STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601482	A. BUILDING: _____ B. WING _____	R 05/07/2025

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CHRIST CHURCH COTTAGE THOMPSON CHILD & FA	6722 ST PETERS LANE MATTHEWS, NC 28105

(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, complaint and follow up survey was completed on 5/7/25. The complaint was substantiated (Intake #NC00228552). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1800 Intensive Residential Treatment for Children and Adolescents. This facility is licensed for 9and has a current census of 6. The survey sample consisted of audits of 2 current clients, 2 former clients.	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;	V 105		

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V 105	Continued From page 1 (B) an assessment of whether or not the facility 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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V 105	Continued From page 2	V 105		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to implement adoption of standards that assure operational and programmatic performance meeting applicable standards of practice for therapeutic services. The findings are:

Review on 5/3/25 of Former Client (FC) #4's record revealed:
- Admission date 2/12/25;
- Age 15 years;
- Diagnoses Attention Deficit Hyperactivity Disorder, Combined Type; Intermittent Explosive Disorder; Dysthymic Disorder;
- Discharge date 3/28/25.

Review on 5/1/25 of the facility's Internal Investigations from October 1, 2024-May 1, 2025 revealed:
- Investigation Report dated 3/10/25 by the Quality Improvement Specialist (QIS);
- The Complaint Allegations: "PQI was notified via email on 3/7/25 of several complaints made by client [FC #4], towards the Christ Church Residential Therapist, [therapist]. The complaints were initially reported to [Supervisor/Qualified Professional (QP)], Christ Church Supervisor by client [FC #4], on 3/4/25. Interim Clinical Supervisor [Clinical Supervisor], also provided an email with consistent concerns after she met with [FC #4].
-The following concerns came from [Clinical Supervisor's] email:

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V 105	Continued From page 3	V 105		

- [Therapist] showed him an article on her computer of a boy who killed his college girlfriend and emphasized that could be [FC #4]. 'Client [FC #4] claimed that [Therapist] told him that would be him if he did not manage his anger.'

- During a therapy session with [Therapist], when asked about his goals, [FC #4] stated 'He wanted to go home, and the therapist responded that his childhood was over and he needed to focus on other goals.'

- 'The client also reported that on Wednesday, the therapist entered the cottage and insisted he take a therapeutic walk with her, which he refused. The client conveyed that the therapist raised her voice, insisting he take the walk, but he declined again, and she left.'

- 'The client reported that the therapist placed a piece of mail from his mother in his lap in an aggressive manner.'

-The following concerns came from [Supervisor/QP] email:

- [Therapist] questioned why he requested to change his medication and her response from his perception was insensitive. [Therapist] stated, 'that's not a reason to change your medications. It's probably not the medication's fault.'

-The same concerns regarding the article on the computer and client's goal to go home were also in [Supervisor/QP] email."

- Evidence/Documents Reviewed- "There were weekly therapy notes since [FC #4's] admission to Thompson. The therapy note from 3/4/25 indicated that [Therapist] shared an article about a boyfriend killing his girlfriend. The note mentions that the intent behind this was to raise awareness about alcoholism and anger management. Verkada footage from 3/4/25 confirms that [Therapist] shared her laptop briefly with [FC #4] during their session. Verkada footage from 3/5/25 revealed that [Therapist]

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V 105	Continued From page 4 approached [FC #4] a few times, but [FC #4] did not ever get up from his seat. At approximately 4:20pm [Therapist] can be seen dropping a letter onto [FC #4]'s lap and then walking away. -QIS reviewed [Therapist]'s previous coaching sessions, focusing on her interactions with clients and staff. She has been coached on communication issues with the cottage supervisor, her professionalism during a CFT (Child Family Team Meeting) a few months ago, and, most recently, her interactions with clients. [Therapist]'s Relias training transcript shows that she completed CARE training on 12/21/23." - Other Actions Taken: "Effective 3/7/25, [Therapist] was removed as the therapist from this client's case." - Conclusion "Based on staff/client interviews, it was confirmed that [Therapist] shared an article with [FC #4] about a college student killing his girlfriend. However, it cannot be confirmed that [Therapist] made the statement about this being [FC #4] one day if he did not manage his anger. Based on the interview with [Therapist], it cannot be confirmed that she made the statement regarding [FC #4]'s childhood being over. Based on staff and client interviews, it can be confirmed that [Therapist] raised her voice while speaking to [FC #4] about going on a therapeutic walk with her. Also, according to the Verkada camera footage, [FC #4] can be seen refusing to leave the cottage with [Therapist]. After reviewing Verkada camera footage, [Therapist] can be seen dropping a letter onto [FC #4]'s lap, not aggressively. Based on the interview with [Therapist], it cannot be confirmed that she made the statement regarding [FC #4]'s medication. Due to making [FC #4] feel uncomfortable, it was decided that [Therapist] will no longer serve as his therapist. Interim Clinical Supervisor will resume that role moving forward. It should be	V 105		

