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V 000	INITIAL COMMENTS A complaint survey was completed on 3/20/25. The complaint was substantiated (Intake #NC00227186). 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 2. The survey sample consisted of audits of 1 current client and 1 former client.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility	V 105		

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V 105	Continued From page 1 can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to develop and implement written policies on delegating management authority for the operation of services. The findings are:

- Requested on 2/26/25 from the House Manager, the written policy for when a client is in crisis (behavioral, medical). Received on 2/26/25 the written policy for Alternative and Restrictive Interventions.
- Requested on 2/27/25 from the Director/Licensee, the written policy for when a client is in crisis. Received an email on 2/27/25 from the Director/Licensee at 10:05pm with 2 attachments: Incident Reporting Policy and certifications;
- Never received any policy on delegating management authority for the operation of services during a crisis, prior to surveyor exit.

Interview on 2/27/25 with Staff #1 revealed:
- "I'm sure I was trained in it (protocol for crisis), it's been so long ...so, I'm sure it slipped my mind;"
- "Can't remember why EMT (Emergency Medical Technicians) were not called;"
- Have not been retrained on policy when a client is in crisis since the incident on 1/28/25;
- The House Manager is the first contact when there is an incident in the facility.

Interview on 2/27/25 with Staff #2 revealed:
- Immediate supervisor was the House Manager;
- After the incident on 1/28/25 with Former Client

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#2, the Qualified Professional discussed the protocol for when a client was in crisis;
- "The protocol now is to notify authorities, make sure managers are able to arrive on the scene and diffuse the situation;
- Unable to provide date when the QP went over the new policy.

Interview on 2/27/25 with the House Manager Revealed:
- Became the House Manager in November 2024;
- "I'm the first line of contact, I'm on call basically 24 hours, except for Sundays;"
- Direct Care staff reported to the House Manager and the House Manager reported to upper management (QP, Director/Licensee);
- "This has been our protocol since I became the House Manager, so all the direct care staff won't call upper management."

Interview on 3/5/25 and 3/30/25 with the Qualified Professional revealed:
- "Our protocol for a crisis is for the direct care staff to contact the House Manager. She (House Manager) will de-escalate the situation and inform us (QP, Director/Licensee) of the crisis that has occurred ...If it's an issue of I'm not just informing you, I need assistance then she will get assistance. That is the immediate protocol."
- Was setting up a training "in lieu of the incidents (incident on 1/28/25 with FC #2, 1/29/25 with Client #1);"
- "Moving forward it's not just notifying [House Manager] but it's notifying us (upper management) as well;"
- Completed an informal refresher on protocol when "looking at a suicidal ideation" with all staff, "right after we learned of the incident on 1/29/25;"
- "We will have an official training, but we have

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V 105	Continued From page 4 already put this into play with staff moving forward, you notify [House Manager] but you also notify additional management as well for any crisis situation. It will be communicated in writing and verbally;" - On March 9, 2025, completed a training called "crisis, protocol and client safety, that went over the protocol for staff and what to do." Interview on 3/4/25 with the Director/Licensee revealed: - Staff called the House Manager as first point of contact; - House Manager would contact upper management if she unavailable when direct care staff reached out to her; - Direct care staff was expected to call upper management as well, to inform upper management about a crisis; - Direct care staff needed one person to contact instead of all of upper management; - "We try to update policy as things happen ..., when we refine the policy, we will retrain everyone to make sure its crystal clear;"	V 105		
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	V 112		

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V 112	Continued From page 5 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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement strategies based on assessments and failed to have written consent or agreement by client's legal guardian or responsible party for 1 of 1 current audited clients (Client #1) and 1 of 1 Former Client (FC #2). The findings are: Review on 2/24/25 of Client #1's record revealed: - Admission date 10/21/24; - Age 14 yrs; - Diagnoses Attention Deficit Hyperactivity Disorder, Reaction to Severe Stress - Person Centered Plan (PCP) updated on 1/29/25; - There was no signature or written consent from the guardian or responsible party on Client #1's	V 112		

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V 112	Continued From page 6 treatment plan. Review on 2/24/25 of Former Client #2's record revealed: - Admission date 10/14/24; - Age 16 yrs; - Diagnoses Attention Deficit Hyperactivity Disorder, Post Traumatic Stress Disorder, Reactive Attachment Disorder; - Comprehensive Clinical Assessment (CCA) dated 10/9/24..Symptoms: "[FC #2] experienced suicidal ideations and required hospitalization to stabilize symptoms ...She is not clear about triggers and becomes elevated and flooded with emotions. This results in her becoming very reactive with caregivers and finding it difficult to self-regulate. At times her decision-making process can be impulsive and she is unable to see the consequences of her actions. [FC #2] is easily bored and this can result in seeking conflicts;" - Person Center Plan updated on 1/29/25: No goals to address suicidal ideation; - There was no signature or written consent from the guardian or responsible party on FC #2's treatment plan; - Discharge date 2/3/25. Review on 2/19/25 of the facility's incident report for FC #2 revealed: - Incident Report: date 1/28/25; client name [FC #2] - Incident Description: blank; - Behind the incident report were two additional sheets of paper with the following typed information: - 1st sheet-"Incident reports 1/27; - "Staff picked up client (FC #2) up from school. Client got home and began to destroy her room. Client was asked to exit her room but while	V 112		

