Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL090-193	A. BUILDING: ~~~~~~~~~~~~~~~~~~~~~~~~ B. WING ##########################	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDERSON HEALTH SERVICES-WALFUS	1915-A HASTY ROAD MARSHVILLE, NC 28103

(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** A complaint and follow up survey was completed on 6/1/18. The complaints were substantiated (Intake # NC00137605, NC00137607, NC00137693, NC00137753, NC00138455, NC0013850 2, NC00139313, NC00139 273). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents. Summary Suspension of License to Operate issued on 6/1/18.	V 000	**RECEIVED** *By MH Lic & Cert Section at 11:16 am, Jul 02, 2018*	
V 105	27G .0 201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0 201 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	V 105	Anderson Health Services has developed and implemented policies and procedures to monitor and evaluate the appropriateness of client care and to address the Judicial Review, Assessment Post Seclusion, Attestation of Facility Compliance, semi-annual training for all staff in alternatives to restrictive interventions and seclusion, physical restraint and isolation time-out, and training in cardiopulmonary resuscitation. Anderson Health Services has developed an Individualized Training Plan to ensure each staff member meets federal, state and MCO training requirements. The Staff Training and Development Coordinator will work with Human Resources to ensure compliance. The QA/QI department will monitor policies and procedures to ensure compliance on a monthly and as needed basis.	6/25/18

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Alfred Anderson	CEO	6-29-18

Division of Health Service Regulation

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V 105	**27G .0 201 (A) (1-7) Governing Body Policies** **10A NCAC 27G .0 201 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**	V 105	Anderson Health Services has developed and implemented policies and procedures to monitor and evaluate the appropriateness of client care and to address the Judicial Review, Assessment Post Seclusion, Attestation of Facility Compliance, semi-annual training for all staff in alternatives to restrictive interventions and seclusion, physical restraint and isolation time-out, and training in cardiopulmonary resuscitation. Anderson Health Services has developed an Individualized Training Plan to ensure each staff member meets federal, state and MCO training requirements. The Staff Training and Development Coordinator will work with Human Resources to ensure compliance. The QA/QI department will monitor policies and procedures to ensure compliance on a monthly and as needed basis.	6/25/18

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V 105	Continued From page 1 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: (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	**Screening** Policy: It is the policy of AHS to screen all referrals for admission to the PRTF to ensure the program meets the consumer treatment needs and is an appropriate fit with the current milieu. Procedure: Referrals for admission should be forwarded via fax and include the current signed Person Centered Plan, Updated CCA, and Psychological or Psychiatric Evaluation recommending PRTF with supporting clinical justification for the level of care requested, CALOCUS, and ASAM if the consumer has an existing substance use diagnosis. The clinical team will review the application and notify the referral source within 7 business days. If the referral is approved for admission, then the Certificate of Need with the appropriate signatures will be forwarded within 24 hours. It is the responsibility of the referral source to arrange for the consumer's transition to the facility. New admissions are accepted Monday-Wednesday between the hours of 9am and 3pm. The completed intake forms including consents are to be brought completed to the intake.	

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V 1 05	Continued From page 2 **This Rule is not met as evidenced by:** **Based on record review and interview the facility failed to develop and implement policies and procedures for monitoring and evaluating the appropriateness of client care, Judicial Review, Assessment Post Seclusion, Attestation of Facility Compliance, semi-annual training for all staff in alternatives to restrictive intervention and seclusion, physical restraint and isolation time-out, and training in Cardiopulmonary Resuscitation (CPR). The findings are:** **Finding #1** **-Attempted review on 4/1 2/18 of a policy and procedure to clarify the specifics for the use of Loss of Privileges (LOP), however no documentation was made available. -There was no explanation of LOP in the Resident Family Handbook;** **-There was no documentation of staff receiving training and/or supervision on LOP.** **Review 4/11/18 on of client #2's record revealed:** **-Admitted to the facility on 9/1 2/17;** **-16 years old;** **-Diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), Disruptive Mood Dysregulation Disorder (DMDD), Conduct Disorder (CD) and Unspecified Trauma and Stressor Related Disorder per treatment plan dated 3/19/18. Treatment plan goal strategies included but were not limited to residential staff utilizing a behavior management system to help manage behaviors, however no documentation to specify and support the Loss of Privileges (LOP) program.** **Interview on 4/17/18 with client #2 revealed:**	V 105	**Intake:** Policy: It is the policy of AHS to complete a formal intake at the time of admission to the facility. Procedure: At the time of Intake which is between the hours of 9am and 3pm Monday-Wednesday, the receiving intake staff will review the consents and accompanying documents to ensure completion. If any of the consents are missing, then they will need to be completed prior to the consumer being admitted to the program. Accompanying documents include Medicaid Card, State ID (if applicable), and court order verifying guardianship (if applicable). **Orientation:** It is the policy of AHS to provide an orientation for all new intakes.	

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V 105	Continued From page 3 **-He received LOP twice since being admitted to the facility;** **-The first LOP started on 1 2/23/17 and lasted for two weeks for hitting peer and jumping the fence, the second LOP started on 3/2/18 and lasted for twenty-two days for having a knife, a hammer and a cell phone. He stole the knife from the cafeteria, was given the hammer by a peer who says was left by a construction worker and stole the cell phone from staff's drawer. After Residential Counselor #1 (RC #1) came and talked with him about whether or not he had the stolen items, he voluntarily gave the items to RC #1.** **-LOP consisted of weekdays/weekends and included confinement to bedroom, 15-minute walks outside versus 30-minute walks outside, 5-minute telephone calls versus 10-minute telephone calls and no television time.** **Review on 4/16/18 of nurse progress notes for client #2 revealed:** **-Registered Nurse #3 (RN #3) documented "3/20/18 - 2000 Resident (client #2) continues to remain on LOP per Crisis Prevention Institute (CPI) Nonviolent Crisis Intervention Trainer. Resident (client #2) is cooperative and calm. He states to this nurse, "They want to make me stay on LOP longer.' When this nurse asks why? Staff redirects resident to 'go back to room' This nurse reported this situation to Licensed Therapist #1. There is some confusion on who we report to. Resident (client #2) is medication compliant. No other concerns. Denies Suicidal Ideation (SI)/ Homicidal Ideation (HI)...";** **-Registered Nurse #1 (RN #1) documented "3/24/18 - 1700 Resident (client #2) off LOP presently...Engaging appropriately with peers."** **-As of 6/1/18, specific information related to the**	V 105	Policy: It is the policy of AHS to Assess consumers receiving treatment at the facility. Procedure: Consumers receiving treatment at AHS will be assessed by a clinically licensed member of the treatment team at 30 and 90 day intervals and also prior to discharge from the facility. If an additional evaluation is clinically justified, then assessments may be completed more frequently. A QA/QI manager has been added to the operations team to provide oversight of internal process and corporate compliance. A written quality improvement plan is available for review and consists of plans for enhancing the services (i.e. training to improve resident communication and problem solving skills), records management, and communication with community stake holders that AHS provides for its residents. Internal audits are scheduled to occur monthly to monitor treatment outcomes, intervention compliance, incident management and reporting, and training schedules.	

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V 105	Continued From page 4 **LOP program was never made available for review.** **Interview on 4/1 2/18 with RC #1 revealed: -He was told by a first shift staff (could not recall name) that client #2 had stolen a knife from a dental visit, obtained a hammer from another cottage and stole a staffs' cell phone...and had all 3 items in his possession;** **-After talking to client #2 about having these items, he (client #2) voluntarily gave him the knife, hammer and cell phone;** **-Client #2 was placed on LOP for approximately 30 days, which consisted of 5 minutes of phone call time versus 10 minutes, 10-15 minutes of outside time, no television time and the remaining time in the bedroom, "up to staff."** **Interview on 4/16/18 with Licensed Therapist #1 (LP #1) revealed:** **-She was aware client #2 was placed on LOP however was not in agreement with the CPI Trainer's decision on the time frame for the LOP.; -She asked CPI Trainer when client #2 would come off LOP, and he responded "when I decide to take him off."** **Interview on 4/16/18 with Registered Nurse #3 (RN #3) revealed:** **-She was aware client #2 was placed on LOP for almost 30 days after having a hammer and knife, unaware where client #2 got the items from; -The LOP program specifics were decided on by the CPI Trainer.** **Interview on 4/1 2/18 with the CPI Trainer revealed:** **-Not currently completing semi-annual refresher courses in CPI;** **-He was unaware if there were specific**	V 105	AHS has amended the routine and crisis operations to reflect the standards and scope of practice outlined in the NCAC as well as the CMS (Center for Medicaid & Medicare Services) Clinical practice guidelines. Clinical and operations staff are trained at orientation and every six months thereafter and expected to demonstrate skill acquisition in the areas of critical thinking, crisis management and response, debriefing, incident reporting, and written communication skills. Consumers receiving treatment at AHS will be assessed at 30 and 90 day intervals and also prior to discharge from the facility. If an additional evaluation is clinically justified, then assessments may be completed more frequently. The resident's treatment plan will be updated monthly to reflect progress in treatment and amended to reflect resident's needs and goals. The Client Handbook has been amended to address the Loss of Privileges Policies that outlines what action will result in the loss of privileges, the length of time the privilege will be lost, and what privileges will be lost. LOP does not	

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V 105	Continued From page 5 procedures documented for LOP. Finding #2 Attempted review on 4/9/18 through 4/18/18 of the facility's Judicial Review, Assessment Post Seclusion, Attestation of Facility Compliance, semi-annual training for all staff in alternatives to restrictive intervention and seclusion, physical restraint and isolation time-out, and training for Registered Nurse #2 (RN #2) in cardiopulmonary resuscitation was unsuccessful. There was no documentation available for Judicial Review. There was no Attestation of Facility Compliance available for review. There was no documentation of staff receiving semi-annual training in alternatives to restrictive intervention and seclusion, physical restraint and isolation time-out. There was no documentation of Registered Nurse #2's current training in cardiopulmonary resuscitation. Review on 4/9/18 of the Restrictive Intervention Policy dated 1 2/6/16 including revisions dated 2/21/17, 4/15/17, 5/1/17, and 5/23/17 revealed: - Each restrictive intervention must include documentation of debriefing of the intervention, documentation of witness of a second qualified staff not involved in the intervention to monitor and document the event, restrictive intervention form reviewed and signed by the supervisor, and a restrictive intervention case note. Multiple requests on 4/1 2/18 through 4/18/18 made to the Human Resource Lead regarding documentation of RN #2 current training in CPR were unsuccessful. No documentation regarding training was provided and no explanation regarding the lack of training documentation was offered.	V 105	include seclusion or bedroom restriction from the general group for more than 30 minutes. AHS has amended the policy and procedures manual to include a policy regarding restricted access areas. Residents at AHS will not have access to the kitchen, maintenance, or supply areas for any reason.	

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V 105	Continued From page 6 Review on 4/17/18 of the facility's policy on Volunteers dated 1 2/6/16 and revised on 4/28/17 revealed: -"It is the policy of Anderson Health Services (Licensee) to not engage volunteers at this time." Interview on 4/9/18 and 4/18/18 with the Volunteer revealed: -He was second in-charge of the facility under the Licensee; -He had been responsible for compliance issues in the recent past; -He did not know who handled Judicial Reviews or where to locate documentation of Attestation of Facility Compliance for the facility; -He was not aware that CPI training needed to be completed on a semi-annual basis; -He did not know why RN #2 had no training in CPR or why the Human Resource Lead could not provide documentation of the required training; -He would work this weekend (4/21/18 and 4/22/18) and require all administrative staff to work to gather all outstanding documents to ensure compliance in the future. Interview on 4/18/18 with the Licensee revealed: -All outstanding issues will be addressed and corrected. This deficiency is cross referenced into 10A NCAC 27G .1901 Psychiatric Residential Treatment Facility-Scope V314 for a Type A1 rule violation.	V 105	Responsible Person: Quality Management Director Areas with associate responsibilities: Staff Training and Development Director QA/QI Department Qualified Professionals	
V 107	27G .0 20 2 (A-E) Personnel Requirements 10A NCAC 27G .0 20 2 PERSONNEL REQUIREMENTS (a) All facilities shall have a written job	V 107		

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V 107	Continued From page 7 **description for the director and each staff position which:** **(1) specifies the minimum level of education, competency, work experience and other qualifications for the position;** **(2) specifies the duties and responsibilities of the position;** **(3) is signed by the staff member and the supervisor; and** **(4) is retained in the staff member's file.** **(b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility:** **(1) is at least 18 years of age;** **(2) is able to read, write, understand and follow directions;** **(3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and** **(4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry?** **(c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying.** **(d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided.** **(e) A file shall be maintained for each individual employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification.**	V 107	Written job descriptions have been completed, reviewed, acknowledged, signed, and placed in the files of Registered Nurse #1, Registered Nurse #3, Medical Doctor/Medical Director/Child Psychiatrist, Residential Counselor Supervisor #2, Residential Counselor #2, and former Volunteer who is now an employee of Anderson Health Services. Anderson Health Services will ensure a written job description is prepared and signed by all employees upon employment. Human Resources will ensure that all job descriptions are part of the hiring/orientation packet. Human Resources will review employee's personnel files quarterly for compliance. QA/QI will monitor for compliance at least monthly.	5/30/18

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V 107	Continued From page 8 This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure a written job description for each staff position affecting 6 of 26 audited staff (Registered Nurse #1 (RN #1), Registered Nurse #3 (RN #3), Medical Doctor/Medical Director/Child Psychiatrist (referred to in the report as MD), Residential Counselor Supervisor #2 (RCS #2), Residential Counselor (RC #2) and Volunteer. The findings are: Review on 4/1 2/18 of RN #1's record revealed: -Hire date of 11/13/17; -No signed job description outlining the minimum level of education and competency and specific duties and responsibilities of the job. Review on 4/1 2/18 of RN #3's record revealed: -Hire date of 4/22/17; -No signed job description outlining the minimum level of education and competency and specific duties and responsibilities of the job. Review on 4/1 2/18 of MD's record revealed: -Hire date of 3/13/18; -No signed job description outlining the minimum level of education and competency and specific duties and responsibilities of the job. Review on 4/1 2/18 of RCS #2's record revealed: -Hire date of 4/22/17; -No signed job description outlining the minimum level of education and competency and specific	V 107	Responsible Person: Human Resources Areas with associated responsibilities: QA/QI Department Qualified Professionals	

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V 107	Continued From page 9 duties and responsibilities of the job. Review on 4/1 2/18 of RC #2's record revealed: -Hire date of 2/7/18; -No signed job description outlining the minimum level of education and competency and specific duties and responsibilities of the job. Review on 4/1 2/18 of the Volunteer's record revealed: -Hire date of 9/22/17; -No signed job description outlining the minimum level of education and competency and specific duties and responsibilities of the job. Review on 4/17/18 of the facility's policy on Volunteers dated 1 2/6/16 and revised on 4/28/17 revealed: -"It is the policy of Anderson Health Services (Licensee) to not engage volunteers at this time." Interview on 4/17/18 with the Human Resources Lead revealed: - Will ensure that all job descriptions are signed and placed in staff records. Interview on 4/9/18 and 4/18/18 with the Volunteer revealed: -He was second in-charge of the facility under the Licensee; -He had been responsible for compliance issues in the recent past; -He would ensure all job descriptions were signed and placed in staff records. Interview on 4/18/18 with the Licensee revealed: - All outstanding issues will be addressed and corrected. This deficiency is cross referenced into 10A	V 107		

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(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 107	Continued From page 10 NCAC 27G .1901 Psychiatric Residential Treatment Facility-Scope V314 for a Type A1 rule violation.	V 107		
V 108	27G .0 20 2 (F-I) Personnel Requirements 10A NCAC 27G .0 20 2 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .560 2(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.	V 108	Residential Counselor Supervisor #4 and Residential Counselor #5 are no longer employed with Anderson Health Services and is not subject for rehire. Registered Nurse #2, Residential Counselor #7, Residential Counselor #8, and former Volunteer who is now employed with Anderson Health Services have completed their training programs, and the completion has been documented. Anderson Health Services will ensure that staff will complete all required trainings with appropriate documentation (certificates) placed in the employee's file for review. A Staff Training & Development Coordinator position has been created and filled to provide educational training and in-service within Anderson Health Services. The Staff Training & Development Coordinator will work with Human Resources to ensure compliance. QA/QI will monitor for compliance monthly.	5/30/18

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V 108	Continued From page 11 This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure completion and documentation of employee training programs in Cardiopulmonary Resuscitation (CPR), Mental Health, Developmental Disabilities, Substance Abuse (MH/DD/SA), Loss of Privileges (LOP), Treatment/Crisis Plans and Diagnoses affecting 7 of 26 staff, Registered Nurse #2 (RN #2), Residential Counselor Supervisor #4 (RCS #4), Residential Counselor #2 (RC #2), Residential Counselor #5 (RC #5), Residential Counselor #7 (RC #7), Residential Counselor #8 (RC #8) and the Volunteer. The findings are: Review on 4/1 2/18 of RN #2's record revealed: -No documentation of training in CPR. -No documentation of training in meeting the MH/DD/SA and diagnostic needs of the clients, -No documentation of training as specified in the individual treatment/crisis plans or LOP. Review on 5/3/18 of RCS #4's record revealed: -No documentation of training in meeting the MH/DD/SA and diagnostic needs of the clients, -No documentation of training as specified in the individual treatment/crisis plans or LOP. Review on 4/1 2/18 of RC #2's record revealed: -No documentation of training on client rights and confidentiality; -No documentation of training in meeting the MH/DD/SA and diagnostic needs of the clients, -No documentation of training as specified in the individual treatment/crisis plans or LOP. Review on 5/3/18 of RC #5's record revealed:	V 108	AHS policy requires that all staff members have a written job description for all staff in accordance with the NCAC. Prior to the first day of employment, education, licensure, experience, and criminal background are verified and the Health Care Registry is checked to confirm eligibility for employment. Responsible Person: Staff Training & Development Coordinator Areas with associated responsibilities: QA/QI Department Human Resources Qualified Professionals	

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V 1 08	Continued From page 12 -No documentation of training in meeting the MH/DD/SA and diagnostic needs of the clients, -No documentation of training as specified in the individual treatment/crisis plans or LOP. Review on 5/31/18 of RC #7's record revealed: -No documentation of training in meeting the MH/DD/SA and diagnostic needs of the clients, -No documentation of training as specified in the individual treatment/crisis plans or LOP. Review on 5/31/18 of RC #8's record revealed: -No documentation of training in meeting the MH/DD/SA and diagnostic needs of the clients, -No documentation of training as specificied in the individual treatment/crisis plans or LOP. Review on 4/1 2/18 of the Volunteer's record revealed: -No documentation of training in general organizational orientation, client rights, confidentiality; -No documentation of training in meeting the MH/DD/SA and diagnostic needs of the clients, -No documentation of training as specificied in the individual treatment/crisis plans or LOP. Review on 4/17/18 of the facility's policy on Volunteers dated 1 2/6/16 and revised on 4/28/17 revealed: -"It is the policy of Anderson Health Services (Licensee) to not engage volunteers at this time." Multiple requests on 4/1 2/18 through 4/18/18 made to the Human Resource Lead regarding documentation of RN #2 having current training in CPR were unsuccessful. No documentation regarding training was provided and no explanation regarding the lack of training required documentation was offered.	V 108		

