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| V 000 | INITIAL COMMENTS<br><br>An annual and complaint survey was completed on May 28, 2025. Two complaints were substantiated (intake #NC00229691 & NC00230440) and three complaints were unsubstantiated (intake #NC00230266, NC00230412 & NC00230725). Deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC .1900 Psychiatric Residential Treatment for Children and Adolescents.<br><br>This facility is licensed for 42 and has a current census of 38. The survey sample consisted of audits of 8 current clients and 4 former clients. | V 000 | | |
| V 105 | 27G .0201 (A) (1-7) Governing Body Policies<br><br>10A NCAC 27G .0201 GOVERNING BODY POLICIES<br>(a) The governing body responsible for each facility or service shall develop and implement written policies for the following:<br>(1) delegation of management authority for the operation of the facility and services;<br>(2) criteria for admission;<br>(3) criteria for discharge;<br>(4) admission assessments, including:<br>(A) who will perform the assessment; and<br>(B) time frames for completing assessment.<br>(5) client record management, including:<br>(A) persons authorized to document;<br>(B) transporting records;<br>(C) safeguard of records against loss, tampering, defacement or use by unauthorized persons;<br>(D) assurance of record accessibility to authorized users at all times; and<br>(E) assurance of confidentiality of records. | V 105 | | |

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| V 105 | Continued From page 1<br>(6) screenings, which shall include:<br>(A) an assessment of the individual's presenting problem or need;<br>(B) an assessment of whether or not the facility can provide services to address the individual's needs; and<br>(C) the disposition, including referrals and recommendations;<br>(7) quality assurance and quality improvement activities, including:<br>(A) composition and activities of a quality assurance and quality improvement committee;<br>(B) written quality assurance and quality improvement plan;<br>(C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services;<br>(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;<br>(E) strategies for improving client care;<br>(F) review of staff qualifications and a determination made to grant treatment/habilitation privileges:<br>(G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death;<br>(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 reviews and interviews, the facility failed to implement written standards that assured operational and programmatic performance meeting applicable standards of practice to ensure within 1 hour of the initiation of an emergency safety intervention (ESI), a face to face assessment was completed by licensed staff for 2 of 4 audited current clients (#4 and #12). The findings are:

Review on 05/13/25 of Code of Federal Regulations §483.358(f) revealed:
- "Within 1 hour of the initiation of the emergency safety intervention a physician, or other licensed practitioner trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological well being of residents, must conduct a face-to-face assessment of the physical and psychological well being of the resident, including but not limited to-(1) The resident's physical and psychological status; (2) The resident's behavior; (3) The appropriateness of the intervention measures; and (4) Any complications resulting from the intervention."

Review on 05/15/25 of an inservice completed by the Program Director from 11/13/24 thru 11/20/24 for all Licensed Nursing Staff revealed:
- Licensed Nursing staff trained in the use of the

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| V 105 | Continued From page 3 | V 105 | | |

software for documentation of the post ESI within 1 hour of the ESI.

Finding #1
Review on 05/13/25 of client #26's record revealed:
- 13 year old male.
- Admission ate of 10/01/24.
- Diagnoses of Post-Traumatic Stress Disorder (PTSD) and Adjustment Disorder.

Review on 05/14/25 of post "ESI-Assessment(s)" for client #26 revealed:
- Date of the ESI: 03/12/25.
- Time ESI began: 2:14pm.
- Time ESI ended: 2:40pm.
- Date and time post ESI assessment documented as completed 03/13/25 at 9:25am (18 hours and 45 minutes after the end of the ESI).

- Date of ESI: 04/15/25.
- Time ESI began: 5:16pm.
- Time ESI ended: 5:25pm.
- Date and time post ESI assessment documented as completed 04/15/25 at 6:31pm (6 minutes after the end of the ESI).

- Date of ESI: 04/21/25.
- Time ESI began: 2:01pm.
- Time ESI ended: 2:06pm.
- Date and time post ESI assessment documented as completed 04/21/25 at 6:07pm (4 hours and 1 minute after the end of the ESI).

Interview on 05/14/25 client #26 stated:
- He received a debriefing after his restrictive intervention.