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V 105	Continued From page 5 noted that between staff and the client interviews, the concerns were consistent." Review on 5/6/25 of emails from the Quality Improvement Specialist dated 5/6/25 revealed: - [Therapist] was not suspended, however, she did not have any other clients so she was isolated from client care during this time. [FC #4] was reassigned to [Clinical Supervisor]. The notes I provided from [Clinical Supervisor] also outline the steps taken; - "I apologize, I misspoke. [FC #4] was reassigned and there were only a few other clients in the cottage but they were seen by [Therapist]." Attempted interview on 5/6/25 and 5/7/25 with the Legal Guardian of FC #4 revealed: - Left a voicemail for the Legal Guardian of FC #4, there was no return call before the exit of survey. Interview on 5/5/25 with the Therapist revealed: - FC #4 was removed from caseload, "through a breach of information on my end;" - FC #4 seen the therapist's computer screen of volunteer work for an organization she volunteers with; - FC #4 was informed about the content on the computer before the computer was turned off; - Did not remember if FC #4 watched the video on the computer; - Denied telling FC #4 that he would turn out like the guy in video who killed his girlfriend; - Denied yelling at FC #4 when she asked him to go for a walk; - Was frustrated with FC #4 when he would not go for a walk; - Left and went for a walk, upon return placed a letter for FC #4 on the arm of the couch FC #4	V 105		

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V 105	Continued From page 6 was sitting on; - "Unintendedly I showed my frustrations with the client;" - There was a lot of "back and forth" about FC #4's medications; - FC #4 stated he wanted to leave the country and use mushrooms and he needed marijuana to stay sane; - Was trained in bias training and extra courses on ethnical boundaries; - Received weekly supervision for 45 days. Interview on 5/5/25 with the Supervisor/QP revealed: - FC #4 had "issues" when the Therapist showed him something online about a guy who killed his girlfriend; - FC #4 was not comfortable with working with the Therapist; - Discussed FC #4's concerns with the Clinical Supervisor; - It was decided that Clinical Supervisor and Supervisor/QP would speak with the Therapist about the concerns; - The Therapist yelled at FC #4 for not wanting to go on a walk with her, before a conversation was had with her about the previous concerns; - FC #4 received a new therapist. Interview on 5/7/25 with the Clinical Supervisor revealed: - Was the therapist's supervisor at the time of the incident on 3/4/25; - Received a report from staff about how the Therapist spoke to FC #4; - As a result of the investigation, meet weekly with the Therapist; - Provided coaching to the Therapist from 3/10/25 to end of April 2025; - There were no further concerns for the	V 105		

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V 105	Continued From page 7 Therapist; - Was assigned FC #4 for therapy; - FC #4 declined to file a complaint on the Therapist; - Did not report the Therapist to the Social Worker Licensure Board.	V 105		
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 (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	V 367		

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V 367	Continued From page 8 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: (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;	V 367		

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V 367	Continued From page 9 (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 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 1 of 4 audited clients (Former Client #4). The findings are: Review on 5/3/25 of Former Client (FC) #4's record revealed: - Admission date 2/12/25; - Age 15 years; - Diagnoses Attention Deficit Hyperactivity Disorder, Combined Type; Intermittent Explosive Disorder; Dysthymic Disorder; - Discharge date 3/28/25. Review on 5/1/25 of the facility's Internal Investigations from October 1, 2024-May 1, 2025	V 367		

