Plan of Correction

Plan of Correction form To: Division of Health Service Regulation Mental Health Licensure and Certification Section Facility Name: Collaborative Hope-Sky view MHL Number: 060-1499 Rule Violation/Tag /Citation Level: (Administrative Action and Crosses) 10A NCAC 27G .0304 V512 FOR Serious Abuse and neglect for a Type A1 citation.	In lieu of mailing the form, you may e-mail the completed electronic form to:

Provider Name:	Collaborative Hope MHL 060-1499	Phone:	[redacted]
Provider Contact Person for follow-up:	[redacted] 1101 S Key View RD Charlotte NC 28208 9700 Research Dr Ste 105 Charlotte NC 28262-8569	Fax:	[redacted]
		Email:	[redacted]
Address:	9700 Research Dr., Ste 105 Charlotte, NC 28262	Provider # 10131556447/3728	

Finding	Corrective Action Steps	Responsible Party	Timeline
1.) Tag V 000 INITIAL COMMENTS V 000 An annual complaint and follow-up survey was completed on 4-7-25. The complaint was substantiated (Intake# NC00228303). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure For Children Or Adolescents. This facility is licensed for 3 and has a current census of 3. They survey sample consisted of audits of 3 current clients.	1. **Staff Training on Alternatives to Restrictive Interventions:** All direct care and clinical staff will complete mandatory retraining on alternatives to restrictive interventions by May 5, 2025. This training will emphasize de-escalation strategies and positive behavior support plans tailored to the population served. 2. **Crisis Response and Management Training:** All staff will be retrained on identifying early signs of behavioral crisis and appropriate response techniques. This will include modules on trauma-informed care and crisis prevention strategies. Training will be documented and maintained in each employee's personnel file. 3. **Training in Managing Disruptive Behaviors:** Staff will receive additional targeted training on managing disruptive behaviors common among youth in residential treatment settings. This training will focus on proactive behavior management, communication techniques, and environmental modifications to reduce incidents. 4. **Monitoring and Quality Assurance:** Supervisory staff will conduct weekly audits for the next 60 days to ensure implementation of learned techniques and proper documentation. Results will be reviewed in staff meetings and corrective feedback provided as necessary.	External Training Consultants contracted by CEO [redacted]	Implementation Date: 4-7-2025 4-9-25 Crisis Identification Response and Management - training completed. 4-10-2025 NCI + National Crisis Intervention Plus Training completed. 4-16-2025 Crisis De-escalation Training completed part 2. Projected Completion Date: Immediately and ongoing

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	5. **Documentation and Compliance Review:** The facility's leadership will review and update relevant policies and procedures to align with training content and state regulations. Evidence of compliance (e.g., sign-in sheets, training materials, observation notes) will be submitted to the appropriate licensing agency. 6. **Ongoing Evaluation:** A quarterly review process will be implemented to assess the effectiveness of training and behavioral interventions. Adjustments will be made based on client outcomes, incident reports, and staff feedback		
2.) Tag 7 V 132G.S. 131E-256(G) 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. 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. Per Compliance Consultant 1:	1. **Biweekly Staff Meetings and Written Notification of Reporting Protocols** Collaborative Hope will conduct **mandatory biweekly staff meetings** to review state-mandated reporting procedures, documentation practices, and client rights. A written protocol outlining these responsibilities will be distributed to all staff. These sessions will focus on staff duties during investigations, including ensuring client protection. 2. **Individual and Group Supervision by the Qualified Professional (QP)** The QP will conduct **individual and group supervisory meetings** to coach staff on their responsibilities regarding incident reporting and the HCPR process. Each staff member will review case scenarios and sign an **attestation** affirming understanding of the five-day reporting requirement and protocols for client safety. 3. **Administrative Oversight and HCPR Compliance Assurance** The facility administrator will ensure that all allegations involving abuse, neglect, or any act defined in G.S. 131E-256(a)(1) are: • **Immediately reported** to the HCPR • Investigated with documentation of interim **protective measures** taken for client safety • The results of the investigation are submitted to DHHS **within five working days** Submissions will be tracked and logged under the administrator's purview. 4. Incident Review and Quality Assurance Audits	[redacted] Jacqueline Thomas-RC-Administrative Professional	Implementation Date: April 7th, 2025 Projected Completion Date: Immediately and ongoing.

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 3-17-25 of the North Carolina Incident Response Improvement System (IRIS) from December 1, 2024 to March 17, 2025	A monthly QA audit will be conducted on all incident reports to ensure timely HCPR notification, proper protective action for clients, and timely completion of investigations. Any deviations will trigger immediate		
3.) Tag 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 develop and implement written policies governing their response to level I, II or III incidents. The policies require the provider to respond by: (1) attending to the health and safety needs 2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a	1. **Conduct Immediate In-Service Training** All staff will receive immediate in-serving training on the contents of the Incident Response Policy, with a focus on Level I, II, III incidents, documentation procedures, timelines, confidentiality requirements, and the assignment of responsivities. 2. **Revise and Reissue Written Response Policies** The incident Response Policy will be revised to clearly outline response steps for Level I, II, and III incidents, in alignment with Rule 10A NCAC 27G.0603. The policy will be distributed to all staff and included in onboarding. 3. **Assign Incident Response Roles and Timelines** Each incident report will now include: assignment of responsible personnel, documentation of the timeline for correction and prevention (not exceeding 45 days), and measures taken to address client safety. 4. **Implement a Tiered Documentation Review Process** A dual-level review of incident documentation will be conducted by the QP. Non-compliance with documentation or follow-through will result in mandatory retraining. 5. **Enforce Accountability Through Targeted Retraining** Staff who fail to complete incident documentation correctly or in a timely manner will be required to attend supplemental documentation training, in-person or online, and may face progressive personnel action.	[redacted] Quality Assurance professional upon hire	Implementation Date: April 7th, 2025. Projected Completion Date: Incident Reporting and Documentation training will occur on 5-7-2025 and remain ongoing.