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V 112	Continued From page 7 in transition client pushed over dresser and began to stomp the back out making physical threats to staff. Client was asked to stop and then put into a CPR restraint. Client continued to rage and eventually stopped. Client then headed to bed after being exhausted from being restrained. The next morning staff processed the incident with client. Client indicated that she "wants to go to the hospital and will do whatever it takes." Staff continued to process with client outlining the possible negative consequences of her actions. Client stated she no longer wanted to reside in group home. Management was informed of the incident;" - Signed off by the Qualified Professional on 1/28/25; - 2nd sheet- 1/28; - Client (FC #2) was picked up from alternative school. Upon arriving home client snatched the phone and called her mom. Soon after client was confronted, by another client (Client #1). Staff (House Manager) got involved and separated clients to avoid confrontation. Following client (FC #2) ran out of the house with the phone. Staff (House Manager) followed client; client sat down on the bricks outside the front door to calm down. Client then stood up threw a brick through the front window. Client then approached staff with closed fist and back turned punching staff 4X (4 times) in the back of the head. Client was the put into CPI restraint until de-escalation. Following client was escorted back into the house. Client ate dinner and stated that she was calm. Management was notified and instructed staff to monitor the client closely to ensure client and staff safety;" -Signed off by QP on 1/28/25. - Incident Report: dated 1/28/25; client name [FC #2];	V 112		

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- Staff involved: Staff #1, Staff #2;
- Incident Description- blank;
- Behind the incident report was an additional sheet of paper with the following typed information:
- "Client (FC #2) was calm after dinner, at approximately 5:30 client walked out of the facility and stood out front of the house. Client proceeded to run before staff could intervene, client picked a piece of glass from the window she broke earlier (approximately 4:30). Client made superficial cuts on palm of her hand and her forearm. Staff (Staff #2) was able to coerce her into putting the piece of glass and escorted back into the home.

Management (House Manager) was notified and instructed staff to ensure client had a one on one for the rest of the evening. At approximately 7pm following night time routine client was sitting in the dinner on the floor. Staff (Staff #1) turned away to get water, client ran into the bathroom indicating she had a jump rope and was going to hang herself. Staff (Staff #2) went into the bathroom cut the rope from client's neck with a pair of scissors. At this point client laid down in the bathrub (bathtub) and finally started to calm down. Client accepted her medication and took it. She treated and bandaged her cuts. Client immediately went to her room and went to sleep. Staff informed the house manager of the incident. The house manager did not notify upper management of the incident. Management become aware of the incident on 1/29/25 client was transported by EMT (Emergency Medical Technician) to (local) hospital for a medical and psychiatric evaluation. Client was admitted to [local hospital] as a result of emotionally instability.

Management informed house manager that she did not follow proper protocol by not notifying

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V 112	Continued From page 9 them of the incident when it occurred;" -Signed by QP for 1/28/25 Interview on 3/20/25 with the Qualified Professional revealed: - Was responsible for treatment plans; - Had signed copies of the PCP's for Client #1 and FC #2; - Aware FC #2 had no goals to address suicidal ideation; - "We will ensure the initial treatment plan coincide with the initial CCA recommendations and when necessary, adjustment every 30 days and thereafter. This is be monitored monthly with CFT (child and family team) meetings."	V 112		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility.	V 132		

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V 132	Continued From page 10 d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure Health Care Personnel Registry (HCPR) was notified of an allegation against facility staff, failed to protect the clients while the investigation was in process and failed to report the results of the investigation within five working days of the investigation. The findings are: Review on 2/19/25 of the North Carolina Incident Response Improvement System (IRIS) from November 19, 2024-February 19, 2025 revealed: - No documentation of Former Client (FC) #2's suicide attempt on 1/28/25 in IRIS. Review on 2/19/25 of the facility's incident report for FC #2 from November 19, 2024- February 19, 2025 revealed: - Incident Report: dated 1/28/25; client name [FC #2]; - Staff involved: Staff #1, Staff #2; - Incident Description- blank; - Behind the incident report was an additional sheet of paper with the following typed information: - "Client (FC #2) was calm after dinner, at approximately 5:30 client walked out of the facility	V 132		

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and stood out front of the house. Client proceeded to run before staff could intervene, client picked a piece of glass from the window she broke earlier (approximately 4:30). Client made superficial cuts on palm of her hand and her forearm. Staff (Staff #2) was able to coerce her into putting the piece of glass and escorted back into the home.
Management (House Manager) was notified and instructed staff to ensure client had a one on one for the rest of the evening. At approximately 7pm following night time routine client was sitting in the dinner on the floor. Staff (Staff #1) turned away to get water, client ran into the bathroom indicating she had a jump rope and was going to hang herself. Staff (Staff #2) went into the bathroom cut the rope from client's neck with a pair of scissors. At this point client laid down in the bathrub (bathtub) and finally started to calm down. Client accepted her medication and took it. She treated and bandaged her cuts. Client immediately went to her room and went to sleep. Staff informed the house manager of the incident. The house manager did not notify upper management of the incident. Management become aware of the incident on 1/29/25 client was transported by EMT (Emergency Medical Technician) to (local) hospital for a medical and psychiatric evaluation. Client was admitted to [local hospital] as a result of emotionally instability.
Management informed house manager that she did not follow proper protocol by not notifying them of the incident when it occurred;"
-Signed by the Qualified Professional for 1/28/25.