Finding #2

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| V 105 | Continued From page 4<br><br>Review on 05/13/25 of client #34's record revealed:<br>- 16 year old female.<br>- Admission date 06/30/24.<br>- Diagnoses of Unspecified Mood Affective Disorder, PTSD, Attention-Deficient Hyperactivity Disorder, and Borderline Intellectual Functioning.<br><br>Review on 05/14/25 of a post "ESI-Assessment" for client #34 revealed:<br>- Date of ESI: 03/28/25.<br>- Time ESI began: 7:56pm.<br>- Time ESI ended: 7:59pm.<br>- Date and time post ESI assessment documented as completed 03/28/25 at 10:54pm (2 hours and 54 minutes after the end of the ESI).<br><br>Interview on 05/14/25 client #34 stated:<br>- He received a debriefing after his restrictive intervention.<br><br>Interview on 05/14/25 the Registered Nurse stated:<br>- A nurse was responsible to completed a face to face assessment within 1 hour after a restrictive intervention.<br><br>Interview on 05/14/25 and 05/15/25 the Director of Nursing stated:<br>- The ESI assessment tool was completed within one hour of a restrictive intervention by the nursing staff.<br>- The computer may put in a default date and time of assessment.<br>- The nursing staff may forget to put the correct time of the assessment.<br>- He had created a document to capture the correct time a nurse completed the 1 hour post ESI assessment. | V 105 | | |

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| V 366 | Continued From page 5 | V 366 | | |
| V 366 | 27G .0603 Incident Response Requirements<br><br>10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS<br>(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:<br>(1) attending to the health and safety needs of individuals involved in the incident;<br>(2) determining the cause of the incident;<br>(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;<br>(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;<br>(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;<br>(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<br>(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.<br>(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.<br>(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond | V 366 | | |

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| V 366 | Continued From page 6<br>by:<br>(1) immediately securing the client record by:<br>(A) obtaining the client record;<br>(B) making a photocopy;<br>(C) certifying the copy's completeness; and<br>(D) transferring the copy to an internal review team;<br>(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:<br>(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;<br>(B) gather other information needed;<br>(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<br>(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 | V 366 | | |

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| V 366 | Continued From page 7<br>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<br>(3) immediately notifying the following:<br>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;<br>(B) the LME where the client resides, if different;<br>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;<br>(D) the Department;<br>(E) the client's legal guardian, as applicable; and<br>(F) any other authorities required by law.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interviews, the facility failed to implement written policies governing their response to Level I incidents as required. The findings are:<br><br>Review on 5/28/25 of client #5's record revealed:<br>-Date of admission: 3/15/25<br>-Diagnoses: Major Depressive Disorder-Moderate, Disruptive Mood Dysregulation Disorder, Reaction to Severe Stress and Attention Deficient Hyperactivity Disorder.<br>-Nursing Progress Notes:<br>3/27/25: "Nursing was called to come assess consumer after being beat up by another | V 366 | | |

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| V 366 | Continued From page 8 | V 366 | | |

consumer. When nursing arrived at house it was noticed consumer had been stomped on around his neck and head. Consumer stated his neck was hurting. Neuro (Neurological) check done and A/Ox4 (Alert and Orient times 4), PERRLA (pupils are equal, round and reactive to light and accommodation). Consumer cleaned up, Neosporin applied to cuts, pictures taken for documentation, AOC (Authorized Operations Contact) called, [Physican] and DON (Director of Nursing) made aware. [Guardian] called at 18:33 and made aware. Patient left for ED (Emergency Department) around 18:50."
3/30/25: "Consumer was fighting with other consumers. Fine scratch and redness noted under right eye. Ice pack applied. Consumer moved to A house to stop fighting."
4/1/25: "this nurse called to assess consumer following fight with peers. Consumers c/o (chief complaint) nose pain and being hit in the back. On assessment nose aligned properly with swelling to bridge. No discoloration noted at this time. ice pack provided for swelling"
4/20/25: "called to assess consumer at 1720 s/p altercation with other consumers. Consumer assessed by this writer. noted to have lump to left occiput posterior. neuro checks WNL. Neuro check protocol implemented. Consumer also has red mark 6 cm in length to lower r forearm trying to block broom. States he was hit over head by metal broom and broom bent in half. states he has a 6/10 throbbing headache above right eye. refused tylenol and did accept ice pack. MD (Medical Doctor) aware and order received to send to ED for eval (evaluation). AOC made aware and his guardian was also notified via phone by this writer."