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V 108	Continued From page 13 Interview on 5/17/18 with the local Police Lieutenant and Police Chief revealed: -" ...(They) don't understand the process (at Anderson Health Services - Licensee) ...(staff) verbally challenge the kids (clients) ...(staff are) unaware how to talk to them (clients) ...(the) lack of rules is such a problem (at Anderson Health Services) ... We (police) are not here to take people (clients) to the hospital from a (mental health) facility ...;" -The volunteer and the Licensee requested to meet with them to discuss the process on how to complete an involuntary commitment process. Interview on 4/1 2/18 with the Human Resource Lead revealed: -RC #2 started with the facility in the position of a Cook in the kitchen/cafeteria and only completed the general orientation training upon hire; -There was no additional client specific population training provided to RC #2 when he was moved from the position of Cook to the position of RC #2. Interview on 4/9/18 and 4/18/18 with the Volunteer revealed: -He was second in-charge of the facility under the Licensee; -He had been responsible for compliance issues in the recent past; -He did not why RN #2 did not have CPR training or the reason the Human Resource Lead could not provide documentation of the training; -He completed all required training and did not know why the documentation was not in his record; -He would work this weekend (4/21/18 and 4/22/18) and require all administrative staff to work to gather all outstanding documents to	V 108		

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V 108	Continued From page 14 ensure compliance in the future. Interview on 4/18/18 with the Licensee revealed: -All outstanding issues will be addressed and corrected. This deficiency is cross referenced into 10A NCAC 27G .1901 Psychiatric Residential Treatment Facility-Scope V314 for a Type A1 rule violation.	V 108		
V 109	27G .0 203 Privileging/Training Professionals 10A NCAC 27G .0 203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS.	V 109	Anderson Health Services will ensure each staff member demonstrates the knowledge, skills and abilities required by the population served. Anderson Health Services has developed and implemented policies and procedures for the initiation of the individualized supervision plan upon hiring each associate professional, and the associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this subchapter. Anderson Health Services will ensure all QP & AP associates will receive clinical supervision from the clinical director and/or qualified designee.	5/30/18

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V 109	Continued From page 15 **(f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional.** **(g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter.** **This Rule is not met as evidenced by: Based on record review and interview 4 of 17 Qualified Professionals, Registered Nurse # 1 (RN #1), Registered Nurse #2 (RN #2), Nurse Practitioner (NP) and Lead Licensed Therapist #2 (LLT #2) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are:** **Finding #1** **Review on 4/1 2/18 of RN #1's record revealed:** **-Hire date of 11/13/17;** **-Multi-state nursing license with an expiration date of 7/31/18.** **Record review on 4/1 2/18 of RN #2 revealed:** **-Hired on 3/19/18 as a RN #2;** **-Multi state license expiration date of 5/31/18.** **Record review on 4/1 2/18 of NP revealed:** **-Hired on 5/7/17 as NP;** **-North Carolina Family (NP) License expiration date of 1 2/7/22.** **Interview on 4/16/18 with RN #1 revealed: -Worked as a relief nurse part-time on the weekends;**	V 109	Anderson Health Services has hired a new Clinical Director and therapists. The clinical director and /or qualified designee will meet with staff as required, and documentation of the training and supervision will be placed in the employee's file for review. Anderson Health Services has installed an automatic self-closing device to the medication room door. Nurses will be trained upon employment. QA/QI will monitor for compliance monthly. Responsible Person: Clinical Director Areas with associated responsibilities: QA/QI Department Qualified Professionals Staff Training and Development	

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V 109	Continued From page 16 -It was the policy to lock medication room doors in each cottage; -She did not lock the medication room door during her shift on the weekend of 3/31/18 and 4/1/18 "because it was a pain in the "a*s" and did not think it was necessary because the medication cart in the medication room was locked. Interview on 4/17/18 with RN #2 revealed: - The medication room doors were left open on 3/31/18 by RN #1. Interview on 4/11/18 with the NP revealed: - When RN #1 was relieved on 3/31/18 by RN #2, RN #2 discovered that RN #1 had left the medication room unlocked. -After the pharmacy technician informed them the pharmacy was closed and would not be able to take the medication (Vyvanse) for disposal, she (NP) left them on top of the refrigerator and did not lock them up, "I made the biggest mistake ever, I'm beating myself up." Interview on 4/18/18 with the Licensee revealed: -All outstanding issues will be addressed and corrected. Finding #2 Record review on 5/17/18 of the facility's incident report revealed: - "...Date: 5/2/18. Time: 0640...[Client #11] received [client #4's] morning medication...Pt given granola bar. [RN] will monitor BS. BS=168 fasting...Physician response cont to monitor Resident for hypoglycemic episodes..." -The names of the medications were not documented on the incident report dated 5/2/18. Interview on 5/31/18 with RN #2 revealed:	V 109		

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V 109	Continued From page 17 -She was not involved with the incident on 5/2/18 where client #11 received client #4's medication, therefore did not write the incident report; -She read the names of the medications to the surveyor written on a pink sticky note which were given to her by the NP, (the names of the medications were Zoloft 100mg, Metformin 500mg and Fish Oil 1000mg); -She would look for the actual documentation, however she never returned with the information. Interview on 5/22/18 with Registered Nurse#4 (RN #4) revealed: -She did not know the specific names of the medications and could not locate any nursing documentation related to the incident report on 5/2/18 where client #11 received client #4's medication, however spoke with the NP who stated she would get the information, however NP never produced the requested documentation. Attempted interviews on 5/17/18, 5/22/18 and 5/31/18 with the NP to discuss the 5/2/18 medication error related to client #11 receiving client #4's medication however the NP was never available for interview. Finding #3 Review on 5/22/18 of the Lead Licensed Therapist (LLT #2) record revealed: -Hire date of 4/23/18; -Job description signed 4/28/18 with job responsibilities of: "Facilitates individual therapy sessions for adolescent clients ages 1 2 through 18...maintaining service records..." Review on 4/11/18 of client 1's record revealed: -Admission date of 3/29/18; -17 year old male; -Diagnoses of Oppositional Defiant Disorder	V 109		

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V 109	Continued From page 18 (ODD) and Attention Deficit Hyperactivity Disorder (ADHD); -Current treatment plan dated 3/22/18 documented weekly individual therapy to explore triggers for anger and learn skills to manage anger, aggresion and other impulsive behaviors. Review on 4/11/18 of client #2's record revealed: -Admission date of 9/1 2/17; -16 year old male; -Diagnoses of ADHD, Disruptive Mood Dysregulation Disorder (DMDD), Conduct Disorder, History of Sexual and Physical Abuse; -Current treatment plan dated 3/19/18 documented weekly individual therapy to explore triggers for anger and learn skills to manage anger, aggresion and other impulsive behaviors. Review on 4/11/18 of client #5's record revealed: -Admission date of 3/7/18; -15 year old male; -Diagnoses of Depressive Disorder and ODD; -Current treatment plan dated 2/19/18 documented weekly therapy. Review on 4/11/18 of client #6's record revealed: -Admission date of 4/3/18; -15 year old male; -Diagnoses of ODD and DMDD; -Current treatment plan dated 3/20/18 documented actively participate in weekly therapy to identify skills to assist in emotional regulation. Review on 4/11/18 of client #7's record revealed: -Admission date of 3/26/18; -15 year old male; -Diagnoses of DMDD, ADHD and Cannabis Dependence; -Current treatment plan dated 3/1 2/18 documented weekly therapy sessions to	V 109		

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V 109	Continued From page 19 implement given skills and strategies daily. Review on 4/11/18 of client #8 revealed: -Admission date of 2/22/18; -17 year old male; -Diagnoses of Conduct Disorder, ODD and Perpetrator; -Current treatment plan prior to discharge dated 3/26/18 documented weekly individual therapy sessions. Review on 5/7/18 of therapy notes provided by LP #2 revealed: -3 individual therapy notes with no dates for client #1; -3 individual therapy notes with no dates for client #2; -3 individual therapy notes with no dates for client #5; -4 individual therapy notes with no dates for client #6; -5 individual therapy notes with no dates for client #7; - 2 individual therapy notes with no dates for client #8; Review on 5/17/18 of LLT #2's therapy notes provided by LP #3 revealed: -3 individual therapy notes dated 4/4,11,18/18 for client #1; -3 individual therapy notes, 1 dated 4/16/18 and 2 with no dates for client #2; -3 individual therapy notes dated 3/8, 15, 26/18 for client #5; -6 individual therapy notes dated 4/9, 18, 26/18 and 5/1/18 for client #6; -5 individual therapy notes dated 3/26/18, 4/4, 9, 16, 23/18 for client #7; - 2 individual therapy notes dated 3/26/18 and 4/4/18 for client #8;	V 109		

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V 109	Continued From page 20 Interview on 5/7/18 with LLT #2 revealed: -She was hired in March 2018 as the "Lead" Therapist, not "Clinical Director"; -She provided therapy to the clients 2 days a week, sometimes 3 days a week, normally Monday and Wednesday and Thursday as needed. -Since she was hired, she provided individual therapy to clients #1, #2, #4, #5, #6, #7, #8; -She was not sure why she had not written the dates on the therapy notes, but stated she could put the dates on the notes. Interview on 5/7/18 with client #1 revealed: -He had one on one therapy maybe 2 times since he was admitted to the facility. Interview on 5/3/18 with client #2 revealed: -He sees a therapist "barely ever." Interview on 5/4/18 with client #4 revealed: -He had never talked to LLT #2 one on one, "only group." Interview on 5/7/18 with client #8 revealed: -He only had group therapy one to two times a week with LLT #2 and recently started one on one therapy with the new therapist. Interview on 5/4/18 with client #10 revealed: -He had therapy 1 time since he was admitted to the facility. This deficiency is cross referenced into 10A NCAC 27G .1901 Psychiatric Residential Treatment Facility-Scope V314 for a Type A1 rule violation.	V 109		

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V 110	Continued From page 21	V 110		
V 110	**27G .0 204 Training/Supervision Paraprofessionals** **10A NCAC 27G .0 204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS** **(a) There shall be no privileging requirements for paraprofessionals.** **(b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter.** **(c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served.** **(d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.** **(e) Competence shall be demonstrated by exhibiting core skills including:** **(1) technical knowledge;** **(2) cultural awareness;** **(3) analytical skills;** **(4) decision-making;** **(5) interpersonal skills;** **(6) communication skills; and** **(7) clinical skills.** **(f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.** **This Rule is not met as evidenced by:** **Based on record review and interview 1 of 9 Paraprofessional staff, Crisis Prevention Institute**	V 110	Anderson Health Services will ensure qualified professionals and associate professionals are displaying knowledge, skills, and abilities required by the population served. Anderson Health Services will ensure each staff member is trained prior to providing direct care for clients. The CPI trainer will be trained in Special Population, Client Rights, and Loss of Privileges training. The CPI trainer will receive clinical supervision. The Staff Training & Development Coordinator will monitor training on an ongoing basis and will update and document training as needed. QA/QI will monitor for compliance monthly.	6/25/18

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V 1 1 0	Continued From page 22 **(CPI) Nonviolent Crisis Intervention Trainer failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are:** **-Attempted review on 4/1 2/18 of a policy and procedure to clarify the specifics for the use of Loss of Privileges (LOP), however no documentation was made available. -There was no explanation of LOP in the Resident Family Handbook;** **-There was no documentation of staff receiving training and/or supervision on LOP.** **Review 4/11/18 on of client #2's record revealed:** **-Admitted to the facility on 9/1 2/17;** **-16 years old;** **-Diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), Disruptive Mood Dysregulation Disorder (DMDD), Conduct Disorder (CD) and Unspecified Trauma and Stressor Related Disorder per treatment plan dated 3/19/18. Treatment plan goal strategies included but were not limited to residential staff utilizing a behavior management system to help manage behaviors, however no documentation to specify and support the Loss of Privileges (LOP) program.** **-Interview on 4/17/18 with client #2 revealed: -He received LOP twice since being admitted to the facility;** **-The first LOP started on 1 2/23/17 and lasted for two weeks for hitting peer and jumping the fence, the second LOP started on 3/2/18 and lasted for twenty two days for having a knife, a hammer and a cell phone. He stole the knife from the cafeteria, was given the hammer by a peer who says was left by a construction worker and stole the cell phone from staff's drawer. After Residential Counselor #1 (RC #1) came and**	V 110	An orientation, annual, and continuing education calendar is in place for all levels of clinical staff (i.e. nursing and residential staff). Licensed/ registered staff members are expected to maintain credentials in accordance with their credentialing body's licensing requirements while employed at AHS. Training include BBP, CPR/ 1st Aide, Crisis Management, CBT, MI, documentation writing, client rights, HIPPA, cultural competency, and trauma informed care. Skill acquisition of staff will be monitored through semi-annual and annual evaluations. Responsible Person: Staff Training & Development Coordinator and CPI Trainer Areas with associated responsibilities: Human Resources QA/QI Department Qualified Professional Clinical Director and/or Qualified Designee	

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V 110	Continued From page 23 talked with him about whether or not he had the stolen items, he voluntarily gave the items to RC #1. -LOP consisted of weekdays/weekends and included confinement to bedroom, 15 minute walks outside versus 30 minute walks outside, 5 minute telephone calls versus 10 minute telephone calls and no television time. Review on 4/16/18 of nurse progress notes for client #2 revealed: -Registered Nurse #3 (RN #3) documented "3/20/18 - 2000 Resident (client #2) continues to remain on LOP per CPI Trainer. Resident (client #2) is cooperative and calm. he states to this nurse, "They want to make me stay on LOP longer.' When this nurse asks why? Staff redirects resident to 'go back to room' This nurse reported this situation to Licensed Therapist #1. There is some confusion on who we report to. Resident (client #2) is medication compliant. No other concerns. Denies Suicidal Ideation (SI)/ Homicidal Ideation (HI)..."; -Registered Nurse #1 (RN #1) documented "3/24/18 - 1700 Resident (client #2) off LOP presently...Engaging appropriately with peers." -As of 6/1/18, specific information related to the LOP program was never made available for review. Interview on 4/1 2/18 with RC #1 revealed: -He was told by a first shift staff (could not recall name) that client #2 had stolen a knife from a dental visit, obtained a hammer from another cottage and stole a staffs' cell phone...and had all 3 items in his possession; -After talking to client #2 about having these items, he (client #2) voluntarily gave him the knife, hammer and cell phone;	V 110		

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V 110	Continued From page 24 -Client #2 was placed on LOP for approximately 30 days, which consisted of 5 minutes of phone call time versus 10 minutes, 10-15 minutes of outside time, no television time and the remaining time in the bedroom, "up to staff." Interview on 4/16/18 with Licensed Therapist #1 (LP #1) revealed: -She was aware client #2 was placed on LOP however was not in agreement with the CPI Trainer's decision on the time frame for the LOP.; -She asked CPI Trainer when client #2 would come off LOP, and he responded "when I decide to take him off." Interview on 4/16/18 with Registered Nurse #3 (RN #3) revealed: -She was aware client #2 was placed on LOP for almost 30 days after having a hammer and knife, unaware where client #2 got the items from; -The LOP program specifics were decided on by the CPI Trainer. Interview on 4/1 2/18 with the CPI Trainer revealed: -He was unaware if there were specific procedures documented for LOP. This deficiency is cross referenced into 10A NCAC 27G .1901 Psychiatric Residential Treatment Facility-Scope V314 for a Type A1 rule violation.	V 110		
V 11 2	27G .0 205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0 205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN	V 112		

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V 112	Continued From page 25 **(c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.** **(d) The plan shall include:** **(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;** **(2) strategies;** **(3) staff responsible;** **(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;** **(5) basis for evaluation or assessment of outcome achievement; and** **(6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.** **This Rule is not met as evidenced by:** **Based on record review and interview the facility failed to implement strategies in client treatment plans affecting 6 of 8 clients (#1, # 2, #5, #6, #7, #8) and failed to ensure written consent or agreement by the client and responsible party for the treatment plan affecting 1 of 8 clients (#5).** **The findings are:** **Finding #1** **-Review on of client #2's record revealed:** **-Admitted to the facility on 9/1 2/17;** **-16 year old male;**	V 112	This plan has been corrected. Anderson Health Services has hired a new Clinical Director and therapists. Anderson has developed new clinical programs. Consumers receiving treatment at AHS will be assessed at 30 and 90-day intervals and also prior to discharge from the facility. If an additional evaluation is clinically justified, then assessments may be completed more frequently. Anderson Health Services will ensure all treatment plans are signed during Child and Family Team Meetings and all client treatment plans are signed by the legally responsible party and filed in the client's record for review. Anderson Health Services will continue to utilize strategies in the treatment plans. The Medical Records Coordinator will review client's records on a monthly or as needed basis. QA/QI will monitor for compliance monthly.	5/30/18

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V 112	Continued From page 26 **-Diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), Disruptive Mood Dysregulation Disorder (DMDD), Conduct Disorder (CD) and Unspecified Trauma and Stressor Related Disorder per treatment plan dated 3/19/18. Treatment plan goal strategies included but were not limited to residential staff utilizing a behavior management system to help manage behaviors, however no documentation to specify and support the Loss of Privileges (LOP) program.** **-Interview on 4/17/18 with client #2 revealed: -He received LOP twice since being admitted to the facility;** **-The first LOP started on 1 2/23/17 and lasted for two weeks for hitting peer and jumping the fence, the second LOP started on 3/2/18 and lasted for twenty two days for having a knife, a hammer and a cell phone. He stole the knife from the cafeteria, was given the hammer by a peer who says was left by a construction worker and stole the cell phone from staff's drawer. After Residential Counselor #1 (RC #1) came and talked with him about whether or not he had the stolen items, he voluntarily gave the items to RC #1.** **-LOP consisted of weekdays/weekends and included confinement to bedroom, 15 minute walks outside versus 30 minute walks outside, 5 minute telephone calls versus 10 minute telephone calls and no television time.** **Interview on 4/1 2/18 with RC #1 revealed: -He was told by a first shift staff that client #2 had a knife from a dental visit, a hammer from another cottage and a cell phone from staff in his possession.** **-After talking to client #2, he (client #2) voluntarily gave him the knife, hammer and cell phone; -Client #2 was placed on LOP for approximately**	V 112	Policy: It is the policy of AHS to Assess consumers receiving treatment at the facility. Procedure: Consumers receiving treatment at AHS will be assessed at 30 and 90 day intervals and also prior to discharge from the facility. If an additional evaluation is clinically justified, then assessments may be completed more frequently. The resident's treatment plan will be updated monthly to reflect progress in treatment and amended to reflect resident's needs and goals. Individual and group therapy will be provided weekly to all residents at AHS. If the resident is in the care of a parent or other natural support, then family therapy will be provided in addition to the individual and group therapy sessions.	