Review on 2/27/25 of the facility's Investigative Memorandum revealed:
- Allegations: "Client [FC #2] had rope marks

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around her neck. [Licensee] noticed marks on 1/29/25 after [FC #2] caused (called) the police requesting to go to the hospital;"
- Summary of Investigation- "[House Manager] was informed that she did not follow appropriate safety protocol by not notifying management nor contacting [local police]. [House Manager] was placed on 90 probation and received a write up. Staff was retrained on safety protocol during crisis situations and CPI (Crisis Prevention Institute). [FC #2]'s social worker was notified of the incident and an incident report was filed in IRIS. [FC #2] was admitted to inpatient hospitalization on 1/29/25. [FC #2] was discharged from [Licensee] on 2/3/25 as a result if medical necessity; recommended client receive a higher level of care to meet her emotional and behavioral needs;"
- No documentation that the facility made every effort to protect clients from abuse, neglect or exploitation while an investigation was in process;
- No documentation of reporting to HCPR of an allegation against the House Manager for not seeking medical treatment for FC #2 due to suicide attempt on 1/28/25.

Interview on 2/19/25 with Client #1 revealed:
- Was told by FC #2 "this place (facility) is making me depressed" on 1/28/25;
- FC #2 broke a window and used the glass to try and cut herself on 1/28/25;
- FC #2 went into the bathroom with a rope and tried to kill herself;
- "I kept telling them (Staff #1, Staff #2, House Manager) to call the hospital and so did the client (FC #2) and they would not call the hospital."

Interview on 3/4/25 with FC #2 revealed:
- "I broke a window and cut my hand" the day before going to the hospital on 1/29/25;

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- "I can't remember what else that happened on yesterday;"
- "They (Emergency Medical Services) brought us to the hospital" on 1/29/25;
- "I stayed in the hospital due to suicidal ideations."

Interview on 2/27/25 with Staff #1 revealed:
- FC #2 was on the telephone with her parent, "crying and visibly upset" upon start of shift on 1/28/25;
- FC #2 went outside and "picked up a brick and threw it through one of our front windows of the house;"
- FC #2 punched the House Manager three times in the head;
- FC #2 "picked up some glass and made superficial cuts on her palms and up one arm before we (Staff #1, Staff #2) could get the glass away from her;"
- FC #2 was sitting in the dining room and grabbed a rope and ran into the bathroom;
- "By the time I got to the bathroom, she had put the jump rope loosely around her neck;"
- "The minute I put my hands on the jump rope she grabbed the ends of it to make it tight;"
- Staff #2 came into the bathroom, while Staff #1 ran to grab the scissors for Staff #2 to cut the rope off her;
- FC #2 then laid in the bathtub until she calmed down and was ready for bed;
- Staff #2 notified the House Manager of the incident;
- Don't know why EMS was not contacted.

Interview on 2/27/25 with Staff #2 revealed:
- Was debriefed by the House Manager upon shift on 1/28/25, that FC #2 was having "bad behavior;"
- FC #2 went outside, "I looked over and seen her

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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 132	Continued From page 14 taking the glass cutting herself with the glass;" - FC #2 was crying and telling us (Staff #1, Staff #2) "back away, back up;" - Client #1 came outside and told FC #2 "it's not worth it, stop;" - FC #2 went into the home crying and washed off her hand; - FC #2 was sitting in the dining room area when she grabbed a rope and ran into the bathroom; - Ran into the bathroom and FC #2 had the rope around her neck but not to tight so that I couldn't grab the rope; - FC #2 stated that she was trying to tie the rope around her neck; - Used scissors to cut the rope from around FC #2's neck; - FC #2 tried to "wrestle" Staff #2 out of the bathroom; - Sat a chair in the doorway of the bathroom and played a song to help FC #2 calm down while she laid the bathtub; - Once FC #2 was calmed down, she took her medications and went to bed for the night; - Called the House Manager during the incident and informed her what was happening at the facility; - House Manager was supposed to have notified upper management; - No one called the local EMS or police. Interview on 2/26/25 with the House Manager revealed: - On, 1/28/25, FC #2 was on the telephone with her parent, when she was informed it was time for Client #1 to make a call; - FC #2 yelled at the House Manager, "stop f*****g talking to me;" - Waited 5 minutes then asked the parent for help with the situation with FC #2 due to them still being on the telephone;	V 132		

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V 132	Continued From page 15 - Client #1 attempted to say something to FC #2 but was redirected for the House Manager to handle the situation; - FC #2 then handed off the telephone to Client #1 with her parent still on the telephone; - FC #2 went outside and sat on the step of the facility; - FC #2 threw a brick through the window of the facility; - Staff #1 had started her shift and was in the facility when FC #2 threw the brick into the facility; - Tried to get FC #2's parent to speak with her on the telephone, but FC #2 attacked the House Manager by punching her in the head; - Staff #2 arrived at the facility; - Told Staff #2 "to keep an eye on" FC #2 due to her behaviors; - Received a text message about 10-15 minutes after leaving the home from Staff #2 concerning FC #2's behavior; - Received a video call from Staff #2 showing FC #2 was outside trying to cut herself; - The conversation was brief, then the House Manager attempted to call the Qualified Professional and the Director/Licensee but there was no answer from either person; - Sent a text message to Staff #2 to check on FC #2 and received a message back saying she was fine; - Received a second call from Staff #2 stating that FC # put a rope around her neck, wand wanted to know what should he do; - Staff #2 asked about calling 911 or EMT, and the House Manager told Staff #2 " let me call [QP] to make sure I'm doing right;" - "[QP] still doesn't answer" - Called Staff #2 back in 3 minutes and was informed FC #2 was laying in the bathtub crying; - Staff #2 stated "they were good, there was no mention of marks on her neck;"	V 132		