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 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. Per Compliance Consultant 1 (This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to implement written policies governing their response to level II incidents)			
4.) Tag V 367 27G .0604 Incident Reporting Requirements 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 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	1. **Mandatory Incident Reporting Training** All direct care and supervisory staff will complete training on incident reporting requirements, including IRIS usage, incident levels, and 72-hour reporting timelines. Training will be offered in-person and online, with required proof of completion and signed attestation. 2. **Staff Competency Verification** Staff will complete a post-training assessment to confirm understanding and demonstrate competency through accurate and timely future incident documentation and reporting. 3. **Leadership Oversight and Accountability Plan** Staff who fail to meet reporting requirements will be subject to a performance improvement plan, with further non-compliance resulting in disciplinary action up to termination. 4. **QA Monitoring and IRIS Audit Schedule** The QA team will perform monthly audits of incident reports to ensure compliance with IRIS reporting requirements and timeliness, with results reviewed by agency leadership. 5. **Reporting Protocol Reinforcement** Collaborative Hope will ensure all Level II and III incidents are reported in IRIS and to the appropriate MCO within 72 hours. A designated administrator will oversee and verify all submissions.	[redacted]	Implementation Date: 4-7-2025 Projected Completion Date: Incident Reporting and Documentation training will occur on 5-7-2025. 4-10-2025 NCI + National Crisis Intervention Plus Training was completed. The documented Corrective Action Steps are immediate and ongoing.

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; (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. Per Compliance Consultant 1: (This Rule is not met as evidenced by: Based on record review and interviews, 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.)			
5.) **V 500 27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted**	1. **Client Rights and Reporting Refresher Training** All staff will complete an immediate in-service and mandatory refresher training on Client Rights and mandatory reporting obligations, with a focus on identifying, documenting, and reporting alleged abuse. Staff will sign an attestation of understanding to be maintained in personnel files. 2. **Timely Internal Investigations** In the event of a client complaint or allegation (founded or unfounded), an internal investigation will be initiated and completed within 24–72 hours. Documentation of findings and actions taken will be reviewed by supervisory and QA staff for compliance. 3. **Mandatory Reporting to DSS** Collaborative Hope will ensure that all alleged or suspected abuse, neglect, or exploitation is reported to the County Department of Social Services (DSS) within 24–72 hours of awareness, as required by G.S. 108A and G.S. 7A. 4. **Staff Accountability Procedures** Any failure to follow documentation or reporting protocols may result in professional disciplinary action, up to and including termination. These procedures will be clearly communicated and monitored by supervisors. 5. **Policy Review and Compliance Oversight** The governing body will review and update the facility's policies on restrictive interventions and client rights restrictions to align with 10A NCAC 27D and 27E. Designated compliance personnel will oversee adherence and maintain documentation of all actions taken.	[redacted]	Implementation Date: **4-7-2025** Projected Completion Date: Training will occur 5-7-25. The documented Corrective Action Steps are immediate and ongoing.

restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention Per Compliance Consultant 1: (This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure all incidents of alleged abuse were reported to the County Department of Social Services (DSS)			
6.) V 512 27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not	1. **Policy Review and Attestation** The Qualified Professional and CEO will review Clinical Coverage Policy 8D-2 and sign an attestation of understanding. This documentation will be placed in their personnel files. 2. **Leadership Accountability and Performance Monitoring** Agency leadership, in collaboration with the QP, will monitor involved staff for adherence to policy. Any continued noncompliance or inability to demonstrate improvement may result in immediate dismissal.	[redacted]	Implementation Date: 4-7-2025 Projected Completion Date: Ongoing-there is no completion date. This is the expectation of the positions as outlined in job descriptions, service definition.

be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs Per Compliance Consultant 1: (This Rule is not met as evidenced by: Based on record reviews, observation and interviews 1 of 4 audited staff (staff #1) abused 3 of 3 clients (client #1, #2, #3) and 3 of 4 audited staff (staff #2, staff #3 and the Associate Professional (AP)) failed to protect 3 of 3 clients (client #1, #2, #3).	3. **Staff Retraining on Client Protection and Reporting Protocols** All staff will undergo mandatory retraining on protocols related to protecting clients from harm, abuse, and neglect, including mandatory reporting procedures for adverse physical or emotional events. 4. **Internal Investigations and Documentation** Collaborative Hope will conduct prompt and thorough internal investigations into all alleged incidents, ensuring interviews are conducted with all relevant parties and documentation is maintained for review and corrective follow-up.		