incident report dated for the incident on 3-16-25. Review on 3-27-25 of picture of Former Client #1 revealed: -Timed 2:34 pm Former Client #1 was climbing over the facility fence, returning to the facility.	V 367		

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V 367	Continued From page 8 Review on 3-31-25 of police report dated 3-18-25 revealed: -No client name was on the report. -Larceny/Misdemeanor. -One pack of cigarettes valued at 8.00 stolen. Review on 3-31-25 of Former Client #1's record revealed: -Admitted 10-26-23. -16 years old. -Diagnoses include: Attention Deficit Disorder, Post Traumatic Stress Disorder, and Oppositional Defiant Disorder. Interview on 2-27-25 with the IRIS Administrator revealed: -There was no incident report related to the incident on 3-16-25 with Former Client #1. Interview on 3-27-25 with local store owner revealed: -Former Client #1 (FC#1) came into the store on 3-16-25 when she was working by herself. -FC#1 told her that someone had spilled a drink in back of the store and walked with her to the back of the store to show her. -She cleaned up the spill, but FC#1 and left her line of site. -After she had finished cleaning, she didn't see FC#1 anymore. -She didn't get a chance to watch the store video of that time period until 3-17-25. -She then saw FC#1 on video, going behind the counter and trying to get into the cigar case, but it was locked. -FC#1 then took at least one pack of cigarettes and a lighter, hung around the front of the store for several minutes and left. -She then called the police to look at the video and the police identified FC #1.	V 367		

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V 367	Continued From page 9 Interview on 3-27-25 with the local police officer revealed: -He was called to the local store on the 17th or 18th about an incident that happened on 3-16-25. -He watched the video and it was clear that FC#1 poured detergent on the floor and then went behind the counter up front. -The officer could identify FC#1 because he had "dealt with him several times before." -He went to the facility and spoke to the Director about the incident. -They facility had not known that FC#1 had left the facility on 3-16-25. -"I gathered they told me they didn't know he was gone the whole time." Interview on 3-27-25 with FC#1's Department of Social Services guardian revealed: -She had not been notified that FC#1 had left campus and stolen items from the local store. Interview on 3-27-25 with Former Client #1 revealed: -Other clients in the facility were threatening to "jump" him if he didn't go get them some cigars. -He took a soda bottle and poured it on the store floor and when the store staff was cleaning it up he took the cigarettes and left. -Staff were "doing other things" when he eloped from the facility. -He was gone from the facility approximately 35 minutes. -Staff saw him run into the woods, but didn't know he had left. -He didn't remember the date or the time that this incident happened. -The clients often play outside behind the	V 367		

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V 367	Continued From page 10	V 367		

facility.
-The staff are always supervising the clients and they are never left alone.

Interview on 3-27-25 with Client #2 revealed:
-He didn't know anything about FC#1 leaving the campus on 3-16-25.
-Staff were always supervising them and they were never left alone.

Interview on 3-27-25 with Client #3 revealed:
-Staff were always supervising them.

Interview on 3-27-25 with Staff #1 revealed:
-On 3-16-25 the facility had a kickball tournament so some clients were on the football field with staff.
-The football field can be accessed by going through the woods.
-FC#1 was supposed to be going up to the field.
-She knew that he was "out of supervision" (meaning staff didn't know where he was).
-She let her supervisor know that FC#1 was out of supervision.
-She didn't know until later that he had stolen anything from the local store.

Interview on 3-27-25 with Staff #2 revealed:
-She had been working at another facility on 3-16-25.
-FC#1 had "got missing, but it wasn't long."
-She did contact the supervisor that FC#1 was out of supervision.
-She had taken a picture of FC#1 climbing back over the fence and sent it to the supervisor.
-They had not realized that FC#1 was off campus until he returned.
-The supervisor had a meeting about supervision later that day (3-16-25).

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V 367	Continued From page 11 Interview on 3-27-25 with the facility supervisor revealed: -He was told that FC#1 was walking around the facility and they had lost site of him. -They thought he might have left the campus. -Several people had phoned him about FC#1 being out of supervision. -He had not known that FC#1 had left the campus until the police came several days later. -He was the one that was supposed to put the incident in IRIS, but he was waiting for more information. from the police. -He knows now that he should have entered the information in IRIS and then gone back in when he had more information, Interview on 3-27-25 with the Director revealed: -Staff knew that FC#1 had run into the woods. -Staff was not sure that he had left the campus. -FC#1 left and came back to the facility on his own. -An incident report should have been completed. -When the police came out and reported that FC#1 had stolen cigarettes, that would raise the incident level to a level II. - He was later told that the supervisor was waiting for more information from the police. -He has IRIS training regularly for the staff. -He also told the supervisor that he should have entered the information and then more information could added later.	V 367		