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V 132	Continued From page 16 - After being informed "they were good, I didn't make another call to management;" - "I didn't know the extent of the injury;" - " I dropped the ball by not doubling back when I was done with work at 7:45pm", at other employment. Interview on 3/5/25 and 3/20/25 with the Qualified Professional revealed: - Became aware of FC #2's suicide attempt on 1/29/25 when the local police were at the home due to another incident with Client #1; - Started an internal investigation on 1/29/25; - Interviewed Staff #1, Staff #2, the House Manager and the Director/Licensee; - Completed an IRIS report on 1/29/25; - Was not aware the IRIS report was not submitted into IRIS; - Was not aware that staff should not have contact with clients during the investigation to ensure safety of clients; - Was not aware about the HCPR forms being completed until the Director/Licensee informed her on 3/20/25 that the information was being completed but not documented in the internal investigation. Interview on 3/4/25 and 3/20/25 with the Director/Licensee revealed: - Was not notified by the House Manager or Direct Care staff about FC #2 suicide attempt on 1/28/25; - Became aware of FC #2's suicide attempt on 1/29/25 when the local police were at the home due to another incident with Client #1; - QP completed the internal investigation; - "We are doing this (completing the HCPR) but it's not being documented" in the internal investigation.	V 132		

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V 293	Continued From page 17	V 293		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in	V 293		

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V 293	Continued From page 18 gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure continuous staff supervision, minimize the occurance of behaviors related to functional deficits and coordinate with individuals within a client's system of care affecting 1 or 1 Former Clients (FC #2). The findings are: Cross Reference: 10A NCAC 27G .1704 Minimum Staffing Requirements (V296). Based on record review, observation and interviews the facility failed to ensure the minimum staff ratio of two staff for up to four children or adolescents. Review on 2/24/25 of FC #2's record revealed: - Comprehensive Clinical Assessment (CCA) dated 10/9/24 Symptoms: "[FC #2] experienced suicidal ideations and required hospitalization to stabilize symptoms ...She is not clear about triggers and becomes elevated and flooded with emotions. This results in her becoming very	V 293		

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reactive with caregivers and finding it difficult to self-regulate. At times her decision-making process can be impulsive and she is unable to see the consequences of her actions. [FC #2] is easily bored and this can result in seeking conflicts."

Review on 2/19/25 of the facility's incident report for FC #2 revealed:
- Incident Report: date 1/28/25;
- Incident Description: blank;
- Behind the incident report were two additional sheets of paper with the following typed information:
- 1st sheet-"Incident reports 1/27 (2025);
- "Staff (House Manager) picked up client (FC #2) up from school. Client got home and began to destroy her room. Client was asked to exit her room but while in transition client pushed over dresser and began to stomp the back out making physical threats to staff. Client was asked to stop and then put into a CPR restraint. Client continued to rage and eventually stopped. Client then headed to bed after being exhausted from being restrained.
- The next morning staff (House Manager) processed the incident with client. Client indicated that she 'wants to go to the hospital and will do whatever it takes.' Staff continued to process with client outlining the possible negative consequences of her actions. Client stated she no longer wanted to reside in group home. Management was informed of the incident;"
- Signed off by the QP (Qualified Professional)on 1/28/25;
- 2nd sheet- 1/28 (2025);
- "Client (FC #2) was picked up from alternative school. Upon arriving home client snatched the phone and called her mom. Soon after client was confronted, by another client

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(Client #1). Staff (House Manager) got involved and separated clients to avoid confrontation. Following client (FC #2) ran out of the house with the phone. Staff (House Manager) followed client; client sat down on the bricks outside the front door to calm down. Client then stood up threw a brick through the front window. Client then approached staff with closed fist and back turned punching staff (House Manager) 4X (4 times) in the back of the head. Client was then put into CPI restraint until de-escalation.
Following client was escorted back into the house. Client ate dinner and stated that she was calm. Management was notified and instructed staff to monitor the client closely to ensure client and staff safety;"

-Signed off by the QP on 1/28/25.

- Incident Report: dated 1/28/25;
- Staff involved: Staff #1, Staff #2;
- Incident Description- blank;

- Behind the incident report was an additional sheet of paper with the following typed information:

- "Client (FC #2) was calm after dinner, at approximately 5:30 pm client walked out of the facility and stood out front of the house. Client proceeded to run before staff could intervene, client picked a piece of glass from the window she broke earlier (approximately 4:30 pm). Client (FC #2) made superficial cuts on palm of her hand and her forearm. Staff (Staff #2) was able to coerce her into putting the piece of glass and escorted back into the home.
- Management (House Manager) was notified and instructed staff to ensure client had a one on one for the rest of the evening. At approximately 7pm following night time routine client was sitting in the dinner on the floor. Staff (Staff #1) turned away to get water, client ran into the bathroom indicating she had a jump rope and was going to hang