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V 112	Continued From page 27 30 days, which consisted of 5 minutes of phone call time versus 10 minutes, 10-15 minutes of outside time, no television time and the remaining time in the bedroom, "up to staff." Interview on 4/16/18 with Licensed Therapist #1 (LT #1) revealed: -She was aware client #2 was placed on LOP however was not in agreement with the CPI Trainer's decision on the time frame for the LOP.; -She asked CPI Trainer client #2 would come off LOP, and he responded "when I decide to take him off." Interview on 4/16/18 with Registered Nurse #3 (RN #3) revealed: -She was aware client #2 was placed on LOP for almost 30 days after having a hammer and knife, unaware where client #2 got the items from; -The LOP program specifics were decided on by the CPI Trainer. Interview on 4/1 2/18 with the Crisis Prevention Institute (CPI) Nonviolent Intervention Trainer revealed: -He was unaware if there were specific procedures documented for LOP. Finding #2 Review on 5/22/18 of the Lead Licensed Therapist #2 (LLT #2) record revealed: -Hire date of 4/23/18; -Job description signed 4/28/18 with job responsibilities of: "Facilitates individual therapy sessions for adolescent clients ages 1 2 through 18...maintaining service records..." Review on 4/11/18 of client 1's record revealed: -Admission date of 3/29/18; -17 year old male;	V 112	Responsible Person: Clinical Director Areas with associated responsibilities: Medical Director Licensed Professionals Medical Records QA/QI Department	

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V 112	Continued From page 28 -Diagnoses of Oppositional Defiant Disorder (ODD) and Attention Deficit Hyperactivity Disorder (ADHD); -Current treatment plan dated 3/22/18 documented weekly individual therapy to explore triggers for anger and learn skills to manage anger, aggresion and other impulsive behaviors. Review on 4/11/18 of client #2's record revealed: -Admission date of 9/1 2/17; -16 year old male; -Diagnoses of ADHD, Disruptive Mood Dysregulation Disorder (DMDD), Conduct Disorder, History of Sexual and Physical Abuse; -Current treatment plan dated 3/19/18 documented weekly individual therapy to explore triggers for anger and learn skills to manage anger, aggresion and other impulsive behaviors. Review on 4/11/18 of client #5's record revealed: -Admission date of 3/7/18; -15 year old male; -Diagnoses of Depressive Disorder and ODD; -Current treatment plan dated 2/19/18 documented weekly therapy. Review on 4/11/18 of client #6's record revealed: -Admission date of 4/3/18; -15 year old male; -Diagnoses of ODD and DMDD; -Current treatment plan dated 3/20/18 documented actively participate in weekly therapy to identify skills to assist in emotional regulation. Review on 4/11/18 of client #7's record revealed: -Admission date of 3/26/18; -15 year old male; -Diagnoses of DMDD, ADHD and Cannabis Dependence; -Current treatment plan dated 3/1 2/18	V 112		

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V 112	Continued From page 29 documented weekly therapy sessions to implement given skills and strategies daily. Review on 4/11/18 of client #8 revealed: -Admission date of 2/22/18; -17 year old male; -Diagnoses of Conduct Disorder, ODD and Perpetrator; -Current treatment plan prior to discharge dated 3/26/18 documented weekly individual therapy sessions. Review on 5/7/18 of therapy notes provided by LLT #2 revealed: -3 individual therapy notes with no dates for client #1; -3 individual therapy notes with no dates for client #2; -3 individual therapy notes with no dates for client #5; -4 individual therapy notes with no dates for client #6; -5 individual therapy notes with no dates for client #7; - 2 individual therapy notes with no dates for client #8; Review on 5/17/18 of LLT #2's therapy notes provided by Licensed Therapist #3 (LT #3) revealed: -3 individual therapy notes dated 4/4,11,18/18 for client #1; -3 individual therapy notes, 1 dated 4/16/18 and 2 with no dates for client #2; -3 individual therapy notes dated 3/8, 15, 26/18 for client #5; -6 individual therapy notes dated 4/9, 18, 26/18 and 5/1/18 for client #6; -5 individual therapy notes dated 3/26/18, 4/4, 9, 16, 23/18 for client #7;	V 112		

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V 112	Continued From page 30 - 2 individual therapy notes dated 3/26/18 and 4/4/18 for client #8; Interview on 5/7/18 with LLT #2 revealed: -She was hired in March 2018 as the "Lead" Therapist, not "Clinical Director"; -She provided therapy to the clients 2 days a week, sometimes 3 days a week, normally Monday and Wednesday and Thursday as needed. -Since she was hired, she provided individual therapy to clients #1, #2, #4, #5, #6, #7, #8; -She was not sure why she had not written the dates on the therapy notes, but stated she could put the dates on the notes. Interview on 5/7/18 with client #1 revealed: -He had one on one therapy maybe 2 times since he was admitted to the facility. Interview on 5/3/18 with client #2 revealed: -He sees a therapist "barely ever." Interview on 5/4/18 with client #4 revealed: -He had never talked to LLT #2 one on one, "only group." Interview on 5/4/18 with client #10 revealed: -He had therapy 1 time since he was admitted to the facility. Finding #3 Review on 4/11/18 of Client #5's record revealed: -Admission date of 3/7/18; -Diagnoses of Depressive Disorder (DD) and Oppositional Defiant Disorder (ODD); -15 year old male; -Treatment Plan dated 2/19/19 with no signatures for consent of treatment from the client or responsible party.	V 112		

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V 112	Continued From page 3 1 Review on 4/17/18 of the facility's policy on Volunteers dated 1 2/6/16 and revised on 4/28/17 revealed: -"It is the policy of Anderson Health Services (Licensee) to not engage volunteers at this time." Interview on 4/9/18 and 4/18/18 with the Volunteer revealed: -He had been responsible for compliance issues in the recent past; -He was second in-charge of the facility under the Licensee; -He was currently responsible for completing intake documentation and coordination for all new clients; -Client #5's treatment plan not being signed was an oversight; -None of the clients treatment plans included LOP specifics; -He would work with the Licensee to hire staff more familiar with the rule requirements in Psychiatric Residential Treatment Facilities (PRTF's) to ensure all paperwork was completed properly in the future. Interview on 4/18/18 with the Licensee revealed: -All outstanding issues will be addressed and corrected. This deficiency is cross referenced into 10A NCAC 27G .1901 Psychiatric Residential Treatment Facility-Scope V314 for a Type A1 rule violation.	V 112		
V 113	27G .0 206 Client Records 10A NCAC 27G .0 206 CLIENT RECORDS (a) A client record shall be maintained for each	V 113		

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V 1 1 3	Continued From page 32 **individual admitted to the facility, which shall contain, but need not be limited to:** **(1) an identification face sheet which includes:** **(A) name (last, first, middle, maiden);** **(B) client record number;** **(C) date of birth;** **(D) race, gender and marital status;** **(E) admission date;** **(F) discharge date;** **(2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV;** **(3) documentation of the screening and assessment;** **(4) treatment/habilitation or service plan;** **(5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician;** **(6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician;** **(7) documentation of services provided;** **(8) documentation of progress toward outcomes;** **(9) if applicable:** **(A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM);** **(B) medication orders;** **(C) orders and copies of lab tests; and** **(D) documentation of medication and administration errors and adverse drug reactions.** **(b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143.**	V 113	Anderson Health Services will ensure a client's record is maintained for each individual admitted to the facility upon admission. Client's records will be maintained to the specifications outlined in the NCAC. Medical records staff will conduct periodic internal reviews to ensure compliance with written standards. The Medical Records Coordinator will monitor client's records for compliance monthly. QA/QI will monitor for compliance. Procedure: Consumers receiving treatment at AHS will be assessed at 30 and 90 day intervals and also prior to discharge from the facility. If an additional evaluation is clinically justified, then assessments may be completed more frequently. The resident's treatment plan will be updated monthly to reflect progress in treatment and amended to reflect resident's needs and goals.	6/25/18

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V 113	**Continued From page 33** **This Rule is not met as evidenced by:** **Based on record review and interview the facility failed to maintain a client record affecting 1 of 8 clients (#4). The findings are:** **Review on 4/11/18 of client #4's record revealed:** **-Admission date of 1/2/18;** **-16 year old male;** **-Diagnoses of Conduct Disorder, Persistent Depressive Disorder and Anti Personality Traits and history of aggression and violence towards people and property resulting in injury; Medical Diagnoses of Juvenile asthma by history, Vitamin D insufficiency, left 4th finger injury, elevated Creatine Phosphokinase (CPK), Nuetropenia, Opthalmologic issues, Nasal colonization with Methicillin-Resistant Staphylococcus Aureus (MRSA), overweight status, chronic enuresis and incomplete age appropriate immunizations per treatment plan dated 3/19/18.** **Review on 5/17/18 of client #4's records revealed:** **-No April 2018 Medication Administration Record available for review;** **-No discharge information available for review.** **Interview on 5/22/18 with Registered Nurse #4 (RN #4) revealed:** **-She was aware client #4 had been discharged however did not know the exact date of the discharge and could not locate the specific discharge documentation in any of client #4's records.** **This deficiency is cross referenced into 10A NCAC 27G .1901 Psychiatric Residential**	V 113	Responsible Person: Medical Records Coordinator Areas with associate responsibilities: Clinical Director and/or Qualified Designee Qualified Professionals QA/QI Department	

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V 113	Continued From page 34 Treatment Facility-Scope V314 for a Type A1 rule violation.	V 113		
V 118	27G .0 209 (C) Medication Requirements 10A NCAC 27G .0 209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118	AHS has hired an interim Director of Nursing and has installed an automatic self-closing device to the medication room door. Anderson Health Services will ensure all discontinued medications are properly stored for all clients. Anderson Health Services will ensure all discontinued medications are disposed of to guard against diversion or accidental ingestion. Director of Nursing will monitor for compliance on a monthly and/or as needed basis. Disposed medications will be documented and placed in the client's record for review. Nurses will be trained upon employment. QA/QI will monitor for compliance monthly. Responsible Person: Director of Nursing Areas with associated responsibilities: Medical Director Residential Supervisor QA/QI Department Qualified Professionals	6/25/18

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	MHL090-193	A. BUILDING: ~~~~~~~~~~~~~~~~~~~~~~ B. WING ##########################	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDERSON HEALTH SERVICES-WALFUS	1915-A HASTY ROAD MARSHVILLE, NC 28103

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V 118	Continued From page 35 This Rule is not met as evidenced by: Based on record review and interview the Nurse Practitioner (NP), Registered Nurse #1 (RN #1) and Registered Nurse (RN #2) failed to demonstrate competency by ensuring all discontinued medications were properly stored affecting 8 of 8 clients (#1, #2, #3, #4, #5, #6, #7, #8) and a Registered Nurse failed to administer the correct medications affecting 1 of 8 clients (#11). The findings are: CROSS REFERENCE: 10A NCAC 27G .0 209 MEDICATION REQUIREMENTS V119. Based on record review and interview the Nurse Practitioner (NP) failed to assure discontinued medication was disposed of to guard against diversion or accidental ingestion affecting 8 of 8 clients (#1, #2, #3, #4, #5, #6, #7, #8). The findings are: Record review on 4/1 2/18 of RN #2 revealed: -Hired on 3/19/18 as a RN; -Multi state license expiration date of 5/31/18. -RN #2 duties included but were not limited to collaborate with various disciplines to ensure the safety of residents by providing the highest standards of care including assessments, medication administration, monitoring, communication and documentation ...ensure staff competency, quality of services and contribute to the professional development of team members ... Record review on 4/1 2/18 of NP revealed: -Hired on 5/7/17 as NP; -North Carolina Family (NP) License expiration date of 1 2/7/22. -NP duties included but were not limited to delivering primary medical care to a wide variety	V 118		

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V 118	Continued From page 36 of patients ...work as a team with nurses ...update patient records and check for accuracy per job description dated 9/17/17. Review on 5/4/18 of client #11's record revealed: -Admission date of 4/24/18; -16 year old male; -Diagnoses of Conduct Disorder, Cannabis Disorder, Nocturnal Enuresis, Generalized Anxiety Disorder (GAD) and USSOP and physical aggression and history of assault with a knife per treatment plan dated 4/10/18; -Prescribed medications order by the physician as documented on the May 2018 Medication Administration Record (MAR) included Desmopressin (DDAVP), Vitamin D3, Levothyroxine, Lithium Carbonate, Multivitamin, Invega, Melatonin and ProAir Inhaler as needed. Review on 4/11/18 of client #4's record revealed: -Admission date of 1/2/18; -16 year old male; -Diagnoses of Conduct Disorder, Persistent Depressive Disorder and Anti Personality Traits and history of aggression and violence towards people and property resulting in injury; Medical Diagnoses of Juvenile asthma by history, Vitamin D insufficiency, left 4th finger injury, elevated Creatine Phosphokinase (CPK), Nuetropenia, Opthalmologic issues, Nasal colonization with Methicillin-Resistant Staphylococcus Aureus (MRSA), overweight status, chronic enuresis and incomplete age appropriate immunizations per treatment plan dated 3/19/18. Review on 5/17/18 of client #4's (now FC #4's) record revealed: -No April 2018 and May 2018 Medication Administration Records available for review. Record review on 5/17/18 of the facility's incident	V 118		

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V 118	Continued From page 37 report revealed: - "...Date: 5/2/18. Time: 0640...[Client #11] received [client #4's] morning medication...Pt given granola bar. [RN] will monitor BS. BS=168 fasting...Physician response cont to monitor Resident for hypoglycemic episodes..." -The names of the medications were not documented on the incident report dated 5/2/18. Interview on 5/22/18 with RN #4 revealed: -She was not sure where client #4's record was kept since he had been discharged, therefore unable to review April 2018 and May 2018 MAR's for client #4; Interview on 5/22/18 with Registered Nurse#4 revealed: -She did not know the specific names of the medications and could not locate any nursing documentation related to the incident report on 5/2/18 where client #11 received client #4's medication, however spoke with the NP who stated she would get the information, however NP never produced the requested documentation. Interview on 5/31/18 with RN #2 revealed: -She was not involved with the incident on 5/2/18 where client #11 received client #4's medication, therefore did not write the incident report; -She read the names of the medications to the surveyor written on a pink sticky note which were given to her by the NP. The medications RN #2 named were Zoloft 100mg, Metformin 500mg and Fish Oil 1000mg. -She would look for the actual documentation, however never returned with the information requested. Interview on 5/22/18 with client #11 revealed: - He recalled a nurse (could not recall the name) administering him (client #4's) medications by	V 118		

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V 118	Continued From page 38 accident. The medications were administered to him from a cup; -It took the nurse a couple of minutes, maybe 5 minutes to realize she had given him the wrong medications, she said "you took someone's meds." -He didn't feel sick. Attempted interviews on 5/17/18, 5/22/18 and 5/31/18 with the NP to discuss the 5/2/18 medication error with client #11 receiving client #4's medication however NP was never available for interview. Review on 4/18/18 of a Plan of Protection dated 4/18/18 written by the Human Resources Lead revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? 1. Anderson health services will follow the medication storage policy. 2. Anderson health services will create a medication disposal policy. 3. Anderson health services will keep all disposed medication under a three lock door system in the main building away from all consumers. 4. Anderson health services will create a document that tracks and records all medication disposed of at Anderson health services. 5. Anderson health services will ensure that all doors are to remain locked at all times to the nurses stations. Describe your plans to make sure the above happens. 1. Anderson health services pharmacy rep will come and train all medical staff on proper medication storage and disposal. 2. Anderson health services Nurse Practitioner and Medical Director will create a monthly committee meeting to address nursing protocols. During those meetings the Nurse Practitioner and Medical Director will update nurses on any changes in medical policies and	V 118		

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V 118	Continued From page 39 protocols. All items listed in the document will be executed no later than April 25, 2018." Review on 6/1/18 of the facility's Plan of Protection dated 6/1/18 and written by the clincial team revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? 1) Anderson Health Services (AHS) (Licensee) will hereby ensure the safety of the consumers in Walfus cottage encompassing the health and safety of the 8 male consumers according to the DHHS Governing Body Policies. 2) Collaboration with the local MCO's to provide assistance with the discharge planning and placement for the residents. 3) Medical, residential, clinical, culinary and educational staff will adhere to the individual needs of the residents. Describe your plans to make sure the above happens. Under direction and approval of the medical director, AHS will consent to the health and safety of the residents by providing a residential staff ratio consist of maintaining the state regulation of 2 residential staff to 6 consumers per shift and 1 registered nurse." A Nurse Practitioner and two Registered Nurses responsible for all medications at the facility failed to ensure all discontinued medications were stored and/or properly disposed of. This failure resulted in 29 pills of discontinued Vyvanse going missing. The facility could not determined if staff or clients removed the Vyvanse from the medication room, in that, the Vyvanse was never recovered. A Registered Nurse administered the wrong medications (Zoloft 100mg, Metformin 500mg and Fish Oil 1000mg) to a client and as a result the client had to be monitored for hypoglycemic episodes. This deficiency constitutes a Type A1 rule violation for serious	V 118		

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V 118	Continued From page 40 neglect and must be corrected within 23 days. An administrative action penalty of $3,000.00 is imposed.	V 118		
V 119	27G .0 209 (D) Medication Requirements 10A NCAC 27G .0 209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge. This Rule is not met as evidenced by:	V 119	Anderson has hired an interim Director of Nursing and has installed an automatic self-closing device to the medication room door. Anderson Health Services Director of Nursing will ensure discontinued medications are disposed of to guard against diversion or accidental ingestion. The Director of Nursing will monitor for compliance on a monthly and/or as needed basis. Disposed medications will be documented and placed in the client's record for review. QA/QI will monitor for compliance monthly. Responsible Person: Director of Nursing Areas with associated responsibilities: Medical Director Residential Supervisor QA/QI Department Qualified Professionals	6/25/18

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V 119	Continued From page 41 Based on record review and interview the Nurse Practitioner (NP) failed to assure discontinued medication was disposed of to guard against diversion or accidental ingestion affecting 8 of 8 clients (#1, #2, #3, #4, #5, #6, #7, #8). The findings are: Record review on 4/11/18 of client #1 revealed: -Admitted to the facility on 3/29/18; -Diagnoses of Post Traumatic Stress Disorder (PTSD), Attention Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD) per treatment plan dated 3/22/18 and prescribed Vyvanse 30mg daily per physician's order dated 3/29/18; Record review on 4/1 2/18 of Nurse Practitioner (NP) revealed: -Hired on 5/7/17 as NP; -North Carolina Family (NP) License expiration date of 1 2/7/22. -NP duties included but were not limited to delivering primary medical care to a wide variety of patients ...work as a team with nurses ...update patient records and check for accuracy per job description dated 9/17/17. Record review on 4/1 2/18 of Registered Nurse #1 (RN #1) revealed: -Hired on 11/13/17 as a RN #1; -Multi state nursing license expiration date of 7/31/18. -RN #1 duties included but were not limited to collaborate with various disciplines to ensure the safety of residents by providing the highest standards of care including assessments, medication administration, monitoring, communication and documentation ...ensure staff competency, quality of services and contribute to the professional development of team members	V 119		

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V 1 1 9	Continued From page 42 ... Record review on 4/1 2/18 of Registered Nurse #2 (RN #2) revealed: -Hired on 3/19/18 as a RN #2; -Multi state license expiration date of 5/31/18. - RN #2 duties included but were not limited to collaborate with various disciplines to ensure the safety of residents by providing the highest standards of care including assessments, medication administration, monitoring, communication and documentation ...ensure staff competency, quality of services and contribute to the professional development of team members ... Record review on 4/1 2/18 of an incident report form dated 4/1/18 on 3rd shift at 0330am (3:30am) revealed: "Location of Incident: Walfus Cottage Medication Room ...Drug count Variance ... Resident (client #1) admitted to facility with (30) 30mg Vyvanse. Resident (client #1) was medicated with (1) dose after being dosed was seen by Medical Doctor [MD] who discontinue medication. Nurse Practitioner [NP] notified Pharmacist to ask if pharmacy could destroy Vyvanse. Pharmacist replied yes pharm tech would pick up ...Actions Taken/Recommendations as result of the incident: initiate urine drug screen for all party involved, reviewed surveillance recording ..." Record review on 4/1 2/18 of the facility's Medication and Trace Contaminated Waste Disposal policy and procedure revealed: "All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion ...Medication Disposal ...The disposal of controlled medication will be witnessed by two	V 119		

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V 119	Continued From page 43 staff members one of which is the nurse assigned to the resident and documented on the appropriate Disposal Log and recorded in resident's chart ...All controlled medications are to be returned back to the pharmacy for disposal ...Designated staff with a witness for accountability purposes will return the controlled medications to the pharmacy ...A note should be entered on the appropriate resident's medication record, the Medication Disposal Form, which will be used as the vehicle for documentation, will be completed and placed in the resident's record ...If Pharmacy is not willing to accept expired/discontinued, recovered spilled medications, controlled-medications should be properly recorded and destroyed following the Drug Enforcement Administration/North Carolina Drug Control Unit (DEA/NC-DCU) guidelines ..." Record review on 4/11/18 of the facility's Medication Storage policy and procedure revealed: "...All medication is to be stored in secure, locked designated area. Medications will be stored in medication carts that will be locked at all times when not in use. The medication cart drawers will not contain items other than medications ...All medication kept in the facility must be in a locked medication cart or a locked room in such a manner that the medication is inaccessible to residents and unauthorized employees. The locked medication cart will be stored in the nurse's station with key entry ...Keep medication storage area clean and orderly. This will assist in preventing errors as well as a reminder to discard outdated and discontinued medications...Controlled substances are stored in a separate locked box within the medication cart, requiring a separate key for entry. All controlled medications are stored in double locked device..."	V 119		

