STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL059-063	A. BUILDING _____ B. WING _____	06/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POSSIBILITIES	81 SOUTH MAIN STREET MARION, NC 28752

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V 000	INITIAL COMMENTS An annual survey was completed on June 5, 2018. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5400 Day Activity for Individuals of All Disability Groups	V 000	**RECEIVED** *By MH Lic & Cert Section at 11:26 am, Jun 27, 2018*	
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 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:	V 105		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE
Monica C. Cook, MHS 4P — 6-27-18

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(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;

This Rule is not met as evidenced by:
Based on interview and record review, the facility failed to implement their written policy for client admission assessment prior to the delivery of services affecting 3 of 4 clients (Client #1, Client #2 and Client #4). The findings are:

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Review on 6/4/18 of Client #1's record revealed:
Admission date: 6/6/17
Diagnoses: Mild Intellectual Developmental Disability, Encopresis, Attention Deficit Hyperactivity Disorder
-No admission assessment completed.

Review on 6/4/18 of Client #2's record revealed:
Admission date: 9/15/15
Diagnoses: Obsessive Compulsive Disorder, Impulsive Control Disorder, Mood Disorder, Attention Deficit Hyperactivity Disorder Combined Type, Disruptive Behavior Disorder, Autism Spectrum Disorder, Mild Mental Retardation, Prader-Willi Syndrome, Asthma, Scoliosis, Osteoporosis, Seasonal Allergies
-No admission assessment completed.

Review on 6/5/18 of Client #4's record revealed:
Admission date: 11/15/17
Diagnoses: Personality Disorder, Hypothyroidism, Borderline Personality Disorder, Intermittent Explosive Disorder, Hypertension, Allergic Rhinitis, Mood Disorder, Pervasive Developmental Disorder, Esophageal Reflux
-No admission assessment completed.

Review on 6/4/18 of the facility's written client admission policy dated November 2013 revealed:
-The policy was located in the program's policy manual;
-A statement that the policy would assure that client admission assessments were completed prior to delivery of services;
-The assessment would be performed by a Qualified Professional with assistance from direct care staff and administration;
-Information would be obtained from the individual client, family members, legal

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V 105	Continued From page 3 responsible individuals and/or case managers. Interview on 6/4/18 and 6/5/18 with the Chief Executive Officer/Qualified Professional revealed: -She was a Qualified Professional (QP); -She completed client admission assessments in the past; -The facility no longer completed the admission assessments; -Client assessments were completed by the client's Local Management Entity (LME); -The LME client assessments were used in facility team meetings as client evaluations; -She believed there was an updated client admission policy; -An updated client admission policy was not provided.	V 105	Policy on admission assessments will be updated to reflect what is actually occurring with admissions. This policy change will also reflect changes that have occurred within the LME/MCO regarding documentation that is available to providers. Responsible individuals Aimee Merrell and Aimee Gibbs.	August 1, 2018
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY AAND 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	V 367		

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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 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).

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V 367	Continued From page 5 (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 interview and record review, the facility failed to report Level II incidents to the Local Management Entity (LME) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident. The findings are: Review of facility incident reports from April 2018-May 2018 revealed: -A 5/11/18 internal incident report was documented that Client #4 verbally threatened to kill himself and engaged in self-harming behaviors; -His self-harming behaviors included biting,	V 367	

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slamming his head against a wall, and attempting to get to a window to jump out;
-Local law enforcement and emergency medical personnel responded to Client #4 at the facility;
-Client #4 taken to the local hospital for an evaluation;
-Client #4's legal guardian was notified.

Review on 6/5/18 of Client #4's record revealed:
Admission date: 11/15/17
Diagnoses: Personality Disorder, Hypothyroidism, Borderline Personality Disorder, Intermittent Explosive Disorder, Hypertension, Allergic Rhinitis, Mood Disorder, Pervasive Developmental Disorder, Esophageal Reflux
History: Recurrent verbalized threats to kill self, displayed past suicidal behaviors by wrapping cords around his neck, physical aggression and property destruction.

Review on 6/5/18 of the facility's written incident reporting policy dated November 2013 revealed:
-A definition of a Level 2 incident as any incident that involved a threat to a client's health or safety;
-A statement that in the event of any incident of Level 2 or 3, facility staff would complete a Department of Health and Human Services (DHHS) Incident Report and the incident would be entered into the North Carolina Incident Response Improvement System (IRIS);

Review of the North Carolina Incident Response Improvement System (IRIS) on 6/4/18 and 6/5/18 revealed no Level II report pertaining to Client #4.

Interview on 6/4/18 with Qualified Professional #1 revealed:
-He had completed the internal incident report on Client #4;

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V 367	Continued From page 7 -He did not witness Client #4's suicidal threat and self-harming behaviors on 5/11/18. Interview on 6/4/18 and 6/5/18 with the Facility Director revealed: -There was no IRIS report for Client #4 regarding the 5/11/18 incident; -She was familiar with the DHHS Criteria for Determining Level of Response to Incidents; -Client #4's behaviors on 5/11/18 were normal occurrences for him; -The incident was a Level 1 incident because Client #4 was not harmed; -"It was less than First Aid", -The incident was verbally reported to the Local Management Entity's (LME) Care Coordinator for Client #4; -Staff who are involved in client incidents complete the incident reports. Interview on 6/5/18 with the Chief Executive Officer/Qualified Professional revealed: -She was familiar with the DHHS Criteria for Determining Level of Response to Incidents; -Aware that the 5/11/18 incident with Client #4 was reported to the LME Care Coordinator and client's guardian; -No IRIS report was completed and submitted on the 5/11/18 incident with Client #4.	V 367	Additional training was provided to staff responsible for completing incident reports and submitting them to the appropriate individual for input into IRIS. Additional training for AFL providers is schedule for July and supervision staff will be attending training at Vaya Health in September. Responsible parties: Aimee Merrill and Jimi Cook	September 30, 2018