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herself. Staff (Staff #2) went into the bathroom cut the rope from client's neck with a pair of scissors. At this point client laid down in the bathrub and finally started to calm down. Client accepted her medication and took it. She treated and bandaged her cuts. Client immediately went to her room and went to sleep.
- Staff informed the house manager of the incident. The house manager did not notify upper management of the incident. Management become aware of the incident on 1/29/25 client was transported by EMT (Emergency Medical Technician) to [local hospital] hospital for a medical and psychiatric evaluation. Client was admitted to [local hospital] as a result of emotionally instability.
Management informed house manager that she did not follow proper protocol by not notifying them of the incident when it occurred;"
-Signed by QP for 1/28/25

Interview on 2/19/25 with Client #1 revealed:
- Was told by FC #2 "this place (facility) is making me (FC #2) depressed" on 1/28/25;
- "[House Manager] was here with us (Client #1 and FC #3) and then [Staff #1] and [Staff #2] came," on 1/28/25;
- FC #2 broke a window and used the glass to try and cut herself on 1/28/25;
- FC #2 went into the bathroom with a rope and tried to "kill herself;"
- "I kept telling them (Staff #1, Staff #2, House Manager) to call the hospital and so did the client (FC #2) and they would not call the hospital on 1/28/25."

Interview on 3/4/25 with FC #2 revealed:
- "I broke a window and cut my hand" the day before going to the hospital on 1/29/25;
- "I can't remember what else that happened on

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that day (1/28/25);"
- "They (Emergency Medical Services (EMS)) brought us (Client #1 and FC #2) to the hospital" on 1/29/25;
- "I stayed in the hospital due to suicidal ideations."

Interview on 2/27/25 with Staff #1 revealed:
- FC #2 was on the telephone with her parent, "crying and visibly upset" upon start of shift on 1/28/25;
- "[House Manager] was at the facility alone with the clients (Client #1 and FC #2);"
- FC #2 went outside and "picked up a brick and threw it through one of our front windows of the facility;"
- FC #2 punched the House Manager three times in the head;
- FC #2 came back into the facility and calmed down;
- House Manager had left the facility, when shift was over, Staff #1 and Staff #2 were at the facility with Client #1 and FC #2;
- FC #2 went back outside and "picked up some glass and made superficial cuts on her palms and up one arm before we (Staff #1, Staff #2) could get the glass away from her;"
- Staff #1 and Staff #2 were able to get FC #2 to come back into the facility;
- FC #2 was sitting in the dining room and grabbed a rope and ran into the bathroom;
- "By the time I (Staff #1) got to the bathroom, she (FC #2) had put the jump rope loosely around her neck;"
- "The minute I put my hands on the jump rope she grabbed the ends of it to make it tight;"
- Staff #2 came into the bathroom, " I ran out, grabbed the scissors, handed him the scissors and he cut the rope off her;"
- FC #2 then laid in the bathtub until she calmed

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down and was ready for bed;
- Staff #2 notified the House Manager of the incident;
- Don't know why EMS was not contacted on 1/28/25 for FC #2 to go to the local hospital.

Interview on 2/27/25 with Staff #2 revealed:
- Was debriefed by the House Manager upon shift (4:30pm-10pm) on 1/28/25, that FC #2 was having "bad behavior;"
- House Manager informed Staff #2 to monitor FC #2 due to her behaviors of throwing a brick in the window and hitting House Manager in the head;
- After the debriefing the House Manger left the facility upon end of shift at 5pm;
- FC #2 went outside, "I looked over and seen her taking the glass cutting herself with the glass;"
- FC #2 was crying and telling us (Staff #1, Staff #2) "back away, back up;"
- Client #1 came outside and told FC #2 "it's not worth it, stop;"
- FC #2 went into the home crying and washed off her hand;
- FC #2 was sitting in the dining room area when she grabbed a rope and ran into the bathroom;
- Ran into the bathroom and FC #2 had the rope around her neck but not to tight so that I couldn't grab the rope;
- FC #2 stated that she was trying to tie the rope around her neck, the other end of the rope was around the shower curtain pole;
- "I said, somebody grab me some scissors;"
- Grabbed scissors from Staff #1 to cut the rope from around FC #2's neck;
- FC #2 tried to "wrestle" Staff #2 out of the bathroom;
- Sat in the doorway of the bathroom and played a song to help FC #2 calm down while she laid in the bathtub;
- Once FC #2 calmed down, she took her

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medications and went to bed for the night;
- Called the House Manager after I cut the rope from around FC #2's neck and informed her what was happening at the facility;
- House Manager was supposed to have notified upper management;
- No one called the local EMS or police on 1/28/25 for FC #2;
- New protocol was to contact the authorities, QP and Director/Licensee.

Interview on 2/26/25 with the House Manager revealed:
- On 1/28/25, FC #2 yelled "stop f*****g talking to me" when she was on the telephone with her parent, due to being told it was time for Client #1 to make a call;
- Waited 5 minutes then asked the parent for help with the situation with FC #2 due to them still being on the telephone;
- Redirected Client #1 when she attempted to say something to FC #2;
- FC #2 then handed off the telephone to Client #1 with her parent still on the telephone;
- Shortly after FC #2 went outside and sat on the step of the facility, she threw a brick through the window of the facility;
- Staff #1 had started her shift and was in the facility when FC #2 threw the brick into the facility;
- Tried to get FC #2's parent to speak with her on the telephone, but was then punched in the head by FC #2 while still on the telephone with FC #2's parent;
- Staff #2 arrived at the facility for his shift;
- Told Staff #2 "to keep an eye on" FC #2 due to her behaviors of hitting and throwing a brick in the window;
- Received a text message about 10-15 minutes after leaving the facility from Staff #2 concerning FC #2's behavior. Staff #2 then video called to