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V 119	Continued From page 44 Record review on 4/1 2/18 of the Health Care Personnel Registry (HCPR) 24-hour initial report revealed: "Allegation Description Incident Date: 4/1/18, Time: 9am, Vyvanse 30mg - 29 pills missing, discontinued medication removed before properly disposed ..." Record review on 4/1 2/18 of HCPR Registry 5-working day report revealed: "Allegation/Incident Details Incident Date: 4/1/18, Time: 9am, Incident location description: 29 pills of Vyvanse was in a bag for disposal at beginning of [RN #1's] 1 2 hour shift, then was found missing out of the bag by the next on-coming nurse. [RN #1] stated she didn't see Vyvanse pills when she went into the bag to retrieve another medication that was accidentally placed in the disposal bag. [RN #1] admits she left med room door open several time throughout her shift. Video proved [RN #1]. [RN #2] and [NP] were only staff utilized medication Rm within 24 hours. All 3 staff had urine drug done and where (-) negative. All 3 staff denies taking Vyance. That same shift [RN #1] worked she locked keys in med room and another medication error - wrong dose to a resident ...No harm to resident ...[RN #2] reported: She and [NP] went through medication cart removing all discontinued medications and placed them in a bag for disposal by pharmacy. The Vyvance were in medication card and control count sheet wrapped around with rubber band and additional meds. Both staff sealed the bag and left it on refrig for pick-up from pharmacy. [RN #2] left the med room before pharmacy arrived. Urine drug screen (-) negative. [NP] reported: [RN #2] and her collected the d/c meds and placed them in a zip lock bag for disposal by pharmacy. She remembers placing 29 pills	V 119		

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V 119	Continued From page 45 Vyvance card with count sheet. She was expecting pick up that same day and placed bag on top of the refrigerator. She handed the keys over to [RN #1] and went home. [NP] received a phone call from [RN #1] asking about a resident's meds. [NP] told [RN #1] to check the disposal bag. [RN #1] retrieved the medication from bag and called [NP] that she found the medication. Then later [RN #1] called she locked the keys in the med room. [RN #1] called again about medication error. [NP] returned to work and relieved [RN #1], noticed the Vyvance card was missing. She call [RN #1] to ask what happen to Vyvance. [RN #1] stated she did not see it and she had left the medication room door opened so anyone could have taken the medication. Surveillance video reviewed, no other staff was near to medication room. [NP's] urine drug screen (-) negative. [RN #1] stated: She had a rough day. She locked the keys in the med cart, gave the wrong dose to a resident (med error). [RN #1] stated she retrieved medication out of the bag for a female resident but didn't see Vyvance only vivals in the bag. She reminded me, she left the med room door open maybe another staff took it. She denies taking the Vyvance. [RN #1] drug screen (-) negative. [RN #1] stated she resigned. [Nurse Manager investigator]." Interview on 4/16/18 with RN #1 revealed: "...Missing meds, all had to be tested, no evidence about where meds went to ...Saturday came in to work, looked for [RN] who she was going to be replacing, [NP] had left at 4am, [NP] left no nurse on site, keys for all meds were left in drawer of residence supervisor's office, kids and staff had access to the keys. She (RN #1) started work at 630am and 645am, no nurse on campus from 4am until 630am-645am. Vyvanse went missing on Sunday and [NP] came in and	V 119		

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V 119	Continued From page 46 said to her [RN #1] 'please tell me you found the missing meds.' Female client was getting her meds but one was missing, she [RN #1] asked [NP] about the med (maybe Ability) and [NP] directed her [RN #1] to look in boy's cottage in plastic bag on top of fridge, she [RN #1] found bag of meds and finds female clients meds. She [RN #1] puts all meds back in bag and put on top of fridge. The next day (Sunday) volunteer approached her [RN #1] looking for the medication 29 pills missing. She [RN #1] does not have any idea why not locked up ...Have lock on med room door, but she [RN #1] did not lock the med room door 'because it was a pain in the a"s', did not think to lock up the ones on the fridge ..." Interview on 4/17/18 with the RN #2 revealed: -She and the NP cleaned out the medication cart to discard discontinued medications, a count sheet was completed and signed by both she and the NP; -The pharmacy was called to set up a day and time to pick up the discarded medications, however the day the pharmacy staff came to the facility she was informed by the pharmacy technician due to the holiday the pharmacy was closed and no one could receive the discarded medications. Thereafter she told the NP what the pharmacy technician said, gave the NP the medications and left her shift for the day; -She returned to work on Saturday night to relieve RN #1. RN #1 told her (RN #2) she locked herself out of the medication room and had medication errors throughout her shift. After RN #1 left her shift, she (RN #2) discovered the medication room doors for both cottages had been left open by RN #1. As she (RN #2) prepared to administer medications, she saw the bag of discarded medications on top of the refrigerator in the boy's cottage. Later the NP	V 119		

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	MHL090-193	A. BUILDING: ~~~~~~~~~~~~~~~~~~~~~~ B. WING ##########################	06/01/2018

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V 119	Continued From page 47 relieved her from her shift but called her at 4am to ask if she had moved the Vyvanse because it was not in the bag. She (RN #2) told the NP she had not moved the Vyvanse. The NP said she would ask RN #1. Interview on 4/11/18 with the NP revealed: -Prior to client #1's admission he (client #1) had been prescribed and brought with him a blister pack of 30 Vyvanse 1 daily am. Day 1 of admission he was administered 1 Vyvanse pill. Day 2 of admission the Medical Doctor (MD) discontinued Vyvanse; -The weekend following the Vyvanse being discontinued, she (NP) called the pharmacy and asked if they would pick up the discontinued medications, which included the remaining 29 Vyvanse pills. The pharmacy agreed to pick up all the discontinued medications, however on 3/30/18 when the pharmacy technician arrived he informed staff due to the holiday the pharmacy was closed and would not be able to take the discontinued medications. The discontinued medications were placed in a bag on top of the refrigerator. -The same day, RN #1 came to work on 3rd shift and called her (NP) to inquire about a clients' medication which could not be located. The NP realized she and RN #2 accidentally put a clients' current medication inside the bag of discontinued medications, therefore instructed RN #1 to look on top of the refrigerator in the bag of discontinued medications where the medication was found. NP later came on shift to relieve RN #1. At 4am she (NP) called RN #2 because she realized the blister pack of Vyvanse was not in the bag with the count sheet wrapped with a rubber band on top of the refrigerator. -RN #2 told her (NP) she had not touched the medications and on 3/31/18, she (RN #2) relieved	V 119		

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V 119	Continued From page 48 RN #1, where she discovered the medication doors in both cottages were unlocked and all discontinued medications were in a bag on top of the refrigerator of unlocked medication room doors. -The next morning RN #1 came onto shift and was asked about the missing Vyvanse. RN #1 reported to her (NP) the bag of medications was open and the Vyvanse had fallen behind the refrigerator, however staff looked behind the refrigerator but no medications were found. RN #1 told her (NP) she did not know where the Vyvanse went. -All nurses including herself (NP) were sent for drug testing, all with negative results; -The 29 Vyvanse pills had never been found; -Camera footage was reviewed and no staff or clients were observed going into the unlocked room. -After the pharmacy technician informed them the pharmacy was closed and would not be able to take the medications, she (NP) left them on top of the refrigerator and did not lock them up, "I made the biggest mistake ever, I'm beating myself up." Interview on 4/1 2/18 with the Director of Nursing/Nurse Manager revealed: -Date of hire 4/2/18, "last week"; -Duties would include but not be limited to managing the nursing staff and department, providing training, orientation, assuring policies and procedures are documented and up to date; -Vyvanse incident occurred prior to her hire date, however she conducted the investigation and physically looked for the medications. The Vyvanse had never been recovered. She was unsure if the clients bedrooms had been checked for the Vyvanse but there had been no behavioral changes on part of boys to suggest accidental ingestion. She interviewed the NP, RN #1 and	V 119		

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V 119	Continued From page 49 RN #2. The NP and RN #2 witnessed each other and had the same story. RN #1 admitted to having rough day, with medication errors, locking keys in the medication cart and leaving the medication room door open. She reviewed surveillance cameras from 3/30/18 to 4/1/18 and observed only nurses in the medication room. The NP, RN #1 and RN #2 received drug screens and their results came back negative. RN #1 resigned on 4/1 2/18. No disciplinary action had been taken with the NP and RN #2. Investigation outcome leaned toward RN #1 taking the Vyvanse because of her (RN #1's) "erratic behaviors." She completed 24 and 5 day Health Care Personnel Registry reports, however 5 day report was late because she was waiting on drug screens to come back. Findings are inconclusive as to where the Vyvanse sent. As a result of the incident she would be looking at the policy and procedure on discarding medications. This deficiency is cross referenced into 10A NCAC 27G .0 209 Medication Requirements V118 for a Type A1 rule violation.	V 119		
V 131	G.S. 131E- 256 (D 2) HCPR - Prior Employment Verification G.S. §131E- 256 HEALTH CARE PERSONNEL REGISTRY (d 2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.	V 131	The Health Care Personnel Registry has been accessed for staff #7 and staff #8. The results have been placed in the employees' files. Anderson Health Services will ensure the Health Care Personnel Registry will be accessed for potential employees and the results reviewed prior to an offer of employment. Documentation/Findings will be placed in employee's files.	5/30/18

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V 131	**Continued From page 50** **This Rule is not met as evidenced by:** **Based on record review and interview the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed and the results documented for each employee prior to an offer of employment affecting 2 of 26 audited staff (staff #7, #8). The findings are:** **Review on 5/31/18 of staff #7's personnel record revealed:** **-Hire date 4/4/18 as a Residential Counselor;** **-HCPR dated 4/20/18.** **Review on 5/31/18 of staff #8's personnel record revealed:** **-Hire date 4/30/18 as a Residential Counselor;** **-HCPR dated 5/7/18.** **Interview on 4/17/18 with the Human Resources Lead revealed:** **- Will ensure HCPR checks be completed prior to an offer of employment in the future.** **Interview on 4/9/18 and 4/18/18 with the Volunteer revealed:** **-He had been second in-charge of the facility under the Licensee;** **-He had been responsible for compliance issues in the recent past;** **-He would ensure HCPR checks be completed prior to an offer of employment in the future.** **Interview on 4/18/18 with the Licensee revealed: - All outstanding issues will be addressed and corrected.** **This deficiency is cross referenced into 10A NCAC 27G .1901 Psychiatric Residential**	V 131	Human Resources will review personnel files on a monthly and as needed basis. QA/QI will monitor for compliance monthly. Responsible Person: Human Resources Areas with associated responsibilities: QA/QI Department Qualified Professional Clinical Director and/or Qualified Designee Residential Supervisor	

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V 131	Continued From page 51 Treatment Facility-Scope V314 for a Type A1 rule violation.	V 131		
V 13 2	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.	V 132	Anderson Health Services will ensure allegations of abuse, harm, neglect, and/or exploitation are reported to the Health Care Personnel Registry within 24 hours of initial notification. The Quality Management Director and/or Qualified Designee will report allegations of abuse, harm, neglect and/or exploitation to the Health Care Personnel Registry within 24 hours of initial notification. QA/QI will monitor for compliance monthly. Responsible Person: Quality Management Director Areas with associated responsibilities: Medical Director Director of Nursing Residential Supervisor QA/QI Department Qualified Professionals Clinical Director and/or Qualified Designee	6/25/18

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V 1 32	Continued From page 52 This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure allegations of abuse, harm, neglect and/or exploitation were reported to the Health Care Personnel Registry (HCPR) within 24 hours of initial notification. The findings are: Finding #1 Record review on 4/11/18 of client #1 revealed: Admitted to the facility on 3/29/18; Diagnoses of Post Traumatic Stress Disorder, Attention Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD) per treatment plan dated 3/22/18 and prescribed Vyvanse 30mg daily per physician's order dated 3/29/18; Review on 4/1 2/18 of an incident report form dated 4/1/18 on 3rd shift at 0330am revealed: "Location of Incident: Walfus Cottage Medication Room ...Drug count Variance ... Resident (client #1) admitted to facility with (30) 30mg Vyvanse. Resident (client #1) was medicated with (1) dose after being dosed was seen by Medical Doctor [MD] who discontinue medication. Nurse Practitioner [NP] notified Pharmacist to ask if pharmacy could destroy Vyvanse. Pharmacist replied yes pharm tech would pick up ...Actions Taken/Recommendations as result of the incident: initiate urine drug screen for all party	V 132		

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V 132	Continued From page 53 involved, reviewed surveillance recording ..." Review on 4/1 2/18 of the HCPR 24-hour initial report revealed: "Allegation Description Incident Date: 4/1/18, Time: 9am, Vyvanse 30mg - 29 pills missing, discontinued medication removed before properly disposed ..." Review on 4/1 2/18 of HCPR Registry 5-working day report submitted 4/6/18 revealed: "Allegation/Incident Details Incident Date: 4/1/18, Time: 9am, Incident location description: 29 pills of Vyvanse was in a bag for disposal at beginning of [RN #1's] 1 2 hour shift, then was found missing out of the bag by the next on-coming nurse. [RN #1] stated she didn't see Vyvanse pills when she went into the bag to retrieve another medication that was accidentally placed in the disposal bag. [RN #1] admits she left med room door open several time throughout her shift. Video proved [RN #1]. [RN #2] and [NP] were only staff utilized medication Rm (room) within 24 hours. All 3 staff had urine drug done and where (-) negative. All 3 staff denies taking Vyance. That same shift [RN #1] worked she locked keys in med room and another medication error - wrong dose to a resident ...No harm to resident ...[RN #2] reported: She and [NP] went through medication cart removing all discontinued medications and placed them in a bag for disposal by pharmacy. The Vyvance were in medication card and control count sheet wrapped around with rubber band and additional meds. Both staff sealed the bag and left it on refrig for pick-up from pharmacy. [RN #2] left the med room before pharmacy arrived. Urine drug screen (-) negative. [NP] reported: [RN #2] and her collected the d/c meds and placed them in a zip lock bag for disposal by pharmacy. She remembers placing 29 pills	V 132		

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V 132	Continued From page 54 Vyvance card with count sheet. She was expecting pick up that same day and placed bag on top of the refrigerator. She handed the keys over to [RN #1] and went home. [NP] received a phone call from [RN #1] asking about a resident's meds. [NP] told [RN #1] to check the disposal bag. [RN #1] retrieved the medication from bag and called [NP] that she found the medication. Then later [RN #1] called she locked the keys in the med room. [RN #1] called again about medication error. [NP] returned to work and relieved [RN #1], noticed the Vyvance card was missing. She call [RN #1] to ask what happen to Vyvance. [RN #1] stated she did not see it and she had left the medication room door opened so anyone could have taken the medication. Surveillance video reviewed, no other staff was near to medication room. [NP's] urine drug screen (-) negative. [RN #1] stated: She had a rough day. She locked the keys in the med cart, gave the wrong dose to a resident (med error). [RN #1] stated she retrieved medication out of the bag for a female resident but didn't see Vyvance only vivals in the bag. She reminded me, she left the med room door open maybe another staff took it. She denies taking the Vyvance. [RN #1] drug screen (-) negative. [RN #1] stated she resigned. [Nurse Manager investigator]." Interview on 4/1 2/18 with the Director of Nursing/Nurse Manager revealed: -Date of hire 4/2/18, "last week"; -Duties would include but not be limited to managing the nursing staff and department, providing training, orientation, assuring policies and procedures are documented and up to date; Vyvanse incident occurred prior to her hire date, however she conducted the investigation and physically looked for the medications. The Vyvanse had never been recovered. She was	V 132		

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V 132	Continued From page 55 unsure if the clients bedrooms had been checked for the Vyvanse but there had been no behavioral changes on part of boys to suggest accidental ingestion. She interviewed the NP, RN #1 and RN #2. The NP and RN #2 witnessed each other and had the same story. RN #1 admitted to having rough day, with medication errors, locking keys in the medication cart and leaving the medication room door open. She reviewed surveillance cameras from 3/30/18 to 4/1/18 and observed only nurses in the medication room. The NP, RN #1 and RN #2 received drug screens and their results came back negative. RN #1 resigned on 4/1 2/18. No disciplinary action had been taken with the NP and RN #2. Investigation outcome leaned toward RN #1 taking the Vyvanse because of her (RN #1's) "erratic behaviors." She completed 24 and 5 day Health Care Personnel Registry reports, however 5 day report was late because she was waiting on drug screens to come back. Findings are inconclusive as to where the Vyvanse sent. As a result of the incident she would be looking at the policy and procedure on discarding medications. Finding #2 -Record review on 4/11/18 of client #5 revealed: -Admitted to the facility on 3/7/18; -Diagnoses of Depressive Episodes and Oppositional Defiant Disorder (ODD) per treatment dated 2/19/18; -History of running away, anger, defiance and lying. Review on 5/31/18 of a letter handwritten by client #5 revealed: -"...May 17th, 2018. This needs to be addressed. Ya'll need to do a background check on ya'll new theripist [Licensed Therapist #2] (LP #3). He done something that made me feel very	V 132		

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V 132	Continued From page 56 uncomfortable. When he had a private session with me in his office. he asked me why I dont like being touched and I didn't answer for at least an hour of my session. I had shut down completely because he had his hand down touching me in a way I hated. I was scared to tell someone but I had enough of it. When he touched me I felt very upset and confused, also I said I'm ready to go back to the cottage, [LP #3] is a person who gets to know you and then tries to take advantage of people. But not me. This is why I have been so pissed off lately. Something came to my mind and said should I tell somebody? So, it hit me. I'm not trying to get in trouble, it's just he is doing something very very wrong..." -The handwritten letter was signed by client #5 and dated 5/17/18. Interview on 5/31/18 with Residential Counselor (RC #7) revealed: -She was hired as a RC in April 2018; -On 5/18/18 as she was completing her notes, RC #8 told her he found a letter folded up in the cottage and asked her had she seen the letter. She replied no and began to read the letter. She folded the letter back up after she read it and immediately called her supervisor who was the Residential Director (RD) three times and received no answer each time. She did not feel comfortable leaving a voicemail message with sensitive and confidential information involved. After she could not get in contact with her supervisor (RD), she then called a Residential Counselor Supervisor (RCS #2) who informed her (RC #7) to try contacting the (RD) again and if she couldn't get in touch with him again to call her (RCS #2) back. She tried calling (RD) again, received no answer only his voicemail again. She called (RCS #2) right back, who then informed her to take a picture of the letter in case it gets	V 132		

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V 132	Continued From page 57 misplaced and place the letter in a secure place to leave for the (RD) to receive on 5/21/18. On 5/21/18, she gave the letter in person to (RCS #2). During the same week, she was either off or had just gotten off her shift and was contacted by her supervisor (RD) who asked her to come back to the facility and complete a incident report. She asked her supervisor (RD) if she could send the details electronically and he instructed her to send the details via text, in which she did. Attempted a telephone interview on 5/31/18 with staff #8, however unsuccessful, in that, staff #8 did not answer the call and the recording stated the voicemail had not been set up in order to leave a message. Interview on 5/31/18 with the RD revealed: - He was originally hired as a Residential Supervisor in 3/2018 and recently "a couple of weeks ago" promoted to RD; -RC #7 received the letter written by client #5 on 5/18/18. RC #7 called him three times but did not leave a message and should have. RC #7 was unaware he was on campus on 5/18/18 between 6:00pm - 8:00pm during her shift. On 5/19/18, he came to work to get paperwork and set up a visit since he would be off the campus in training the next week. RC #7 was off on 5/19/18. On 5/21/18 he and other administrative staff left at 5:30am to attend a training out of town. On 5/21/18 at 6:00pm while he and administrative staff were traveling back from the training, the Licensee received a call about the allegation client #5 made against LP #3. He called and/or left RC #7 a voice mail message about the importance of completing an incident report. When he finally spoke to RC #7, he told her she should have left a voicemail message and he would have returned the call. Thereafter he	V 132		

