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	MHL036-374	A. BUILDING: _____ B. WING _____	R 05/02/2025

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 5-2-25. The complaint was unsubstantiated (Intake #NC00229736). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure For Children or Adolescents. This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 3 current clients.	V 000	**Corrective Action Plan – Mecca of Beacons LLC** **1. Measures to Correct the Deficient Area of Practice: Mecca of Beacons will implement two mandatory trainings for all active staff:** **Medication Management Training** **Population-Specific Behavioral Training** **These trainings have already been completed by all current staff, and any individuals requiring refresher or initial instruction will also receive both trainings** **moving forward. Additionally, both the facility nurse and clinician will now attend** **monthly staff meetings to address concerns, discuss new or emerging client behaviors, and provide ongoing support and guidance to staff.** **2. Measures to Prevent Recurrence: To prevent recurrence of the issues identified:** **Staff are now strictly required to administer medications in the designated area** **with one staff member present, as outlined in original training protocols. Any failure to follow this policy will result in disciplinary action—beginning with** **suspension and escalating to termination, if necessary.** **Staff have been further trained to understand population-specific behavioral cues and to ensure appropriate responses and supervision, especially when offsite.** **Adjustments have been made to staffing protocols to ensure that proper coverage is maintained, including during shift changes.** **3. Monitoring and Oversight: The Executive Director and Clinical Supervisor will** **jointly monitor compliance with all updated policies and procedures. This includes reviewing training completion, observing medication administration practices, and ensuring staffing plans are appropriate to client needs.** **4. Monitoring Frequency: Monitoring will occur on a weekly basis for the first 90** **days following implementation. Thereafter, it will transition to monthly oversight** **to ensure long-term compliance and identify any further areas for improvement.** **5. Additional Staffing Adjustments: Mecca of Beacons has adjusted its staffing** **model to ensure adequate coverage aligned with client needs. Any new contracts or client intakes will be reviewed by the leadership team. Where appropriate, clients will receive one-on-one staffing support, resulting in a**	
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. d. Diversion of drugs belonging to a health care facility or to a patient or client.	V 132		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Reginald V. Richardson, ED/DP — TITLE — (X6) DATE: 5/19/25

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V 132	Continued From page 1 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 reviews and interviews the facility failed to ensure that the Health Care Personnel Registry (HCPR) was notified of all allegations of abuse against health care personnel. The findings are: Review on 4-28-25 of client #1's record revealed: -Date of admission: 2-14-25. -Age: 13. -Diagnoses: Other unspecified Trauma; Obesity child; Physical Abuse; Child Neglect, Parent Child Relationship Problems; major Depressive Disorder. Review on 4-25-25 and 5-2-25 of facility records revealed an internal investigation completed by the Licensee/Qualified Professional (QP) documenting an allegation that on 4-21-25 staff #1 hit client #1 on his leg. Review on 4-25-25 and 5-2-24 of the HCPR revealed no documentation to support reporting of an allegation that on 4-21-25 staff #1 hit client #1 on his leg. Review on 5-2-25 of the North Carolina Incident Response Improvement System (IRIS) system revealed documentation of an IRIS report	V 132	Mecca will ensure that all incidents are reported in the IRIS and HCPR systems within 24 hours of being advised	

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V 132	Continued From page 2 submitted on 4-25-25 reporting the allegation that staff #1 hit client #1 on his leg, however the HCPR section was not completed. Interview on 4-25-25 with the Licensee/QP revealed: -He was made aware of the allegation on 4-21-25 after receiving a call from client #1's guardian informing him of the allegation. -Staff #1 was suspended on 4-21-25 and an internal investigation was imitated. -Licensee/QP did not complete an HCPR report. "I knew y'all (Department of Social Services (DSS) and Department of Health Services Regulations (DHSR) were coming. I was waiting to see what the results of your investigation was going to be before I did all that (reported to HCPR)." -"I didn't know about the 24 hour reporting rule. I thought that had to be done after everybody (DSS/DHSR) had done their investigation." -No reporting of the incident to HCPR had been completed by survey exit date.	V 132		
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	V 367		

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V 367	Continued From page 3	V 367		

be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:
(1) reporting provider contact and identification information;
(2) client identification information;
(3) type of incident;
(4) description of incident;
(5) status of the effort to determine the cause of the incident; and
(6) other individuals or authorities notified or responding.
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information 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

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V 367	Continued From page 4 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. This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to submit a level III incident report to the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the	V 367		

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V 367	Continued From page 5 catchment area where services are provided within 24 hours of learning of the incident. The findings are: Review on 4-28-25 of client #1's record revealed: -Date of admission: 2-14-25. -Age: 13. -Diagnoses: Other unspecified Trauma; Obesity child; Physical Abuse; Child Neglect, Parent Child Relationship Problems; major Depressive Disorder. Review on 4-25-25 and 5-2-25 of facility records revealed an internal investigation completed by the Licensee/Qualified Professional (QP) documenting an allegation that on 4-21-25 staff #1 hit client #1 on his leg. Review on 4-25-25 of the North Carolina Incident Response Improvement System (IRIS) revealed no documentation to support reporting of an allegation that on 4-21-25 staff #1 hit client #1 on his leg. Review on 5-2-25 of the IRIS system revealed documentation of an IRIS report submitted on 4-25-25 reporting the allegation that staff #1 hit client #1 on his leg. Interview on 4-25-25 with the Licensee/QP revealed: -He was made aware of the allegation on 4-21-25 after receiving a call from client #1's guardian informing him of the allegation. -Licensee/QP did not complete an IRIS report. "I knew y'all (Department of Social Services (DSS) and Department of Health Services Regulations (DHSR) were coming. I was waiting to see what the results of your investigation was going to be before I did all that (reported to HCPR)."	V 367		

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V 367	Continued From page 6 -"I didn't know about the 24 hour reporting rule. I thought that had to be done after everybody (DSS and DHSR) had done their investigation. I will complete the IRIS today (4-25-25)."	V 367		
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:	V 500		

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V 500	Continued From page 7 (1) the permitted 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. 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). The findings are: Review on 4-25-25 of the facility's record revealed: -No documentation to support County DSS notification for the 4-21-25 incident where client	V 500		

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V 500	Continued From page 8 #1 was abused by staff #1 when staff #1 hit client #1 on his leg. Review on 4-25-25 of the Incident Response Improvement System (IRIS) revealed: -No documentation of a report made to the local DSS regarding staff #1 abusing client #1 by hitting client #1 on his leg. Interview on 4-25--25 with the Licensee/Qualified Professional (QP) revealed: -"DSS knew (about the allegation). They were there (client #1's DSS guardian was present during the incident)." -" I was not aware of that. (the rule for DSS reporting). I will do that (ensure that a report is made DSS after an allegation of client abuse) from here on out."	V 500		