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V 293	Continued From page 25 show FC #2 cutting herself; - After a brief conversation with Staff #2, attempted to call the Qualified Professional and the Director/Licensee but there was no answer from either person; - Sent a text message to Staff #2 to check on FC #2 and received a message back saying she was fine; - Received a second call from Staff #2 stating that FC #2 put a rope around her neck, and wanted to know what should he do; - Staff #2 asked about calling 911 or EMT, told Staff #2 " let me call [QP] to make sure I'm doing right;" - "[QP] still doesn't answer" - Called Staff #2 back in 3 minutes and was informed FC #2 was laying in the bathtub crying; - Staff #2 stated "they were good, there was no mention of marks on her neck;" - After being informed "they were good, I didn't make another call to management;" - "I didn't know the extent of the injury;" - "I dropped the ball by not doubling back when I was done with work (other employment) at 7:45pm on 1/28/25;" - "I'm the first line of contact, I'm on call basically 24 hours, except for Sundays;" - Direct Care staff reported to the House Manager and the House Manager reported to upper management (QP, Director/Licensee); - "This has been our protocol since I became the House Manager, so all the direct care staff won't call upper management." Interview on 2/28/25 with the Department of Social Services Social Worker/Legal Guardian of FC #2 revealed: - Was informed about FC #2's suicide attempt on 1/29/25; - "I never got a straight story from the group	V 293		

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home about what happened," when FC #2 attempted suicide on 1/28/25;
- FC #2 reported that "she attempted suicide in the evening (1/28/25) and woke up with marks" around her neck and "that's when the group home decided to send her to the hospital;"
- " I understand how they got to that point (not taking her suicide attempts serious) because [FC #2] threatens suicide all the time and she is always threatening to go to the hospital, so I can see how it happened, but that attempt was pretty serious;"
- "There were serious marks from cutting herself with the glass;"
- "I'm concerned they (staff) didn't send her to the hospital that night (1/28/25);"
- "I talked with [Director/Licensee] twice and I asked specific questions about why client (FC #2) didn't go to the hospital that night (1/28/25) and he stated he didn't know both times on the separate days so I don't know their reasoning for not taking her to the hospital."

Interview on 3/5/25 and 3/20/25 with the Qualified Professional revealed:
- "According to [House Manager], she tried to call myself and [Director/Licensee] but we didn't answer, which very well could have been the case."
- Became aware of FC #2's suicide attempt on 1/29/25 when the local police were at the facility due to another incident with Client #1;
- Started an internal investigation on 1/29/25;
- Interviewed Staff #1, Staff #2, the House Manager and the Director/Licensee;
- House Manager was placed on a 90 day probation and written up on 1/29/25;
- "Our protocol for a crisis is for the direct care staff to contact the House Manager. She (House Manager) will de-escalate the situation and inform

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V 293	Continued From page 27 us (QP, Director/Licensee) of the crisis that has occurred ...If it's an issue of I'm not just informing you, I need assistance then she will get assistance. That is the immediate protocol" - "Recently it's been a problem to have someone (staff) to come in the 2:30pm-6:00pm slot; - "[House Manager] is the backup a lot of the time, but when she is already on schedule then that becomes the problem;" - "It's a problem we are trying to rectify to ensure there is never anytime of the lapse between any two people being there;" Interview on 3/4/25 and 3/20/25 with the Director/Licensee revealed: - Was not notified by the House Manager, Staff #1 or Staff #2 about FC #2 suicide attempt on 1/28/25; - Became aware of FC #2's suicide attempt on 1/29/25 when the local police were at the home due to another incident with Client #1; - QP completed the internal investigation; - Staff called the House Manager as first point of contact; - House Manager would contact upper management if she unavailable when direct care staff reached out to her; - Direct care staff was expected to call upper management as well, to inform upper management about a crisis; - Direct care staff needed one person to contact instead of all of upper management; - "We try to update policy as things happen ..., when we refine the policy, we will retrain everyone to make sure its crystal clear;" Review on 3/20/25 of the Plan of Protection dated 3/20/25 written by the Director/Licensee revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care?	V 293		

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V 293	Continued From page 28 -To ensure compliance with required staff-to-client ratios, additional staff coverage has been arranged, and shift schedules have been revised to help maintain consistent coverage. Clear contingency plans have been established to address absences and designated on-call staff are now in place to manage unexpected shortages, preventing future non-compliance. What has been arranged to ensure staff coverage is the schedule always has two people and a person on call in weekly rotation when staff call out. House Manger is in charge of creating the schedule and the director will oversee for compliance. This is effective March 20, 2025; - To ensure proper crisis intervention and compliance with safety protocols, all staff members have been required to complete immediate refresher training on crisis response procedures. The training was completed on March 9th 2025 by all staff. The name of the training is called Crisis Protocol and Client Safety. The Qualified Professional will be responsible for conducing all future trainings. The administrative team consist of (QP, House Manager, Director (Director/Licensee)) This training includes de-escalation techniques, risk assessment strategies, and emergency response protocols specifically related to self-harm incidents. Additionally, a clear decision-making protocol has been established and distributed to all staff, outlining the circumstances under which emergency services-such as 911, mobile crisis teams, or law enforcement-must be contacted in situations involving an imminent risk of harm to self or others. To further enhance client safety, individuals identified as having a history of self-harm or suicidal ideation are now monitored more closely, with their crisis plans updated to include specific intervention steps tailored to their needs;	V 293		