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V 132	Continued From page 58 instructed RC #7 and RC #8 to complete an incident report, however she was off and sent details of the incident via text. The incident report was not submitted to IRIS until 5/22/18; Interview on 5/31/18 with Licensed Therapist #3 (LT #3) revealed: -He was hired on 4/23/18 as a Therapist; -On 5/21/18, he was informed of the allegation client #5 made against him, placed on suspension and told by the facility they would inform him of his employment status after the investigation. Review on 5/31/18 of the facility's internal investigation revealed: -The allegation was made on 5/17/18; - The facility did not complete the Incident Reporting and Improvement System (IRIS) /HCPR reports until 5/22/18. Interview on 4/18/18 with the Licensee revealed: -All outstanding issues will be addressed and corrected. This deficiency is cross referenced into 10A NCAC 27G .1901 Psychiatric Residential Treatment Facility-Scope V314 for a Type A1 rule violation.	V 132		
V 133	G.S. 1 22C-80 Criminal History Record Check G.S. §1 22C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse	V 133	The criminal background check for Residential Counselor #2 has been completed. Anderson Health Services will ensure that background checks are completed within five business days of an offer of employment to all candidates. Documentation/Findings will be placed in employee's files for review.	5/30/18

Division of Health Service Regulation

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	MHL090-193	A. BUILDING: ~~~~~~~~~~~~~~~~~~~~~~~~ B. WING ##########################	06/01/2018

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V 133	**Continued From page 59** **services that is licensable under Article 2 of this Chapter.** **(b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105- 277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the**	V 133	Human Resources will review personnel records on a monthly basis. QA/QI will monitor for compliance monthly. Responsible Person: Human Resources Areas with associated responsibilities: Clinical Director and/or Qualified Designee QA/QI Department	

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V 133	Continued From page 60 information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency. (c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant: (1) The level and seriousness of the crime. (2) The date of the crime. (3) The age of the person at the time of the conviction. (4) The circumstances surrounding the commission of the crime, if known. (5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.	V 133		

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V 133	Continued From page 61 (6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed. (7) The subsequent commission by the person of a relevant offense. The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant. (d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for: (1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual. (2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section. (e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers;	V 133		

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V 1 33	Continued From page 62 Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-30 2 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. (f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor. (g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record	V 133		

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V 133	Continued From page 63 check regarding the applicant if both of the following requirements are met: (1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-1 24, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.) This Rule is not met as evidenced by: Based on record review and interview the facility failed to request criminal background checks completed within five business days of an offer of employment affecting 1 of 26 audited Residential Counselor #2 (RC #2). The findings are: Review on 4/1 2/18 of RC #2's record revealed: -Hire date of 2/7/18; -Criminal background check requested 2/15/18. Interview on 4/17/18 with the Human Resources Lead revealed: -Would ensure all criminal background checks be requested within five business days of an offer of employment in the future. Interview on 4/9/18 and 4/18/18 with the Volunteer revealed: -He had been second in charge of the facility under the Licensee; -He had been responsible for compliance issues	V 133		

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V 133	Continued From page 64 in the recent past; -He would ensure all criminal background checks be completed within five days of an offer of employment in the future. Interview on 4/18/18 with the Licensee revealed: - All outstanding issues will be addressed and corrected. This deficiency is cross referenced into 10A NCAC 27G .1901 Psychiatric Residential Treatment Facility-Scope V314 for a Type A1 rule violation.	V 133	Anderson Health Services disagrees with the summary statement that concludes that it is in violation of this rule.	5/30/18
V 314	27G .1901 Psych Res. Tx. Facility - Scope 10A NCAC 27G .1901 SCOPE (a) The rules in this Section apply to psychiatric residential treatment facilities (PRTF)s. (b) A PRTF is one that provides care for children or adolescents who have mental illness or substance abuse/dependency in a non-acute inpatient setting. (c) The PRTF shall provide a structured living environment for children or adolescents who do not meet criteria for acute inpatient care, but do require supervision and specialized interventions on a 24-hour basis. (d) Therapeutic interventions shall address functional deficits associated with the child or adolescent's diagnosis and include psychiatric treatment and specialized substance abuse and mental health therapeutic care. These therapeutic interventions and services shall be designed to address the treatment needs necessary to facilitate a move to a less intensive community setting. (e) The PRTF shall serve children or adolescents for whom removal from home or a	V 314	Anderson Health Services will continue to ensure supervision and services are designed to provide therapeutic interventions to address functional deficits associated with the adolescent's diagnosis. Anderson will provide additional training to staff on the consumer's diagnosis as needed. Weekly staff meetings with the medical director will be conducted and documented per the statute to monitor the consumer's progress or lack thereof while in treatment. The Clinical Director and/or qualified designee will provide clinical supervision to staff. Clinical Supervision will be documented in employee's files for review.	

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V 314	Continued From page 65 community-based residential setting is essential to facilitate treatment. (f) The PRTF shall coordinate with other individuals and agencies within the child or adolescent's catchment area. (g) The PRTF shall be accredited through one of the following; Joint Commission on Accreditation of Healthcare Organizations; the Commission on Accreditation of Rehabilitation Facilities; the Council on. Accreditation or other national accrediting bodies as set forth in the Division of Medical Assistance Clinical Policy Number 8D-1, Psychiatric Residential Treatment Facility, including subsequent amendments and editions. A copy of Clinical Policy Number 8D-1 is available at no cost from the Division of Medical Assistance website at http://www.dhhs.state.nc.us/dma/. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure supervision and services were designed to provide therapeutic interventions to address functional deficits associated with the child or adolescent's diagnoses affecting 8 of 8 current clients (#1, #2, #3, #4, #5, #6, #7, #8). The findings are: CROSS REFERENCE: 10A NCAC 27G .0 201 GOVERNING BODY POLICIES (V105). Based on record review and interview the facility failed to develop and implement policies and procedures for monitoring and evaluating the appropriateness of client care, Judicial Review, Assessment Post Seclusion, Attestation of Facility Compliance,	V 314	An orientation, annual, and continuing education training schedule has been created to ensure that all staff members are thoroughly trained prior to their first day of employment. Training includes special populations, crisis management, CBT, client rights, CPI, and BBP. Documentation of trainings will be placed in employee's file for review. Human Resources will monitor for compliance on a monthly and/or as needed basis. QA/QI will monitor for compliance monthly. Responsible Person: Medical Director Areas with associated responsibilities: Clinical Director and/or Qualified Designee Director of Nursing Qualified Professionals QA/QI Department	

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V 314	Continued From page 66 semi-annual training for all staff in alternatives to restrictive intervention and seclusion, physical restraint and isolation time-out, and training in Cardiopulmonary Resuscitation (CPR). CROSS REFERENCE: 10A NCAC 27G .0 20 2 Personnel Requirements (V107). Based on record review and interview the facility failed to ensure a written job description for each staff position affecting 6 of 26 audited staff (Registered Nurse #1 (RN #1), Registered Nurse #3 (RN #3), Medical Doctor/Medical Director/Child Psychiatrist (referred to in the report as MD), Residential Counselor Supervisor #2 (RCS #2), Residential Counselor (RC #2) and Volunteer. CROSS REFERENCE: 10A NCAC 27G .0 20 2 Personnel Requirements (V108). Based on record review and interview the facility failed to ensure completion and documentation of employee training programs in Cardiopulmonary Resuscitation (CPR), Mental Health, Develpmental Disabilities, Substance Abuse (MH/DD/SA), Loss of Privileges (LOP), Treatment/Crisis Plans and Diagnoses affecting 7 of 26 staff, Registered Nurse #2 (RN #2), Residential Counselor Supervisor #4 (RCS #4), Residential Counselor #2 (RC #2), Residential Counselor #5 (RC #5), Residential Counselor #7 (RC #7), Residential Counselor #8 (RC #8) and the Volunteer. CROSS REFERENCE: 10A NCAC 27G .0 203 Competencies of Qualified (V109). Based on record review and interview 4 of 17 Qualified Professionals, Registered Nurse # 1 (RN #1), Registered Nurse #2 (RN #2), Nurse Practitioner (NP) and Lead Licensed Therapist #2 (LLP #2) failed to demonstrate the knowledge,	V 314		

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V 314	Continued From page 67 skills and abilities required by the population served. CROSS REFERENCE: 10A NCAC 27G .0 204 Competencies of Paraprofessionals (V110). Based on record review and interview 1 of 9 Paraprofessional staff, Crisis Prevention Institute (CPI) Nonviolent Crisis Intervention Trainer failed to demonstrate the knowledge, skills and abilities required by the population served. CROSS REFERENCE: 10A NCAC 27G .0 205 TREATMENT/HABILITATION PLANS (V11 2). Based on record review and interview the facility failed to implement strategies in client treatment plans affecting 1 of 8 clients (#2) and failed to ensure written consent or agreement by the client and responsible party for the treatment plan affecting 1 of 8 clients (#5). CROSS REFERENCE: 10A NCAC 27G .0 206 Client Records (V113). Based on record review and interview the facility failed to maintain a client record affecting 1 of 8 clients (#4). CROSS REFERENCE: General Statute. 131E-256 Health Care Personnel Registry (V131). Based on record review and interview the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed and the results documented for each employee prior to an offer of employment affecting 2 of 26 audited staff (staff #7, #8). CROSS REFERENCE: General Statute. 31E- 256 Health Care Personnel Registry (V13 2). Based on record review and interview the facility failed to ensure allegations of abuse, harm, neglect and/or exploitation were reported to the Health Care Personnel Registry (HCPR) within 24 hours of	V 314		

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V 314	Continued From page 68 initial notification. CROSS REFERENCE: General Statute 1 22C-80 Criminal History Record Check Required for Certain Applicants for Employment (V133). Based on record review and interview the facility failed to request criminal background checks completed within five business days of an offer of employment affecting 1 of 26 audited staff (RC #2). CROSS REFERENCE: 10A NCAC 27G .190 2 Staff (V315). Based on record review and interview the facility failed to ensure at least two direct care staff members were present with every six adolescents affecting 8 of 8 clients (#1, #2, #3, #4, #5, #6, #7, #8). CROSS REFERENCE: 10A NCAC 27G .1903 Operations (V316). Based on observation, record review and interview the facility failed to ensure that all children residing in the facility received educational services as required by State law affecting 8 of 8 clients (Clients #1, #2, #3, #4, #5, #6, #7, #8). CROSS REFERENCE: General Statute 1 22C-6 2 Additional Rights in 24-Hour Facilities (V364). Based on record review and interview the facility failed to ensure clients were allowed to keep and use personal clothing under appropriate supervision affecting 8 of 8 clients (#1, #2, #3, #4, #5, #6, #7, #8). The findings are: CROSS REFERENCE: 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367). Based on record review and interview the facility failed to report all Level II and Level III incident reports to the Local Management Entity (LME) responsible for the	V 314		

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V 314	Continued From page 69 catchment area where services are provided within 7 2 hours of becoming aware of the incident. CROSS REFERENCE: 10A NCAC 27E .0107 Training on Alternatives to Restrictive Intervention (V536). Based on record review and interview the facility failed to ensure all staff were trained in alternatives to restrictive interventions affecting 4 of 26 audited staff members Registered Nurse #2 (RN #2), Corporate Compliance Officer, Lead Licensed Therapist #2 (LLT#2), Medical Doctor/Medical Director/Child Psychiatrist (referred to in the report as MD). CROSS REFERENCE: 10A NCAC 27E .0108 Training in Seclusion, Physical Restraint, and Isolation Time-Out(V537). Based on record review and interview the facility failed to ensure all staff were trained in seclusion, physical restraint and isolation time-out affecting 4 of 26 audited staff members Registered Nurse #2 (RN #2), Corporate Compliance Officer, Lead Licensed Therapist #2 (LLT #2), Medical Doctor/Medical Director/Child Psychiatrist (referred to in the report as MD): The findings are: Review on 5/17/18 and 5/22/18 of the facility's Incident Reports revealed: -On 4/21/18 (client #4) hit roommate in the face several times. (Client #4) went outside to attack roommate. He (client #4) picked up a board and ran after him. He (client #4) then turned and attempted to destroy staff members cars but stopped at the main building. -On 4/21/18 (client #4) went in behind (client #2) and began to hit him repeatedly until staff and the other clients intervened...staff walked (client #2) outside to deescalate...shortly thereafter (client #4) came outside and "took a piece of wooden	V 314		

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V 314	Continued From page 70 chair that was previously broken" and ran after [client #2] with it..." -On 4/21/18 (client #2) was outside and had to be calmed down because he was upset and refusing to go inside...(client #2) was allowed to verbally express his frustrations...moments after (client #2) returned to the cottage, he (client #2) and (client #4) got into a physical altercation...staff was able to break up the altercation by getting space between the residents and removing (client #2) from the room. Staff brought (client #2) outside to allow things to calm down while remaining staff spoke with (client #4) to get him calm down as well. (Client #4) would not deescalate. He insisted that he was going to fight (client #2) because he was tired of (client #2) running his mouth. (Client #4) escaped the cottage to go after (client #2), picking up a piece of broken chair along the way to use as weapon. Despite reasoning and redirection, (client #4) continued to go after (client #2) until staff was able to return (client #2) to the cottage safely... (client #4) began to threaten to destroy cars of staff...the police arrived shortly to speak to both residents...(client #4) was significantly calmer and willing to talk to them about what happened. Review on 5/17/18 of the responding police officers report revealed: -"On April 21, 2018 at approximately 19:30 hrs...dispatched to the Anderson for a disturbance call...arrived on scene and spoke with one of the faculty members who stated that earlier there had been an incident involving the two mentioned subjects. She stated that [client #4] had assaulted [client #2] for no apparent reason...spoke to [client #4] and he advised me that he had been having problems with [client #2] all day because he was cussing and taunting him all day. He said that he told one of the faculty	V 314		

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V 314	Continued From page 71 members, but [client #2] kept on talking crap to him. [Client #4] never admitted to hitting [client #2] but said he wanted to...spoke to [client #2] and he said that [client #4] had hit him in the head 5 or 6 times. I did not notice any evidence such as redness, swelling or bleeding and he refused EMS. Another staff member stated to me that [client #4] and [client #2] were in confrontation. She did not physically see it, but heard the commotion. She also said that [client #2] had been 'taunting' [client #4] for most of the day and that she and others tried to intervene. [Client #2] was referred to the Magistrates Office after the administrator (volunteer) advised me that its [client #2's] legal right to have someone charged. [Client #2] was attempting to get one of the staff to take him there however no one is authorized to take him off of the premises. No further information at this time." Review on 4/18/18 of the Plan of Protection dated 4/18/18 and completed by the Human Resources Lead documented: "What immediate action will the facility take to ensure the safety of the consumers in your care? 1. Anderson health services will create a LOP guideline for all residents and guardians to review in the resident handbook upon admission. 2. Anderson health services will begin the process of including the LOP policy into each residence treatment plan. 3. Anderson health services will utilize scope as a part of it's therapeutic interventions and how it complements the LOP program of Anderson health services. Describe your plans to make sure the above happens. 1. Anderson health services clinical team and residential team will create a uniformed guideline for the LOP process which outlines how long the LOP will be in effect when it will occur and what justifies the need for the use of the LOP policy. Anderson health	V 314		

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V 3 1 4	Continued From page 72 services will train staff on the LOP process and discuss the scope of the program. 3. Anderson health services will begin the process to update all treatment plans for residence specifically specifying the LOP guidelines and protocols and have each guardian sign the updates to the treatment plans. All items listed in the document will be executed no later than April 25, 2018." Review on 6/1/18 of the facility's Plan of Protection dated 6/1/18 and written by the clinical team revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? 1) Anderson Health Services (AHS) (Licensee) will hereby ensure the safety of the consumers in Walfus cottage encompassing the health and safety of the 8 male consumers according to the DHHS Governing Body Policies. 2) Collaboration with the local MCO's to provide assistance with the discharge planning and placement for the residents. 3) Medical, residential, clinical, culinary and educational staff will adhere to the individual needs of the residents. Describe your plans to make sure the above happens. Under direction and approval of the medical director, AHS will consent to the health and safety of the residents by providing a residential staff ratio consist of maintaining the state regulation of 2 residential staff to 6 consumers per shift and 1 registered nurse." Clients #1 - #8 ranged in age from 14 years to 16 years old. The clients had multiple mental health diagnoses including but not limited to Disruptive Mood Dysregulation Disorder, Oppositional Defiant Disorder, Conduct Disorder, Post-Traumatic Stress Syndrome Disorder, Attention Deficit Hyperactivity Disorder, Generalized Anxiety Disorder, Sexual and	V 314		

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V 314	Continued From page 73 Physical Abuse, and substance abuse needs. The clients had histories of severe physical aggression, running away, drug abuse, extreme anger which has resulted in assault and violence towards people and property, and pending legal charges. The facility did not meet the needs of the clients through a series of systemic failures: -There were no Policies and Procedures developed for Clinical Licensed Therapists, Residential Counselors and Residential Counselors Supervisors to implement clients Loss of Privileges (LOP) program. The LOP program criteria decisions were being decided upon by individual staff as incidents occurred versus a collective clinical and therapeutic team decision. i.e. A client was left on LOP for 22 days with no clinical oversight as to LOP's who, what, when , where and how to implement. -The Treatment Plans were not inclusive of all the clients' individual needs, therefore the staff were unaware of the appropriate strategies and therapeutic interventions to implement. i.e. Clients personal belongings specifically shoes were taken away and replaced with slides/flip flops for the first 30 days of treatment without any documentation of justification or reason and consent from the legal guardians to acknowledge understanding and no strategies for LOP. i.e. Staffs lack of knowledge about a clients natural support visit and crisis plan, leading client into an anger outburst and staff not using the identified strategies in the crisis plan. -Therapy was not provided one time weekly as indicated in the clients treatment plans. The Lead Licensed Therapist #2 (LLT #2) presented therapy notes for review with no dates of service documented and no explanation or concern, then a week later sent the therapy notes with dates of	V 314		

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V 314	Continued From page 74 services documented via the new therapist, Licensed Therapist #3 (LT #3). Per 4 client reports who the LLT #2 reported she was responsible for providing individual therapy revealed they had not received individual therapy every week with LLT #2. -The clients were not receiving the 5.5 daily educational service hours as required due to the lack of educational staff and/or educational director to oversee the program. -The required staff to client ratios were not being maintained as reported as only one staff was working, resulting in limited supervision. i.e. Clients being able to obtain staffs personal belongings (cell phone) and items to use as weapons and threaten peers and staff (hammer, knife, wooden piece from a broken chair that staff did not discard of properly). -Qualified Professionals and Paraprofessionals did not have the necessary clinical support/supervision or the mental health, developmental disabilities and substance training (diagnoses, treatment plans strategies) required to gain the knowledge and skills to work with the clients intricate needs. The Crisis Prevention Intervention (CPI) Nonviolent Crisis Prevention Trainer and administrative staff were not aware training in Alternatives to Restrictive Interventions and Physical Restraints was required semi-annually for a PRTF. Registered Nurses whom administrative staff were aware worked alone at the facility did not all have required CPR training. A Registered Nurse did not demonstrate the competence required by not locking the medication room door because she felt it was an annoying job duty, 29 Vyvanse pills have never been recovered which were not disposed of properly by the Nurse Practitioner (NP). A discharged clients medication administration record (MAR) and discharge information could	V 314		

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V 314	Continued From page 75 not be located by any staff after numerous requests. All incidents (fights, threatening behaviors, a client allegation of staff inappropriate touching) were not being documented into IRIS within the required time frame and as result HCPR was not reported, if applicable. Follow up documentation of incidents was limited, in that, documentation was not complete in order to obtain important details, i.e. Client was administered another clients medication however the medication was not listed on the incident report and staff were unable to provide specific details, until after multiple requests on separate survey days. After multiple requests, documents such as Judicial Reviews and Attestation of Facility Compliance were not available for review because no staff had any knowledge about the documents being requested, where the documents could be located or who was responsible for maintaining the documentation. The Corporate Compliance Officer reported later that she had those documents but no staff had informed her of our request to review. Human Resources staff did not maintain complete staff personnel records to review. It was unclear what the job responsibilities were for each position because there were no written job descriptions for Registered Nurses, Residential Counselor Supervisors, Residential Counselors, the Medical Director/Child Psychiatrist/Medical Director or Volunteer. The HCPR and Criminal Background Checks had not been completed for all staff in the required timeframe's; -The grounds of the facility had not been maintained in a safe manner, i.e. A client stole a knife from the cafeteria, a client found a hammer and passed it on to another client, a client found a piece of a broken wooden chair that had been placed outside the facility by a staff instead of being thrown away and was used to hit and/or	V 314		