Review on 5/28/25 of the client #5's "After Visit summary" on 3/27/25 from the local emergency

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| V 366 | Continued From page 9<br>department revealed:<br>-"You were seen and evaluated here in the ED following a traumatic event. Your imaging studies were all stable and unremarkable for any evidence of traumatic injury. You may continue to ice the areas as well as use Tylenol and/or Ibuprofen for any pain or relief of discomfort... Imaging Test: CT (cat scan) cervical spine without contrast, CT head without contrast and XR (x-ray) Chest 1 view."<br><br>Review on 5/28/25 of facility's incident reports from 3/1/25 to 5/28/25 revealed:<br>-No level I incident reports for client #5 on 3/27/25, 3/30/25, 4/1/25 or 4/20/25.<br><br>Interiew on 5/28/25 the Assistant Program Director stated:<br>-A level I incident should have been completed by direct care staff.<br>-He was not sure why the incident reports were not completed.<br>-He would follow up with staff to ensure all incient reports were completed.<br><br>Interview on 5/28/25 the Program Director stated:<br>-No level I incidents were completed for client #5 on 3/27/25, 3/30/25, 4/1/25 or 4/20/25.<br>-Level I incident reports should have been completed for those incidents. | V 366 | | |
| V 736 | 27G .0303(c) Facility and Grounds Maintenance<br><br>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS<br>(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. | V 736 | | |

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| V 736 | Continued From page 10<br><br>This Rule is not met as evidenced by:<br>Based on observation and interview, the facility was not maintained in a clean, attractive and orderly manner. The findings are:<br><br>Observation on 5/14/25 during the facility tour at approximately 10:40 am-11:45 am revealed:<br>-The locked door which lead to the front entrance of the facility had an approximately 12 inch by 12 inch white unpainted area on the left side. The inside of the same door had an approximately 5 foot by 2 foot section of unpainted plastered and raw plywood repaired area.<br>-The wall outside of the dining room/kitchen area had a an approximately 2 foot by 2 foot white plastered unpainted repair area.<br><br>Unit 1:<br>-In the hallway outside of Pod A there was a white plastered area on a yellow wall approximately 3 feet by 4 feet.<br>-In the day room inside Pod A there was a white plastered area on a blue wall approximately 5 feet 2 feet.<br>-In Room 25 there was a white plastered area on a tan wall approximately 4 feet by 2 feet and one area behind the door approximately 1 feet in diameter.<br>-Room #26 had an approximately 4 foot by 3 foot unpainted white plastered repair area. The closet had an approximately 3 foot by 3 foot unpainted white plastered repair area.<br>-Room 27 had an approximately 5 foot by 5 foot unpainted white plastered and raw plywood repair area.<br>-Room 28 was missing a section of baseboard approximately 3 feet long near the foot of the bed.<br>-The hallway had various sized areas of dark | V 736 | | |

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| V 736 | Continued From page 11<br>scuff marks on the ceiling.<br>-The wall in the hallway near POD A had an approximately 4 foot by 4 foot unpainted white plastered repair area.<br>-The area under the television had an area of approximately 5 foot by 5 foot of black and dark scuff marks of various sizes.<br>-The hallway in POD B had an approximately 2 foot by 3 foot white plastered unpainted repair area. The wall between room #28 and #29 had an approximately 2 foot by 2 foot plastered white unpainted repair area.<br><br>Unit 2:<br>-The inside of the door had various sized black scuff marks on the bottom half of the door.<br>-The hallway had an approximately 6 inch by 12 inch and a 1 foot by 1 foot white plastered repair areas.<br>-Room #31 had a dried brown liquid with streaks down half the wall and spattered on the receptacle behind the door.<br>-Room #32 had multiple white plastered areas of various sizes throughout the walls of the room. 2 approximately 3 foot by 3 foot white patched and raw plywood unpainted repair areas.<br>-In Room 33 there were 2 areas of white plastered on a tan wall one was approximately 2 feet by 3 feet and the other area was approximately 2 feet by 2 feet.<br>-The hallway walls had 2 approximately 3 foot by 3 foot white plastered repair areas and an approximately 2 foot by 2 foot white plastered areas.<br><br>Unit 3:<br>-In room 37 there was an area near the light receptacle approximately 2 feet by 2 feet of varous words/writing.<br>-In the day room beside the television there was a | V 736 | | |

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| V 736 | Continued From page 12<br>white plastered area on a blue wall approximately 2 feet by 2 feet.<br>-The #2 seclusion room had various bits of white debris scattered on the floor. A large crayon had drawn a line approximately eye level around the entire room.<br>-Room #40 and room #41 had several white plaster unpainted repair areas of various sizes on the walls.<br><br>Interview on 5/14/25 the Maintenance worker stated:<br>-Holes in the wall were repaired with the white plaster after consumers kicked holes in the wall.<br>-The maintenance department were working on painting the walls to cover the white plaster.<br>-The maintenance department were replacing the base board in Room 28 within the next week.<br><br>Interview on 5/15/25 the Program Director stated:<br>-The consumers frequently put holes in the walls.<br>-The maintenance department made repairs daily. | V 736 | | |