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V 293	Continued From page 29 - Specific Training was completed with All Staff: March 9, 2025; - Describe your plans to make sure the above happens; - To maintain compliance with minimum staffing requirements, the facility will implement a structured system of monthly internal audits to monitor staff levels and ensure consistent adherence to regulations. These audits will involve a thorough review of staffing schedules, attendance records, and shift coverage to identify any gaps or potential concerns. The administrative team will assess whether the current staffing structure meets the needs of clients and aligns with regulatory expectations. Any discrepancies or staffing shortages will be promptly addressed through adjustments in scheduling, additional staff recruitment, or enhanced contingency planning. - Supervisors will conduct random case reviews and crisis response drills to ensure that staff consistently adhere to emergency protocols and respond appropriately to crisis situations. Additionally, regular self-harm risk assessments will be conducted for clients both at intake and throughout their treatment to ensure that crisis plans remain up to date and tailored to their individual needs. These measures will help maintain compliance, enhance staff preparedness, and improve overall client safety. - Specific Case review will be completed: March 30, 2025." The facility served clients ranging in age 12-17 years with diagnoses that include Attention Deficit Hyperactivity Disorder, Post Traumatic Stress Disorder, Reactive Attachment Disorder and Reaction to Severe Stress. On 1/28/25, the House Manager was at the facility alone with two clients when FC #2 started to have aggressive	V 293		

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V 293	Continued From page 30 behaviors and was unable to de-escalate the situation. Within an hour of Staff #1 and Staff #2 starting their shift, FC #2 inflicted self-harm by cutting herself with glass. Within hours later, FC #2 attempted suicide by tying a rope around her neck in the bathroom. The staff failed to coordinate medical or psychiatric services for the clients' care. Staff did not seek medical or psychiatric attention for FC #2 until 1/29/25. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 293		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four	V 296		

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V 296	Continued From page 31 children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on record review, observation and interviews the facility failed to ensure the minimum staff ratio of two staff for up to four children or adolescents. The findings are: Review on 2/24/25 of Client #1's record revealed: - Admission date 10/21/24; - Age 14 years; - Diagnoses Attention Deficit Hyperactivity Disorder, Reaction to Severe Stress.	V 296		

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V 296	Continued From page 32 Review on 2/24/25 of Former Client (FC) #2's record revealed: - Admission date 10/14/24; - Age 16 yrs; - Diagnoses Attention Deficit Hyperactivity Disorder, Post Traumatic Stress Disorder, Reactive Attachment Disorder; - Discharge date 2/3/25. Review on 2/27/25 of Client #3's record revealed: - Admission date 7/15/20; - Age 16; - Diagnoses Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, Unspecified Trauma, Intellectual Disorder. Observations on 2/19/25, 2/26/25 and 2/27/25 of the facility revealed: - On 2/19/25, at 11:10am, Staff #2 was the only staff at the facility with Client #1 and Client #3; - Director/Licensee arrived at the facility at 11:53am on 2/19/25; - On 2/26/25, at 2:40pm, the House Manager was the only staff at the facility with Client #1 and Client #3; - Director/Licensee arrived at the facility at 3:06pm on 2/26/25; - On 2/27/25, at 11:35am, the House Manager was the only staff at the facility with Client #1; - No staff came to the facility before the Division Health Service Regulation (DHSR) surveyor left at 1:30pm on 2/27/25. Interview on 2/19/25 with Client #1 revealed: - "Sometimes it's 1 staff and sometimes it's 2 staff depending on who can come in and who is on schedule;" - House Manager left about 10 minutes before surveyor came to the facility on 2/19/25; - Director/Licensee left the facility before Staff #2	V 296		

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came to the facility on 2/19/25.
- "It depends on the situation" as to how many staff are on shift.

Interview on 3/4/25 with FC #2 revealed:
- "Two staff worked, sometimes there would be one staff there with us (clients)."

Interview on 2/19/25 with Client #3 revealed:
- Two staff "normally" worked each shift;
- House Manager and Director/Licensee worked night shift on 2/19/25;
- Director/Licensee left the facility in the morning of 2/19/25;
- Staff #2 came to the facility to work with the House Manager on the morning of 2/19/25;
- "[House Manager] just left before you (DHSR surveyor) got here, about maybe 5 minutes," on 2/19/25.

Interview on 2/27/25 with Staff #1 revealed:
- "[House Manager] was at the home (facility) with the clients (Client #1, FC #2)" on 1/28/25;
- Two staff normally worked each shift.

Interview on 2/19/25 and 2/27/25 with Staff #2 revealed:
- House Manager had "just left the home about 10 minutes ago," (before DHSR surveyor entered the facility at 11:10am on 2/19/25);
- Two staff worked each shift.