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V 314	Continued From page 76 threaten another client. -The facility had a policy on not using volunteers, yet the Volunteer reported he was second in charge of the facility and responsible for multiple administrative positions including but not limited to, corporate compliance, intake documentation and supervision. Observations revealed both staff and clients constantly sought out the Volunteer for administrative decisions and he (volunteer) assisted the state surveyors throughout the survey process. This deficiency constitutes a Type A1 rule violation for serious harm and neglect. An administrative penalty of $3,000.00 is imposed.	V 314		
V 315	27G .190 2 Psych. Res. Tx. Facility - Staff 10A NCAC 27G .190 2 STAFF (a) Each facility shall be under the direction a physician board-eligible or certified in child psychiatry or a general psychiatrist with experience in the treatment of children and adolescents with mental illness. (b) At all times, at least two direct care staff members shall be present with every six children or adolescents in each residential unit. (c) If the PRTF is hospital based, staff shall be specifically assigned to this facility, with responsibilities separate from those performed on an acute medical unit or other residential units. (d) A psychiatrist shall provide weekly consultation to review medications with each child or adolescent admitted to the facility. (e) The PRTF shall provide 24 hour on-site coverage by a registered nurse.	V 315	Anderson Health Services has employed additional direct care staff to ensure at least two direct care staff members are present with every six adolescents. Anderson Health Services will ensure at least minimum staffing requirements are met. When necessary, based on the consumer(s) behavioral needs, additional staff will be scheduled. Documentation and work schedule will reflect staff presence at the facility. QA/QI will monitor for compliance monthly.	5/30/18

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V 315	**Continued From page 77** **This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure at least two direct care staff members were present with every six adolescents affecting 8 of 8 clients (#1, #2, #3, #4, #5, #6, #7, #8). The findings are:** **Review on 4/11/18 of client 1's record revealed:** **-Admission date of 3/29/18;** **-17 year old male;** **-Diagnoses of Oppositional Defiant Disorder (ODD) and Attention Deficit Hyperactivity Disorder (ADHD).** **Review on 4/11/18 of client #2's record revealed:** **-Admission date of 9/1 2/17;** **-16 year old male;** **-Diagnoses of ADHD, Disruptive Mood Dysregulation Disorder (DMDD), Conduct Disorder, History of Sexual and Physical Abuse.** **Review on 4/11/18 of client #3's record revealed: -Admission date of 9/20/17;** **-14 year old male;** **-Diagnoses of Post-Traumatic Stress Disorder (PTSD), ODD and DMDD.** **Review on 4/11/18 of client #4's record revealed: -Admission date of 1/2/18;** **-16 year old male;** **-Diagnoses of Conduct Disorder, Persistent Depressive Disorder and Anti Personality Traits.** **Review on 4/11/18 of client #5's record revealed: -Admission date of 3/7/18;** **-15 year old male;** **-Diagnoses of Depressive Disorder and ODD.**	V 315	Responsible Person: Residential Lead/Supervisor Areas with associated responsibilities: Human Resources Qualified Professional Clinical Director and/or Qualified Designee QA/QI Department	

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V 315	Continued From page 78 Review on 4/11/18 of client #6's record revealed: -Admission date of 4/3/18; -15 year old male; -Diagnoses of ODD and DMDD. Review on 4/11/18 of client #7's record revealed: -Admission date of 3/26/18; -15 year old male; -Diagnoses of DMDD, ADHD and Cannabis Dependence. Review on 4/11/18 of client #8 revealed: -Admission date of 2/22/18; -17 year old male; -Diagnoses of Conduct Disorder, ODD and Perpetrator. Interview on 4/16/18 with Registered Nurse #1 (RN #1) revealed: -There was usually only one staff working with the clients, but "maybe two if you are lucky." Interview on 4/16/18 with Registered Nurse #3 (RN #3) revealed: -There was one staff working in each cottage (which is licensed separately by the Division of Health Service Regulation); -There are not enough staff to complete restraints. Interview on 4/16/18 with Licensed Therapist #1 (LP #1) revealed: -There was usually one staff working in each cottage (which is licensed separately by the Division of Health Service Regulation), but sometimes there was two staff. Interview on 4/9/18 and 4/18/18 with the Volunteer revealed:	V 315		

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V 315	Continued From page 79 -He had been second in-charge of the facility under the Licensee; -He had been responsible for compliance issues in the recent past; -At least two staff work per shift; -Would ensure proper staff to client ratio in the future. Interview on 4/18/18 with the Licensee revealed: - All outstanding issues will be addressed and corrected. This deficiency is cross referenced into 10A NCAC 27G .1901 Psychiatric Residential Treatment Facility-Scope V314 for a Type A1 rule violation.	V 315	Anderson Academy began serving all students for five and one-half hours each day beginning on September 18, 2017. A brief interruption of services occurred due to an illness. The educational services have been corrected. Anderson Health Services provides at least five and one half (5 ½) hours of facility-based educational services to each client. The educational services are provided by a North Carolina Licensed EC Teacher. Anderson Health Services will ensure all children residing in the facility receive educational services which meet the applicable standards of state law. Each client will receive at a minimum 5 ½ hours of education, Monday through Friday per school schedule. QA/QI will monitor for compliance monthly.	6/8/18
V 316	27G .1903 Psych. Res. Tx. Facility - Operations 10A NCAC 27G .1903 OPERATIONS (a) A PRTF may have more than one residential unit. Each unit of a PRTF shall serve no more than 1 2 children or adolescents except as set out in Paragraph (b) of this Rule. Each residential unit shall be administered, staffed, and located to function separately from all other residential units in the facility. (b) A facility licensed to provide PRTF services with a unit capacity of greater than 1 2, as of the effective date of these Rules may continue to provide these services at that greater capacity and may continue to renew its license at that greater capacity. (c) Discharge planning shall begin on the day of admission. Efforts for discharge to a less restrictive community residential setting shall be documented from the date of admission. Legally responsible persons, family members or both and the child or adolescent shall be present at	V 316		

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V 316	Continued From page 80 discharge planning meetings. (d) Each facility shall operate 24-hours a day, seven days a week and each day of the year. (e) Family members or other legally responsible persons shall be involved in the development and implementation of treatment plans in order to assure a smooth transition to a less restrictive setting. (f) Children or adolescents residing in a PRTF shall receive educational services through a facility-based school. Educational services shall meet applicable standards as required by federal and State law. (g) Each child or adolescent shall be entitled to age-appropriate personal belongings unless such entitlement is counter-indicated in the treatment plan. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that all children residing in the facility received educational services as required by State law affecting 8 of 8 clients (Clients #1, #2, #3, #4, #5, #6, #7, #8). The findings are: Observation on 5/31/18 from approximately 1:05pm-1:50pm of the facility's educational classroom revealed: -8 male clients attended educational classes during the afternoon hours after they had lunch; -An Exceptional Children's (EC) teacher and a teacher were the educational staff present in the classroom with the 8 male clients.	V 316	Responsible Person: Principal Areas with associate responsibilities: Clinical Director and Qualified Designee Qualified Professionals QA/QI Department	

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V 316	Continued From page 81 Review on 5/22/18 of the facility's Policy and Procedure Handbook revealed: -Daily schedule indicated school was scheduled Monday through Friday from 8:00am until 2:00pm with two 30 minute lunch periods from 1 2:00pm until 1 2:30pm and 1 2:30pm until 1:00pm. Interview on 6/1/18 with the Department of Public Instruction representative revealed: -Classroom instruction at a Psychiatric Residential Treatment Facility is recommended to be a minimum of 5.5 hours of instruction per school day. Interview on 5/31/18 with the Residential Director (RD) revealed: -He was hired on 3/5/18 as a Residential Supervisor; -When he was hired, the educational classes were co-ed and clients were receiving educational services Monday through Friday in the classrooms, however this stopped at the end of March or early April; -This week he met with the Licensee about the educational requirements and learned clients are required to have 5 educational hours per day, however the last couple of weeks the male clients had only received 2.5 hours per day of educational services separately from the female clients because they were in search of a new teacher and/or Educational Director; -The times for the educational services would rotate i.e. male clients would attend from 8:30am until 11:30am and female clients would attend 1 2noon until 2:00pm and then switch from week to week or bi-weekly, i.e. today female clients had AM school and the males had PM school. -No Residential Counselor (RC) had ever filled in for teachers because they were not qualified to provide the educational services;	V 316		

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V 3 1 6	Continued From page 82 -The clients last day of school would be 6/30/18 because the educational services at the facility started late, in 9/2017. This deficiency is cross reference into 10A NCAC 27G .1901 Scope (V314) fora Type A1 rule violation.	V 316	Anderson Health Services will offer the consumer the option to retain his/her own shoes unless restricted or limited in consumer's treatment or habilitation treatment. Details and reasons for the limitations or restrictions will be in writing. The restriction will be effective for no more than 30 days and reviewed every 7 days, at which time the restriction may be removed. Anderson Health Services will utilize Child and Family Team meetings to discuss personal clothing if it becomes a health and safety issue. Residential Supervisor/Lead will monitor weekly.QA/QI will monitor for compliance monthly.	6/25/18
V 364	G.S. 1 22C- 6 2 Additional Rights in 24 Hour Facilities § 1 22C-6 2. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 1 22C-51 through G.S. 1 22C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and (3) Contact and consult with a client advocate if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times. (b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to: (1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Receive visitors between the hours of 8:00	V 364		

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	MHL090-193	A. BUILDING: ~~~~~~~~~~~~~~~~~~~~~~ B. WING ##########################	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDERSON HEALTH SERVICES-WALFUS	1915-A HASTY ROAD MARSHVILLE, NC 28103

(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 364	Continued From page 83 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies; (3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals; (4) Make visits outside the custody of the facility unless: a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding; b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-100 2; A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision; (5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week; (6) Except as prohibited by law, keep and use personal clothing and possessions, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-100 2; (7) Participate in religious worship; (8) Keep and spend a reasonable sum of his own money; (9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and (10)Have access to individual storage space for	V 364	Responsible Person: Residential Supervisor/Lead Areas with associated responsibilities: Qualified Professionals Clinical Director and/or designee Medical Director QA/QI Department	

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V 364	Continued From page 84 his private use. (c) In addition to the rights enumerated in G.S. 1 22C-51 through G.S. 1 22C-57 and G.S. 1 22C-59 through G.S. 1 22C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise. Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to: (1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him; (2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and (3) Contact and consult with a client advocate, if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times. (d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving	V 364		

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V 364	Continued From page 85 treatment or habilitation in a 24-hour facility has the right to: (1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary; (3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies; (4) Receive special education and vocational training in accordance with federal and State law; (5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs; (6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Have access to individual storage space for the safekeeping of personal belongings; (9) Have access to and spend a reasonable sum of his own money; and (10)Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes. (e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be	V 364		

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V 364	Continued From page 86 reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure clients were allowed to keep and use personal clothing under appropriate supervision affecting 8 of 8 clients (#1, #2, #3, #4, #5, #6, #7, #8). The findings are: Review on 4/11/18 of the facility's Resident Family Handbook revealed: -Resident rights include the right " ...to keep and use personal property and clothing under appropriate supervision ..."	V 364		

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V 364	Continued From page 87 Review on 4/11/18 of client 1's record revealed: -Admission date of 3/29/18; -17 year old male; -Diagnoses of Oppositional Defiant Disorder (ODD) and Attention Deficit Hyperactivity Disorder (ADHD); -Current treatment plan dated 3/22/18 did not document the need for removal of the client's shoes from his possession. Review on 4/11/18 of client #2's record revealed: -Admission date of 9/1 2/17; -16 year old male; -Diagnoses of ADHD, Disruptive Mood Dysregulation Disorder (DMDD), Conduct Disorder, History of Sexual and Physical Abuse; -Current treatment plan dated 3/19/18 did not document the need for removal of the client's shoes from his possession. Review on 4/11/18 of client #3's record revealed: -Admission date of 9/20/17; -14 year old male; -Diagnoses of Post-Traumatic Stress Disorder (PTSD), ODD and DMDD; -Current treatment plan dated 2/16/18 did not document the need for removal of the client's shoes from his possession. Review on 4/11/18 of client #4's record revealed: -Admission date of 1/2/18; -16 year old male; -Diagnoses of Conduct Disorder, Persistent Depressive Disorder and Anti Personality Traits; -Current treatment plan dated 3/19/18 did not indicate the need for removal of the client's shoes from his possession. Review on 4/11/18 of client #5's record revealed: -Admission date of 3/7/18;	V 364		

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V 364	Continued From page 88 -15 year old male; -Diagnoses of Depressive Disorder and ODD; -Current treatment plan dated 2/19/18 did not document the need for removal of the client's shoes from his possession. Review on 4/11/18 of client #6's record revealed: -Admission date of 4/3/18; -15 year old male; -Diagnoses of ODD and DMDD; -Current treatment plan dated 3/20/18 did not document the need for removal of the client's shoes from his possession. Review on 4/11/18 of client #7's record revealed: -Admission date of 3/26/18; -15 year old male; -Diagnoses of DMDD, ADHD and Cannabis Dependence; -Current treatment plan dated 3/1 2/18 did not document the need for removal of the client's shoes from his possession. Review on 4/11/18 of client #8 revealed: -Admission date of 2/22/18; -17 year old male; -Diagnoses of Conduct Disorder, ODD and Perpetrator; -Current treatment plan prior to discharge dated 3/26/18 did not document the need for removal of the client's shoes from his possession. Interview on 4/1 2/18 with Residential Counselor (RC#1) revealed: -All clients have their shoes taken away for the first thirty days at the facility; -Shoes are kept in the storage room; -"Happens for all kids...in place since 9/2017" Interview on 4/1 2/18 with Residential Counselor	V 364		

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V 364	Continued From page 89 (RC #2) revealed: -All clients have their shoes taken away for the first thirty days at the facility; -Shoes are kept in the recreational area where the boys have no access. Interview on 4/11/18 with the Corporate Compliance Officer revealed: -All clients shoes are taken away for the first thirty days of treatment; -Shoe removal is included in the admissions policy; -Removal of clients shoes does not interrupt treatment. Review on 4/17/18 of the facility's policy on Volunteers dated 1 2/6/16 and revised on 4/28/17 revealed: -"It is the policy of Anderson Health Services (Licensee) to not engage volunteers at this time." Interview on 4/9/18, 4/11/18 and 4/18/18 with the Volunteer revealed: -He had been second in-charge of the facility under the Licensee; -He had been responsible for compliance issues in the recent past; -Shoes are removed from all clients for the first thirty days at the facility to prevent attempts of running away; -Would make sure that all paperwork was completed and updated and consent granted to remove clients' shoes from their possession. Interview on 4/18/18 with the Licensee revealed: -All outstanding issues will be addressed and corrected. This deficiency is cross referenced into 10A NCAC 27G .1901 Psychiatric Residential	V 364		

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V 364	Continued From page 90 Treatment Facility-Scope V314 for a Type A1 rule violation.	V 364		
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 7 2 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	V 367	Anderson Health Services has implemented a formal reporting plan and will ensure all Level II and Level III incident reports are reported to the Local Management Entity/Managed Care Organization within 72 hours of becoming aware of the incident. All incident reports will be sent to the Qualified Professional within 24 hours of the incident occurring. All Level II and Level III incidents will be submitted timely into IRIS data base as required. QA/QI will monitor for compliance monthly. Responsible Person: Qualified Professional Areas with associated responsibilities: Quality Management Director Director of Nursing Qualified Professionals Residential Supervisor/Lead Consumer Advocate	5/30/18

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V 367	Continued From page 91 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 7 2 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 7 2 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	V 367		

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V 367	Continued From page 92 (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 Level II and Level III incident reports to the Local Management Entity (LME) responsible for the catchment area where services are provided within 7 2 hours of becoming aware of the incident. The findings are: Review on 6/1/18 of Incident Reporting Improvement System (IRIS) revealed: -An incident on 4/28/18 with client #6 involving staff improperly holding client #6 resulting in injury was not reported to IRIS until 5/1/18; -An incident on 4/26/18 with client #4 involving aggression and being transported to the hospital was not reported to IRIS until 5/17/18; -An incident on 5/26/18 with client #4 involving threats, a fight with a peer, property damage, sheriff response and client #4 being transported to the hospital was not reported to IRIS until 6/1/18; -An incident on 5/26/18 with client #11 involving a weapon, a fight with a peer and complaint of neck pain resulting in him being transported to the hospital via ambulance was not reported to IRIS until 6/1/18; -An incident on 5/2/18 with client #11 being administered client #4's medications was not reported in the IRIS system.	V 367		

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V 367	Continued From page 93 -An incident report dated 4/1/18 documented the missing controlled substance/medication Vyvanse however was not reported in the IRIS system. The medications were never recovered. Review on 5/31/18 of the facility's internal investigation revealed: -Client #5 wrote a letter dated 5/17/18, alleging Licensed Therapist #3 (LP #3) touched him inappropriately during a therapy session; -The facility did not report the allegation to Incident Reporting Improvement System (IRIS)/HCPR until 5/22/18. Review on 4/17/18 of the facility's policy on Volunteers dated 1 2/6/16 and revised on 4/28/17 revealed: -"It is the policy of Anderson Health Services (Licensee) to not engage volunteers at this time." Interview on 4/9/18 and 4/18/18 with the Volunteer revealed: -He had been second in-charge of the facility under the Licensee; -He had been responsible for compliance issues in the recent past; -He did not know why the Corporate Compliance Officer had not reported all Level II and Level III incidents through Incident Response Improvement System (IRIS); -He confirmed the missing controlled medication (Vyvanse) had never been recovered; -He would ensure that all Level II and Level III incident reports were completed through IRIS in the future; -The facility recently hired a new staff member who would be responsible for completing all IRIS reports. Interview on 4/18/18 with the Licensee revealed:	V 367		

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V 367	Continued From page 94 -All outstanding issues will be addressed and corrected. This deficiency is cross referenced into 10A NCAC 27G .1901 Psychiatric Residential Treatment Facility-Scope V314 for a Type A1 rule violation.	V 367		
V 51 2	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. 1 22C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .010 2 of this Chapter. (c) Goods or services shall not 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 (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on record review, observation and interview 3 of 3 staff, Residential Counselors	V 512	Anderson Health Services Residential Counselor #4, Residential Counselor #2, and Residential Supervisor Counselor #5 are no longer employed with Anderson Health Services and not subject for rehire. Anderson Health Services will ensure that no client is subjected to harm and abuse. Anderson Health Services will ensure that staff will complete all required training programs with appropriate documentation (certificates) placed in the employee's file for review. A Staff Training & Development Coordinator position has been created and filled to provide educational training and in-service within Anderson Health Services. The Staff Training & Development Coordinator will work with Human Resources to ensure compliance. QA/QI will monitor for compliance monthly.	5/30/18

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	MHL090-193	A. BUILDING: ~~~~~~~~~~~~~~~~~~~~~~ B. WING ##########################	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDERSON HEALTH SERVICES-WALFUS	1915-A HASTY ROAD MARSHVILLE, NC 28103