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V 367	Continued From page 10 revealed: Review on 5/1/25 of the facility's Internal Investigations from October 1, 2024-May 1, 2025 revealed: - Investigation Report dated 3/10/25 by the Quality Improvement Specialist (QIS); - The Complaint Allegations: "PQI was notified via email on 3/7/25 of several complaints made by client [FC #4], towards the Christ Church Residential Therapist, [therapist]. The complaints were initially reported to [Supervisor/Qualified Professional (QP)], Christ Church Supervisor by client [FC #4], on 3/4/25. Interim Clinical Supervisor [Clinical Supervisor], also provided an email with consistent concerns after she met with [FC #4]. -The following concerns came from [Clinical Supervisor's] email: - [Therapist] showed him an article on her computer of a boy who killed his college girlfriend and emphasized that could be [FC #4]. 'Client [FC #4] claimed that [Therapist] told him that would be him if he did not manage his anger.' - During a therapy session with [Therapist], when asked about his goals, [FC #4] stated 'He wanted to go home, and the therapist responded that his childhood was over and he needed to focus on other goals.' - 'The client also reported that on Wednesday, the therapist entered the cottage and insisted he take a therapeutic walk with her, which he refused. The client conveyed that the therapist raised her voice, insisting he take the walk, but he declined again, and she left.' - 'The client reported that the therapist placed a piece of mail from his mother in his lap in an aggressive manner.' -The following concerns came from [Supervisor/QP] email:	V 367		

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V 367	Continued From page 11 - [Therapist] questioned why he requested to change his medication and her response from his perception was insensitive. [Therapist] stated, 'that's not a reason to change your medications. It's probably not the medication's fault.' -The same concerns regarding the article on the computer and client's goal to go home were also in [Supervisor/QP] email." - Evidence/Documents Reviewed- "There were weekly therapy notes since [FC #4's] admission to Thompson. The therapy note from 3/4/25 indicated that [Therapist] shared an article about a boyfriend killing his girlfriend. The note mentions that the intent behind this was to raise awareness about alcoholism and anger management. Verkada footage from 3/4/25 confirms that [Therapist] shared her laptop briefly with [FC #4] during their session. Verkada footage from 3/5/25 revealed that [Therapist] approached [FC #4] a few times, but [FC #4] did not ever get up from his seat. At approximately 4:20pm [Therapist] can be seen dropping a letter onto [FC #4]'s lap and then walking away. -QIS reviewed [Therapist]'s previous coaching sessions, focusing on her interactions with clients and staff. She has been coached on communication issues with the cottage supervisor, her professionalism during a CFT (Child Family Team Meeting) a few months ago, and, most recently, her interactions with clients. [Therapist]'s Relias training transcript shows that she completed CARE training on 12/21/23." - Other Actions Taken: "Effective 3/7/25, [Therapist] was removed as the therapist from this client's case." - Conclusion "Based on staff/client interviews, it was confirmed that [Therapist] shared an article with [FC #4] about a college student killing his girlfriend. However, it cannot be confirmed that [Therapist] made the statement about this being	V 367		

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V 367	Continued From page 12 [FC #4] one day if he did not manage his anger. Based on the interview with [Therapist], it cannot be confirmed that she made the statement regarding [FC #4]'s childhood being over. Based on staff and client interviews, it can be confirmed that [Therapist] raised her voice while speaking to [FC #4] about going on a therapeutic walk with her. Also, according to the Verkada camera footage, [FC #4] can be seen refusing to leave the cottage with [Therapist]. After reviewing Verkada camera footage, [Therapist] can be seen dropping a letter onto [FC #4]'s lap, not aggressively. Based on the interview with [Therapist], it cannot be confirmed that she made the statement regarding [FC #4]'s medication. Due to making [FC #4] feel uncomfortable, it was decided that [Therapist] will no longer serve as his therapist. Interim Clinical Supervisor will resume that role moving forward. It should be noted that between staff and the client interviews, the concerns were consistent." Review on 5/1/25 of the IRIS reports from October 1, 2024- May 1, 2025 revealed: - No incident report for the alleged emotional abuse incident on 3/4/25 with FC #4. Review on 5/6/25 of emails from the Quality Improvement Specialist dated 5/6/25 revealed: - [Therapist] was not suspended, however, she did not have any other clients so she was isolated from client care during this time. [FC #4] was reassigned to [Clinical Supervisor]. The notes I provided from [Clinical Supervisor] also outline the steps taken; - "I apologize, I misspoke. [FC #4] was reassigned and there were only a few other clients in the cottage but they were seen by [Therapist]." Interview on 5/7/25 with the Chief Performance	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601482	A. BUILDING: _____ B. WING _____	R 05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRIST CHURCH COTTAGE THOMPSON CHILD & FA	6722 ST PETERS LANE MATTHEWS, NC 28105

(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 367	Continued From page 13 Quality Officer revealed: - Reviewed criteria for level 2 incident reports and didn't realize an IRIS report needed to be completed.	V 367		