Interview on 2/19/25, 2/26/25, and 2/27/25 with the House Manager revealed:
- 2/19/25:
  - Left the facility due to having a hair appointment on 2/19/25;
  - "The kid's (clients) school closed last minute and I had a hair appointment;"
- 2/26/25:

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V 296	Continued From page 34 - Just arrived at the facility alone with Client #1 and Client #3 from school on 2/26/27; - Was in charge of making the schedule for staff; - 2/27/25: - Was at the facility alone with Client #1 due to client being suspended from school on 2/27/25; - Was on call 24 hours; - Worked from 2:30pm -5:30pm Monday -Friday; - Worked the shift if someone called out. Interview on 3/5/25 and 3/20/25 with the Qualified Professional revealed: - House Manager made the work schedule and Director/Licensee reviewed the schedule; - House Manager's work schedule 2:30pm-5pm daily; - "Recently it's been a problem to have someone (staff) to come in the 2:30pm-6:00pm slot; - "[House Manager] is the backup a lot of the time, but when she is already on schedule then that becomes the problem;" - "It's a problem we are trying to rectify to ensure there is never anytime of the lapse between any two people being there;" - "[House Manager] is not on call 24/7." Interview on 2/19/25 and 3/4/25 with the Director/Licensee revealed: - Was not aware that the House Manager was not at the facility with Staff #2 on 2/19/25; - Was at the facility alone with Client #1 and FC #2 on 1/29/25, when an incident happened with Client #1 being defiant and the local police were called to the facility; - "[House Manager] is in charge of the scheduling of the staff in the facility;" - House Manager was not on call 24 hours; - Aware the House Manager had another job;	V 296		

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V 296	Continued From page 35 - "I don't keep up with her other schedule." This deficiency is cross referenced into: 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 296		
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. (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	V 366		

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V 366	Continued From page 36 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, 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	V 366		

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V 366	Continued From page 37 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 interview, the facility failed to implement written policies governing their response to level I and II incidents. The findings are: Review on 2/19/25 of the North Carolina Incident Response Improvement System (IRIS) from November 19, 2024- February 19, 2025 revealed:	V 366		

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V 366	Continued From page 38 - No level II incident report from the incident dated 1/3/25 with Client #1 aggressive behaviors and client was placed in a restraint; - No level II incident report from the incident dated 1/3/25 with FC #2 hitting staff and was in a restraint; - No level II incident report from the incident dated 1/27/25 with FC #2 damaging property; - No level incident report from the incident dated 1/28/25 with FC #2 suicide attempt on 1/28/25. Review on 2/26/25 of the facility's records from November 19, 2024-February 19, 2025 revealed: - No documentation to support the above incidents had been evaluated to: - Developed and implemented corrective measures according to provider specified timeframe not to exceed 45 days; - Developed and implemented measures to prevent similair incidents according to provider specified timeframes not to exceed 45 days. Interview on 3/5/25 and 3/20/25 with the Qualified Professional revealed: - Staff completed the fcaility incident reports, "I review the incident reports and sign off on them;" - Was in charge of putting incident reports into IRIS; - Was not aware the incident for 1/28/25 was not submitted into IRIS; - Planned to recreate the facility's incident report form to cover the risk/cause/analysis requirements; - Planned to print a copy of the IRIS manual and train staff on the different incident levels and reporting.	V 366		
V 367	27G .0604 Incident Reporting Requirements	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601413	A. BUILDING: _____ B. WING _____	C 03/20/2025

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V 367	Continued From page 39 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit,	V 367		

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V 367	Continued From page 40 upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1)	V 367		

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V 367	Continued From page 41 through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview the facility failed to report all critical incidents in the Incident Response Improvement System (IRIS) and notify 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 2 of 2 audited clients (Client #1, Former Client (FC) (FC#2). The findings are: Review on 2/19/25 of the North Carolina Incident Response Improvement System (IRIS) from November 19, 2024- February 19, 2025 revealed: - No level II incident report from the incident dated 1/3/25 with Client #1 aggressive behaviors and client was placed in a restraint; - No level II incident report from the incident dated 1/3/25 with Former Client (FC) #2 hitting staff and was in a restraint; - No level II incident report from the incident dated 1/27/25 with FC #2 damaging property; - No level incident report from the incident dated 1/28/25 with FC #2 suicide attempt on 1/28/25. Interview on 3/5/25 and 3/20/25 with the Qualified Professional revealed: - Staff completed the facilty incident reports, "I review the incident reports and sign off on them;" - Was in charge of putting incident reports into IRIS;	V 367		

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V 367	Continued From page 42 - Was not aware the incident for 1/28/25 was not submitted into IRIS; - Planned to rewrite the facility's incident report form to cover the risk/cause/analysis requirements; - Planned to print a copy of the IRIS manual and train staff on the different incident levels.	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 observation and interview, the facility was not maintained in a clean, attractive and orderly manner. The findings are: Observation on 2/19/25 at approximately 1:05pm revealed: - The vacant bedroom in the front of the facility: -Bottom left window with 6 panel frames were covered with plastic due to the bottom left frame of the 6 panels had a hole in the window. Interview on 2/19/25 with Client #1 revealed: - Former Client (FC) #2 threw a brick in the window on 1/28/25. Interview on 3/4/25 with FC #2 revealed: - "I broke a window and cut my hand" on 1/28/25. Interview on 2/27/25 with Staff #1 revealed: - FC #2 went outside and "picked up a brick and threw it through one of our front windows of the	V 736		

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V 736	Continued From page 43 house" on 1/28/25. Interview on 2/26/25 with the House Manager revealed: - FC #2 threw a brick through the window of the facility on 1/28/25. Interview on 3/20/25 with the Qualified Professional revealed: - "The window is on back order for three weeks, we are working on it."	V 736		