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V 512	Continued From page 95 (RC#2, RC#5) and Residential Supervisor Counselor #4 (RSC #4) subjected 2 of 8 clients (#6, #2) to harm and abuse. The findings are: Review on 4/1 2/18 of RC #2's record revealed: -Hire date of 2/7/18 as a RC; -Completed Crisis Prevention Institute (CPI) Nonviolent Crisis Intervention training dated 3/7/18; -No special population training documentation. Review on 5/3/18 of RCS #4's record revealed: -Hire date of 1/27/18 as a RCS; -Completed CPI training dated 3/24/18. -No special population training documentation. Review on 5/3/18 of RC #5's record revealed: -Hire date of 4/20/18 as a RC; -Completed CPI Training dated 4/19/18; -No special population training documentation. Review on 4/11/18 of client #6's record revealed: -Admission date of 4/3/18; -15 year old male; -Diagnoses of Oppositional Defiant Disorder (ODD), Disruptive Mood Dysregulation Disorder (DMDD) and a history of anger, aggressive posturing, being argumentative and resistance to medication management per treatment/crisis plan dated 3/20/18. Further treatment/crisis plan documented "What's not working...'When people don't believe me'...thrives in a structured environment...How can others help me and what can I do to help myself to address a crisis early on? Describe prevention and intervention strategies that have been effective in reducing stress, problem solving...Recognize triggers, Talk through emotions at a later time...give him space and allow him to take a walk to calm down, avoid yelling...If I am in crisis, what are ways that others	V 512	Responsible Person: Staff Training & Development Coordinator Areas with associated responsibilities: QA/QI Department Human Resources Qualified Professionals Residential Supervisor Consumer Advocate	

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V 512	Continued From page 96 can help me...What strategies do not work well for me?...Focus first on the least restrictive steps including natural and community supports...Give clear, simple directions/answers. Do not engage in power struggles/discussions. Move into another activity and try to engage resident (client #6). When agitated, do not attempt to discuss/problem solve at this time. When resident (client #6) starts to escalate, encourage resident (client #6) to think and try to remain calm, provide time away, remove the audience or the resident (client #6); whichever is most appropriate and safe. 'It helps when people leave me alone'... " -Review on 4/11/18 of client #2's record revealed: -Admitted to the facility on 9/1 2/17; -16 year old male; -Diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), Disruptive Mood Dysregulation Disorder (DMDD), Conduct Disorder (CD) and Unspecified Trauma, Stressor Related Disorder and a history of anger, aggression and impulsive behaviors per treatment plan dated 3/19/18. Review on 5/3/18 of facility video from 4/28/18 incident revealed: -Bedroom door to client #5 and #6 is open; -Client #6 goes into his bedroom; -RC #5 and RCS #4 go into client #6's bedroom; -Client #5 (client #6's roommate) comes out of the bedroom; -RC #2 goes into the bedroom and comes right back out the bedroom, leaving RC #5 and RCS #4 inside the bedroom alone with client #6; -RC #2 walks to the bedroom door and the door is then closed, however unable to see who actually closed the door; -Client #7 is pushing the bedroom door trying to get inside; -RC #2 comes out of the bedroom but stands	V 512		

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V 512	Continued From page 97 near the bedroom, redirecting other clients to stay away; -Client #6 is seen lying in the middle of the doorway on the floor. RC #5 is laying on top of client #6, while client #6 has his arm around RC #5 in a hugging position. RCS #4 is holding client #6's left leg in the air (the other leg cannot be seen). RCS #4 continues to hold client #6's leg and foot in the air, where his shoe eventually comes off. -Client #2 lunges at RC #2, grabbing his hand and employee badge; -RC #2 then grabs client #2 from behind in a choke hold position around the neck; -Client #8 is then seen pushing client #2 in an effort to get him to stop fighting. -Client #7 is seen holding client #6 who had a pen and is kicking the door. -RC #5 goes to the door where client #6 is kicking the door. -RCS #4 is redirecting other clients, then he and RC #5 are seen talking with client #6; -Other clients are pointing and speaking (no audio-unknown what is being said) -Client #2 is now acting out again by attempting to bust through a door; -Client #6 is seen hobbling up and limping away from staff. Review on 5/4/18 of a physician progress note handwritten by the Medical Doctor/Medical Director/Child Psychiatrist (referred to in the report as MD) revealed: -"4/28/18-10:15, Psych Note. Chart reviewed Pt seen. He is hostile and aggressive as well as threatening. He has been refusing increase in Zyprexa. MSE (Mental Status Examination) affect + threatening 'I got something for you' Imp Bipolar. Plan 1. assault precaution 2. encourage med compliance"	V 512		

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V 512	Continued From page 98 Review on 5/4/18 of a nursing note documented by the Nurse Practitioner (NP) revealed: -"Date: 4/28/18 Time: 1430 [2:30] pm...Evaluation of the following complaint/health concern: c/o (complaint of) right knee pain s/p (status post) nonviolent crisis intervention...Other objective findings: scratch right neck line. laceration to right knee. scratch under left eye (2) bruises left side of neck. Subjective findings/patient report: c/o right knee pain, superficial laceration. Additional Narrative: Resident c/o of right knee pain. S/P nonviolent crisis intervention. Resident was assessed and the above injuries noted. (MD) notified new orders rec'd. Resident refused any prn pain medications or agitation medication. Assessed by medic deemed necessary to get evaluated @ local hospital if resident agreed. Resident declined service will continue to monitor...consulted with...MD...New orders received...placed on assault precautions..." Review on 5/17/18 of an incident/investigation report provided by the local responding police department revealed: " ...Date/Time reported 04/28/2018 14:07 [2:07pm] Sat ...On April 28, 2018 at about 2pm I was dispatched to Anderson for a fight in progress. Upon my arrival the male residence were very agitated and one child had a cut on his knew. I advised him to stop outside for EMS to check him. I then spoke to [client #2] about what had occurred. He stated that [client #6] was upset and had gone to his room. [Client #2] was also directed to go to his room as were boys. He heard a loud bang and [client #6] yelling so he come out of his room and saw two staff members [RCS #4 and RC #5] on top of [client #6]. He stated that one had [client #6's] leg and he looked like he was going to break it so he struck the staff	V 512		

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V 512	Continued From page 99 member to get him to stop hurting [client #6]. I then spoke to [RCS #4] and [RC #5] they stated that [client #6] had asked to use the phone to call his mother about her visiting today. [RCS #4] stated he was unaware of a visit but [RC #2] then stated he was supposed to get a visit. [Client #6] was insisting on calling his mother himself. [RCS #4] told him no. [Client #6] then went into his room when [RCS #4 and RC #5] went into the room they stated that [client #6] had a toothbrush and tried to attack them with it. The men had handed me a toothbrush and a ball point pen when I came to speak to them. I asked them where the pen had come from and they said that was later when he grabbed it from the desk in the kitchen and he had also tried to get a glass bottle to throw. The men stated that they had to restrain him because he was out of control. I asked if they were trying to get him into their quiet room and [RCS #4] said no. The other boys were yelling at the men to put [client #6] in the room, but they do not do what the boys want. [RCS #4] had two small cuts on his face near his nose on the right side of his face. [Client #6] was waiting on EMS when I asked him what had happened. He stated the same thing the staff members had said. He wanted to call his mother and he was told no. He said that he went into his room and locked himself in the bathroom (later I was informed by [RC #2] that he was told to take a shower while [RCS #4] called his mother). He stated he was in there maybe 30 seconds and he came out. When he came into the bedroom [RCS #4] and [RC #5] attacked him. [RC #5] choked him while [RCS #4] held his legs. [Client #6] stated he was screaming for help but started to loose consciousness. He then stated that when the door opened he went to get out and they tackled him again. I then was able to watch video footage of the incident. I observed [client	V 512		

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V 512	Continued From page 1 00 #6] going into his room (4) then [RCS #4] and [RC #5] follow him in. [Client #6's] room mate left the room and [RC #2] came to the door. [RC #2]then left and went into the kitchen area (later [RC #2] told me he was asked to go get something to open the locked bathroom door). [RC #2] came back and then shut the bedroom door (later [RC #2] told me that he was told to shut the door). [RC #2] stayed on the in the main area with the other boys. Then the boys went into their rooms (as [client #2] had said they were told to do). The door was closed for about 4-5 minutes with [client #6], [RCS #4] and [RC #5] inside. The boys then came out of their rooms ([client #2] stated he heard a loud noise). A resident by the name of [client #7] wearing a white sure and a black cloth on his head opened the door to room 4. [Client #7] informed the deputy that he observed the staff members choking [client #6] and started to yell. [RC #2] then goes to the door and he stated that he heard [client #6] yelling for help and [client #6] was up against the door. The door opens and [client #6] falls out. [RCS #4] grabs [client #6's] leg; dragging him back. Then [RC #5] gets on top of [client #6], laying on top of him. [RCS #4] then puts weight on [client #6's] left leg and extends his right one. I then observed [RCS #4] push downward on [client #6's] right knee cap. [Client #2] then begins to strike the staff members. When this happens, [RC #5] and [RC #2] restrain [client #2] using what appears to be correct CPI [Crisis Prevention Intervention] techniques. [RCS #4] lets go of [client #6] and he gets up and hopples towards the kitchen. I asked the Director (Licensee) if it was okay that the door was closed to the room, he stated that the door should have not been closed. I asked if the knee cap maneuver was okay and he stated it was not and either was laying on the child's body. I	V 512		

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V 512	Continued From page 1 0 1 photographed [client #6's] wounds. He had a large mark on the right/back side of his neck. Cuts behind his right ear, under his left eye and left side of his forehead. Broken blood vessels on the left side and front of his neck. He also had a mark on his right jaw next to his chin. His right side knew had a cut, a mark on the back of the right and left knee. I informed [client #6's] mother that I would be opening an investigation. I asked the Director (Licensee) if they were going to start and investigation. He stated that they had to report it to the State within 24 hours and they would probably be coming to investigate on Monday or Tuesday. If they find an offense (child was in danger) the facility would be fined. I let the Director (Licensee) know I would be opening an investigation and the detective may have follow questions on Monday. [Client #2] had also broken the door to the building. Nothing further at this time ...On May 2, 2018 at about 11:30am I spoke to the [Anderson] administration. I was advised that the two staff members involved in the assault had been suspended pending a state investigation. I was also told that they had found both men had used non CPI holds (improper holds). I was told that the state should be done with their investigation with a week or so ...The administration believes that the victim more then likely came at the staff members first. Nothing further at this time ..." Review on 5/22/18 at approximately 5:45pm of pictures of client #6 taken by the local responding police department on 4/28/18 revealed: -Mark on back right side of neck approximately 5-6 inches; -Mark on right bend in ear, approximately size of a quarter; -Mark on left front neck collar bone, approximately size of a quarter;	V 512		

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V 5 1 2	Continued From page 1 02 -Open wound abrasion on right knee, approximately 3 inches; -Scratch on left knee rear, approximately 3 inches; -Scratch on right knee rear and bruise, approximately half dollar piece. Observation on 5/4/18 of client #6 at approximately 1 2:43pm revealed: -Red abrasions and red scratches to the neck area; -Cut on left knee area; -Bruise (yellow in color) to the right forearm. Interview on 5/4/18 with client #6 revealed: - Staff didn't allow him to make a phone call, he went inside his bedroom and slammed the bathroom door; -RC #5 and RCS #4 closed the bedroom door, blocked him from getting out by pulling on his legs to keep him inside the room; -While he was in the bedroom with RC #5 and RCS #4 with the door closed, client #7 opened the bedroom door and saw him in the corner of the room where RCS #4 and RC #5 was hitting him on the back of his leg. -He managed to crawl out of the bedroom where he ended up on his back on the floor; -While on his back, RCS #4 held his left leg in the air, while RC #5 laid on top of him, choking him with his forearm; -RC #2 heard him screaming and ignored it; -The police came and talked to him and took pictures of his injuries. -A nurse (unknown name) came in at some point and asked him (client #6) did he need or want to go to the hospital and he said no; -First restraint he had at the facility; -RCS #4 and RC #5 only worked the weekends and he had not seen them at the facility since the	V 512		

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V 512	Continued From page 1 03 incident; -RCS #4 and RC #5 worked the rest of their shifts after the incident on 4/28/18; Interview on 5/7/18 with client #1 revealed: -Client #6 got mad, hit bedroom and bathroom doors; -RCS #4 and RC #5 told RC #2 to "get out" and they restrained client #6 inside the bedroom with the door closed. While they were all inside the bedroom he heard a "choke sound" and client #6 yelling "I'm sorry." He then peeked into the bedroom and thereafter client #7 pushed the bedroom door open. Client #6 crawled out real fast, crying and started to grab stuff and was restrained by staff RCS #4 and RC #5. He observed "grab marks on his neck and bruises on his neck, arm, face and eye." -The police took pictures of client #1. -Everybody turned up, got mad and telling staff the restraint was not right. Then because client #2 also defending client #6, he was restrained by RC #2. Interview on 5/5/18 with client #2 revealed: -RC #5 restrained client #6 correctly but RCS #4 did not restrain client #6 correctly, "It looked like he was trying to break his leg." -Client #2 busted a door to get free, the glass slid down and swung on RC #2 three times. Client #2 was restrained by RC #2 but he did the restraint correctly and was not hurt. -Five police officers came to the facility. Interview on 5/7/18 with client #5 revealed: -He is client #6's roommate at the facility. -Client #6 walked into the bedroom, he was mad, then went into the bathroom and hit the wall. He told staff to come check on client #6 and he (client #5) walked out toward the back of the	V 512		

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V 512	Continued From page 1 04 facility. -RCS #4 and RC #5 went into the bedroom and one of the staff (unsure which) closed the door. -Client #6 started to yell, "get off me, I'm sorry, ouch." -He didn't see who opened the bedroom door but saw client #6 was trying to climb out of the bedroom. Then saw RCS #4 holding one of client #6 legs up, while staff #5 was trying to hold his chest down. -Other clients were "flipping out." Client #1 said to RCS #4 to do the restraint right, RCS #4 said I am, then others said no you're not. -Observed client #6's neck was red and puffy and one of his leg was bleeding. -NP took client #6 out of the facility to the cafeteria with staff #6 and NP returned to the facility. -Client #2 heard client #6 and went after staff and was then restrained by RC #2, he was okay and calmed down. - 20 police officers came out but he did not talk to him. Interview on 5/7/18 with client #7 revealed: -Heard client #6 screaming "I'm sorry, please no, I won't do it again", he (client #7) opened the bedroom door, client #6 then tried to climb out but RCS #4 and RC #5 grabbed him, RCS #4 had the lower part of client #6's body and RC #5 had the top part of client #6's body. Client #6's leg was in the air and bent backwards. He (client #6) was picking up stuff and making threats to staff but didn't. -RC #2 was helping when client #6 was slamming the toilet and told everyone to go to their bedrooms. -Client 2 wanted attention and started fighting staff, so he held him back to not hit RCS #4. Interview on 5/7/18 with client #7 revealed:	V 512		

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V 512	Continued From page 1 05 -He was trying to save client #6; -He heard screaming "I'm sorry, please no, I want do it again," and when he opened the door, client #6 was trying to climb out the door. RCS #4 and RC #5 grabbed him, RCS #4 grabbed him at the bottom and RC #5 grabbed him at the top. His leg was in the air bent backwards. He had long scratches and marks on his neck. The police came " 23 cars deep." The police took pictures. His (Client #6) mom came the same day; -RC #2 was also present during the incident, he was talking and telling everyone to go in their rooms. -Client #2 wanted attention and started fighting RC #2, but he (client #7) backed him up and held him to avoid hitting RCS #4. Interview on 5/7/18 with client #8 revealed: -Client #6 upset about a phone call or a visit. Client #6 started slamming on and punching the wall and that is why staff went into his bedroom. While in the room he heard "choking noises" and client #6 crying and saying "I'm sorry" when he came out. -RC #2 tried to talk to client #6 first but RC #5 and RCS #4 told staff #2 to come out and they were told to go to their rooms. -He heard client #6 yelling, then client #7 opened the door and when client #6 came out of the bedroom he had marks and scratches on his neck, eye and leg. Client #6 was still mad, picking up pencils. -One staff had client #6's leg and holding down by knee. Client #6 screamed "get off me I can't move." Interview on 5/7/18 with client #10 revealed: -Client #6 was upset but did not know why, but client #6 went into his bedroom and started beating on the wall, staff told him to stop and	V 512		

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	MHL090-193	A. BUILDING: ~~~~~~~~~~~~~~~~~~~~~~ B. WING ##########################	06/01/2018

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V 512	Continued From page 1 06 closed the door. RCS #4 and RC #5 told RC #2 to "get out of the room" He then heard a "slamming sound" "choking sound" and heard client #6 calling for help. Client #6 tried to crawl out of the room to get away. RCS #4 had client #6's leg in the air and hand on his knee cap pushing down. RC #5 held client #6's arms and body on the ground. Client #1 fell back down because he couldn't walk. Client #6 had a cut on his leg, "deep and red blood" and a bruise on his neck. Other clients were screaming telling staff to restrain client #6 right and pushing through other staff to get to client #6. Client #2 tackled RC #2. Peers telling client #2 to calm down and pushing him away from staff. -Felt staff had no reason to restrain client #6 the way they did "differently." -Felt something was off about RCS #4, "he had a look, strange," RC #2 was with all other clients and called the police; -He kind of got scared so he tried to call his dad but didn't get the right number. Interview on 5/22/18 with RC #5 revealed: -He had worked at the facility "a month or two" and he thought he may have started in March as a Residential Counselor but was not sure of the exact month or day; -He could not recall the name of the cottage but understood he was hired to oversee the cottage by monitoring the clients behaviors and intervening with prompts; -Incident on 4/28/18 involving client #6 occurred with he (RC #5) and RCS #4 on the weekend shift. Client #6 kept asking RCS #4 about a family visit, so client #6 was sent to his room, then client #6 came out of his room asked to call his mother about the visit, RCS #4 told him no again, but to "relax we'll get to it." Client #6 began to stare at RCS #4, a "blank stare" then walked away into	V 512		

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V 512	Continued From page 1 07 his bedroom, where he started kicking and banging the bathroom door. By the time he (RC #5) and RCS #4 went to the bathroom, he (client #6) had barricaded himself inside the bathroom, the door was locked from the inside. He (staff #5) and RCS #4 attempted to give client #6 verbal commands to relax however his behaviors continued to escalate. Client #6 finally opened the bathroom door, pushing RCS #4, cursing, jumping on the bed, kicking the walls and kicking the door which completely closed; -Behind closed doors, client #6 was "flinching at staff" and held a "blunt weapon" specifically a toothbrush, which could have been used to stab staff and grabbed RCS #4's face, therefore he (RC #5) and RCS #4 attempted to restrict client #6's movement, by "take him down" to gain control. Client #6 yelled "yaul trying to hurt me." Client was on the ground for a few minutes and then "let up" and the door was then opened by client #6. Client #6 came out of the door. Surveyor asked what occurred immediately after client #6 came out of the door, "I'm drawing a blank." Surveyor then revealed to RC #5 there was a video reviewed revealing more details involving he and RCS #4 after the bedroom door was opened. RC #5 then says Client #6 reached up and opened the door and broke the restraint, they let him up and he (client #6) went out into the rest of the cottage. Client #6 continued to threaten staff by picking up objects, specifically a "cable box" to hit staff. He (RC #5) then heard sirens and the situation started to de-escalate. He (RC #5) worked the remainder of his weekend shift on 4/28/18; -He (RC #5) could not recall any part of the incident after client #6 opened and came out of the door and before client #6 went out into the rest of the cottage; -He (RC #5) and RCS #4 were not aware of client	V 512		

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V 512	Continued From page 1 08 #6 having a family visit, visits were normally documented in the shift log but there was no documentation confirming a visit for client #6. - He had not received any client specific training. The volunteer told him he would have him (RC #5) to read the clients charts, however he had not had a chance to review the charts to date. Interview on 5/22/18 with RCS #4 revealed: - He was the first shift weekend residential supervisor; -Duties included providing therapeutic care and documenting negative and positive behaviors; - Training provided by the facility was "sparse" but included CPR, First Aid and note writing. -4/28/18 earlier in the day, client #6 saw the MD for medication management. Client #6 became upset after MD increased his medication, he was cursing and threatening physical aggression. He called CPI instructor who came and was able to get client #6 to calm down. Thereafter the boys had outside recreational activity time for approximately 45 minutes and returned inside; -Client #6 asked him if he could call his mother about a visit. He was not aware client #6 had a visit so he told client #6 he would check it out and get back with him, but in the mean time go take a shower first and talk afterwards. Client #6 replied "you gonna deny me the right to call my mom" and runs off into his bedroom into the bathroom slamming the toilet seat down and banging on the walls. He walked in with RC #5 and client #6 had isolated himself in the bathroom with the door locked. RC #2 also came into the bedroom and he (RCS #4) asked him to get a screw driver, but before he could get the screwdriver, client #6 snatched the door open and tries to push him (RCS#4) down. He (RCS #4) tried to verbally deescalate client #6, but then saw he had a toothbrush, therefore he and RC #5 restricted his	V 512		

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V 512	Continued From page 1 09 movement with open hands and discussed boundaries, however client #6's behaviors continued to escalate and make physical contact and jumping on the bed. RC #5 was on his left closest to the bedroom door and he was on right side of client #6. Client #6 kicked at RC #5's hand and the bedroom door closed. Client #6 then jumps down off the bed, trying to get into the bathroom, where they restricted his movement to avoid him going back into the bathroom. Client #6 started jumping on the bed again and then onto the floor in a defensive stance. Client #6 would not respond to verbal de-escalation and grabbed his (RCS#4) face, therefore he had to "engage him" in order for client #6 to release his face, in that, he held the lower torso while RC #5 held the upper torso. Client #6 grabbed the door and pulled it open. He, RC #5 and client #6 were now out of the bedroom in the door jam. To avoid client #6 kicking and to maintain control of his legs, he held client #6's foot/shoe, which eventually came off and thereafter he released the hold. After client #6 was released he went into the Day room area where he continued to look for items to assault staff. Client #6's peers were trying to engage him to calm down. RC #2 asked did he want him to call the police, initially he said no but after observing the situation getting worse, he did ask RC #2 to call the police for assistance. Interview on 5/17/18 with RC #2 revealed: -He was hired as a cook in 2/2018 and took a position as a RC 3 weeks after. He worked 1st and 2nd shifts; -Incident occurred on 4/28/18 approximately 3:00pm, he worked until 7:00pm that shift; -Incident occurred on a Saturday client #6 asked to call his mother, RCS #4 told him he could not call his mother until he cleaned up. Client #6 told	V 512		

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V 512	Continued From page 1 1 0 RCS #4 his mother was coming for a visit and RCS #4 told client #6 "I'll find out for sure." Client #6 got mad and locked himself in the bathroom. He (RC #2) went into the room to try and talk to client #6, however client #6 had locked himself in the bathroom and by that time RCS #4 and RC #5 had come into the room and instructed him to get a screwdriver. Immediately after he walked out of the bedroom to get the screwdriver, the bedroom closed behind him. Some of the clients were in their bedrooms while others were standing outside the door and they all suddenly heard "loud rumbling, thumping noises" and heard client #6 yell "help me (RC #2) help me I'm not gonna do it anymore I'm sorry." (RCS #4) him to get the rest of clients in their rooms. Client #7 somehow cracked open the door to client #6's bedroom and client #6 hollered out to him, "you see this, you gonna let them do this to me?" He (RC #2) observed client #6 in an "ankle lock, he was really hurting, they were bending his legs." When he (client #6) got up he could hardly walk, "he limped away." Client #6 was crying and had red marks around his neck. Client #6 was still irate after they released him, he grabbed a pen and was restrained again standing up, but client #7 was able to persuade him to give him the pen. RCS #4 told him to call the police, the police and ambulance arrived and the situation calmed down. Client #6 was treated in the ambulance and did not go the hospital. -He was aware the RCS #4 had prison work background and had seen him a couple of times at work (the facility) with his "gear on," specifically his gun and his badge; -He had had to remind him this facility was not detention, "he showed a lot of frustration with the clients." He also told them both this place was a mental health facility and they needed to look at the clients charts to understand them better and	V 512		

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V 512	Continued From page 1 1 1 how to work with them. "I have a heart, I'm trying to send back to positive, I have a rapport, this is treatment, you have to have boundaries, they are not our friends." -He (RC #2) then could see in client #2's eyes and hear in his voice "talking junk" that he was extremely angry, so he focused on him (client #2) to try and calm him down, but client #2 lunged at him (RC #2) out of anger after witnessing how RC #5 and RCS #4 treated client #6. He (RC #2) knew he wasn't the target but he took client #2 to the ground two times and after the second time he (client #2) was "chill and calm." He did not deny placing client #2 in a chokehold, he had to "subdue" client #2 the best way he could, "it was not long, it was spur of the moment." Afterwards he took client #2 to the side, he was cool and able to express his ill feelings on how RC #5 and RCS #4 treated client #6. He (RC #2) also knew the restraint was wrong, but was always told he could not go against his supervisor and staff had to stick together, however couldn't recall who told him. He (RC #2) even told the nurse on site the restraint was not right and the situation could have been handled differently, because the bedroom door should have never been closed. Interview on 5/4/18 with the MD revealed: -He was not aware he had written an order for the restraint hold on 4/28/18, but acknowledged he was on campus during the incident and received the call, however was leaving when the police arrived; -He sees the clients once a week; -He saw client #6 in his office that morning of 4/28/18 about medication compliance and resistance and client #6 made threats to him "you're gonna get yours" requiring staff assistance, so he was not surprised by client #6's behavior.	V 512		

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V 5 1 2	Continued From page 1 12 -He spoke to the Licensee and a Former Registered Nurse (FRN#5) afterwards and thought about sending client #6 out to the hospital, but he became compliant, so he was not sent out. Attempted interviews on 5/17/18, 5/22/18 and 5/31/18 with the NP to discuss the 4/28/18 incident involving client #6 however NP was never available for interview. Review on 5/4/18 of the facility's Plan of Protection dated 5/4/18 and written by the CPI Instructor and Director of Operations (formerly a volunteer) revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? 1. Anderson Health Services will use de-escalation as the first plan of action with the residents. 2. Anderson Health Services will create an environment that will rotate staff in the event of a crisis to de-escalate the environment for safety a residents and staff. 3. Anderson Health Services Is in the process of seeking another training model for restrictive interventions to accommodate the population served. 4. Clinical department will provide training on abuse and neglect. 5. Anderson health services will suspend the three staff involved in the incident until the completion of the investigation effective immediately May 4, 2018. Describe your plans to make sure the above happens. 1. The clinical department will document all steps that have been used to correct the deficiencies of the harm citation in abuse and neglect. 2. The director of operation (former volunteer) and the CMT manager will meet with all staff to address alternative restrictive interventions (CPI de-escalations). 3. All staff will sign a document acknowledging the understanding of the proper	V 512		

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V 512	Continued From page 1 1 3 use of CPI. 4. Anderson Health Services have hired and trained staff in CPI to meet the needs of a crisis situation if needed effective today 5/4/18. All things addressed in this document will be completed by May 7, 2018." Review on 6/1/18 of the facility's Plan of Protection dated 6/1/18 and written by the clinical team revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? 1) Anderson Health Services (AHS) (Licensee) will hereby ensure the safety of the consumers in Walfus cottage encompassing the health and safety of the 8 male consumers according to the DHHS Governing Body Policies. 2) Collaboration with the local MCO's to provide assistance with the discharge planning and placement for the residents. 3) Medical, residential, clinical, culinary and educational staff will adhere to the individual needs of the residents. Describe your plans to make sure the above happens. Under direction and approval of the medical director, AHS will consent to the health and safety of the residents by providing a residential staff ratio consist of maintaining the state regulation of 2 residential staff to 6 consumers per shift and 1 registered nurse." Client #6 had diagnoses of Oppositional Defiant Disorder (ODD), Disruptive Mood Dysregulation Disorder (DMDD) with a history of anger and aggressive. Strategies for addressing these issues included: Talking through emotions, give him space and allow him to take a walk to calm down, do not engage in power struggles/discussions, when agitated, do not attempt to discuss/problem solve at this time. and to leave him alone. Client #2 had diagnoses of Attention Deficit	V 512		

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V 512	Continued From page 1 1 4 Hyperactivity Disorder (ADHD), DMDD, Conduct Disorder (CD) and Unspecified Trauma and Stressor Related Disorder with a history of anger and aggression. As a result of the lack of communication between staff, prior to their shifts, RCS #4 and RC #5 were not made aware that client #6 had a visit with his mother. After their shift began, client #6 asked RC #4 and RCS #5 if he could call his mother about the upcoming visit. Client #6 was told by RC #4 and RCS #5 that he could not call his mother because they had no knowledge about the visit, because no one had informed them and there was no documentation to read to confirm a visit. Client #6 became angry and aggressive, went into his bedroom/bathroom and began to hit and bang the walls. There were 3 male staff (RC #5, RCS #4, RC #2) in the facility. RC #2 initially went inside client #6's bedroom to see what was going on, then RCS #4 and RC #5 went inside the bedroom and told RC #2 to leave client #6's bedroom. Client #6's bedroom door was then closed. Interviews with clients and RC #2, who was told to leave, all reported hearing client #6 crying, apologizing, yelling for help and making choking noises while in the bedroom with RCS #4 and RC #5 with the door closed. Another client who was concerned pushed the bedroom door open and client #6 is reported to have either fallen or crawled out of the bedroom area into the middle of doorway of the bedroom. While client #6 was lying in the doorway one of the staff laid on top of client #6's body, while the other staff held client #6's left leg in the air. Interviews with clients reported client #6's left leg was held in the air by RCS #4 and twisted around causing pain to client #6, while RC #5 was laying on him. Further the facility made no efforts to assure clients were protected after this incident, in that, all the staff involved, RCS #4, RC #5 and RC #2 worked the	V 512		

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V 512	Continued From page 1 1 5 remainder of their shifts in the facility after the incident with all 8 clients under their supervision. This deficiency constitutes a Type A1 rule violation for serious harm and abuse and must be corrected within 23 days. An administrative penalty of $3,000.00 is imposed.	V 512		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually).	V 536	Anderson Health Services will ensure all staff members are trained in alternatives to restrictive interventions. All staff members have received training in Alternatives to Restrictive Interventions. All new staff will be trained in Alternatives to Restrictive Interventions prior to employment. Training documentation will be filed in the employee's personnel record for review. The Clinical Director, CEO, and staff attended a two-day class related to The Six Core Strategies (Preventing Violence, Trauma and the Use of Seclusion and Restraint in Behavioral Health Setting). The Clinical Director has provided the Six Core Strategies training to all direct care staff. Human Resources will review personnel records on a monthly and as needed basis. QA/QI will monitor for compliance monthly.	5/30/18

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V 536	Continued From page 116 (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may	V 536	Responsible Person: Clinical Director Areas with associated responsibilities: Staff Training & Developmental Coordinator Human Resources QA/QI Department	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL090-193	A. BUILDING: ~~~~~~~~~~~~~~~~~~~~~~ B. WING ##########################	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANDERSON HEALTH SERVICES-WALFUS	1915-A HASTY ROAD MARSHVILLE, NC 28103

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V 536	Continued From page 117 review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years.	V 536		

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V 536	Continued From page 118 (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure all staff were trained in alternatives to restrictive interventions affecting 4 of 26 audited staff members Registered Nurse #2 (RN #2), Corporate Compliance Officer, Lead Licensed Therapist #2 (LLT #2), Medical Doctor/Medical Director/Child Psychiatrist (referred to in the report as MD): The findings are: Review on 4/1 2/18 of RN #2's record revealed: -Hire date 3/19/18; -No documentation of training in alternatives to	V 536		

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V 536	Continued From page 119 restrictive interventions. Review on 4/1 2/18 of the Corporate Compliance Officer's record revealed: -Hire date 9/22/17; -No documentation of training in alternatives to restrictive interventions. Review on 4/1 2/18 of the LLT #2's record revealed: -Hire date 3/1/18; -No documentation of training in alternatives to restrictive interventions. Review on 4/1 2/18 of the MD's record revealed: -Hire date 3/13/18; -No documentation training in alternatives to restrictive interventions. Review on 5/3/18 of Residential Counselor Supervisor (RCS #4) record revealed: -Hire date of 1/27/18 as a RCS; -Crisis Prevention Institute (CPI) Nonviolent Crisis Intervention Blue Card documented "RCS #4 has completed 8 hours of training in the Nonviolent Crisis Intervention training program. Issued 3/24/18. Expires 3/24/19. Units completed 1-10. Instructor (facility's CPI Trainer signature)...NE8BBC97." Review on 5/3/18 of Residential Counselor (RC #5')s record revealed: -Hire date of 4/20/18 as a RC; -CPI Blue Card documented "RC #5 has completed 8 Hr hours of training in the Nonviolent Crisis Intervention training program. Issued 4/19/18. Expires 4/19/19. Nonviolent Crisis Intervention Training Integrating PBIS. Instructor (facility's CPI Trainer signature)...NEC7EEA3."	V 536		

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V 536	Continued From page 1 20 Review on 4/17/18 of the facility's policy on Volunteers dated 1 2/6/16 and revised on 4/28/17 revealed: -"It is the policy of Anderson Health Services (Licensee) to not engage volunteers at this time." Interview on 4/1 2/18 with the Human Resource Lead revealed: -The Corporate Compliance Officer had "no CPI (Crisis Prevention and Intervention alternatives to restrictive interventions) training for years because of a bad back;" - The MD was "disabled ....does not interact with CPI ...has residence team assist him at all times when meeting with clients;" -Would ensure all untrained staff received the necessary training as soon as possible. Interview on 4/9/18 and 4/18/18 with the Volunteer revealed: -He had been second in-charge of the facility under the Licensee; -He had been responsible for compliance issues in the recent past; -He would would ensure all staff have training in alternatives to restrictive interventions. Interview on 4/18/18 with the Licensee revealed: -All outstanding issues will be addressed and corrected. Interview on 5/22/18 with RC #5 revealed: -He received CPI training from the facility's CPI trainer who he confirmed was on the training card located on the back of his facility staff badge he wore, however revealed he only received CPI verbal commands training and had "not yet" recieved the physical restraint training in CPI; -He had 7 years of prior group home experience where he had recalled receiving PIC (Prevention	V 536		

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V 536	Continued From page 1 21 Intervention Course) training; Interview on 5/22/18 with RCS #4 revealed: -Training provided by the facility was "sparse," he had not received CPI from the facility. -He brought CPI training with him from another facility but that training did not apply to getting client #6 off of him when he (client #6) grabbed his face. Interview on 5/22/18 with the CPI Trainer revealed: -He trained RC #5 and RCS #4 in CPI, which included both de-escalation and physical restraint interventions; -He verified his signatures on the CPI Blue Cards for RC #5 and RCS #4 provided to the surveyor. Based on the record reviews and interviews it could not be determined if RC #5 and RCS #4 received training in alternatives to restrictive interventions. This deficiency is cross referenced into 10A NCAC 27G .1901 Psychiatric Residential Treatment Facility-Scope V314 for a Type A1 rule violation.	V 536	Registered Nurse #2, Corporate Compliance Officer, Lead License Therapist #2, and Doctor/Medical Director/Child Psychiatrist have received the training in seclusion, physical restraint, and isolation time-out. Training documentation is filed in the employee's record for review. Corporate Compliance Officer and Medical Director will receive training. Staff will be trained in seclusion, physical restraint, and isolation time-out on a semi-annual basis.	5/30/18
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that	V 537		

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V 537	Continued From page 122 staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and	V 537	QA/QI will monitor for compliance. Responsible Person: Staff Training & Development Coordinator Areas with associated responsibilities: Residential Supervisor/Lead Clinical Director and/or Designee Medical Director Human Resources QA/QI Department	

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V 537	Continued From page 1 23 incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by	V 537		

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V 537	Continued From page 1 24 observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name.	V 537		

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V 537	Continued From page 1 25 (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure all staff were trained in seclusion, physical restraint and isolation time-out affecting 4 of 26 audited staff members Registered Nurse #2 (RN #2), Corporate Compliance Officer, Lead Licensed Therapist #2 (LLT #2), Medical Doctor/Medical Director/Child Psychiatrist (referred to in the report as MD): The findings are: Review on 4/1 2/18 of RN #2's record revealed: -Hire date 3/19/18; -No documentation of training in seclusion, physical restraint and isolation time-out. Review on 4/1 2/18 of the Corporate Compliance Officer's record revealed: -Hire date 9/22/17; -No documentation of training in seclusion, physical restraint and isolation time-out. - Review on 4/1 2/18 of the LLT #2's record revealed:	V 537		

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V 537	Continued From page 1 26 -Hire date 3/1/18; -No documentation of training in seclusion, physical restraint and isolation time-out. - Review on 4/1 2/18 of the MD's record revealed: -Hire date 3/13/18; -No documentation of training in seclusion, physical restraint and isolation time-out. Review on 5/3/18 of Residential Counselor Supervisor (RCS #4) record revealed: -Hire date of 1/27/18 as a RCS; -Crisis Prevention Institute (CPI) Nonviolent Crisis Intervention Blue Card documented "RCS #4 has completed 8 hours of training in the Nonviolent Crisis Intervention training program. Issued 3/24/18. Expires 3/24/19. Units completed 1-10. Instructor (facility's CPI Trainer signature)...NE8BBC97." Review on 5/3/18 of Residential Counselor (RC #5')s record revealed: -Hire date of 4/20/18 as a RC; -CPI Blue Card documented "RC #5 has completed 8 Hr hours of training in the Nonviolent Crisis Intervention training program. Issued 4/19/18. Expires 4/19/19. Nonviolent Crisis Intervention Training Integrating PBIS. Instructor (facility's CPI Trainer signature)...NEC7EEA3." Review on 4/17/18 of the facility's policy on Volunteers dated 1 2/6/16 and revised on 4/28/17 revealed: -"It is the policy of Anderson Health Services (Licensee) to not engage volunteers at this time." Interview on 4/1 2/18 with the Human Resource Lead revealed: -The Corporate Compliance Officer had "no CPI (Crisis Prevention and Intervention alternatives to	V 537		

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V 537	Continued From page 1 27 restrictive interventions) training for years because of a bad back;" - The MD was "disabled ....does not interact with CPI ...has residence team assist him at all times when meeting with clients;" -Would ensure all untrained staff received the necessary training as soon as possible. Interview on 4/9/18 and 4/18/18 with the Volunteer revealed: -He had been second in-charge of the facility under the Licensee; -He had been responsible for compliance issues in the recent past; -He would would ensure all staff have training in alternatives to restrictive interventions. Interview on 4/18/18 with the Licensee revealed: - All outstanding issues will be addressed and corrected. Interview on 5/22/18 with RC #5 revealed: -He received CPI training from the facility's CPI trainer who he confirmed was on the training card located on the back of his facility staff badge he wore, however revealed he only received CPI verbal commands training and had "not yet" recieved the physical restraint training in CPI; -He had 7 years of prior group home experience where he had recalled receiving PIC (Prevention Intervention Course) training; Interview on 5/22/18 with RCS #4 revealed: - Training provided by the facility was "sparse," he had not received CPI from the facility. -He brought CPI training with him from another facility but that training did not apply to getting client #6 off of him when he (client #6) grabbed his face.	V 537		

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V 537	Continued From page 1 28 Interview on 5/22/18 with the CPI Trainer revealed: -He trained RC #5 and RCS #4 in CPI, which included both de-escalation and physical restraint interventions; -He verified his signatures on the CPI Blue Cards for RC #5 and RCS #4 provided to the surveyor. Based on the record reviews and interviews it could not be determined if RC #5 and RCS #4 received training in seclusion, physical restraint and isolation time-out. This deficiency is cross referenced into 10A NCAC 27G .1901 Psychiatric Residential Treatment Facility-Scope V314 for a Type A1 rule violation.	V 537		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (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. This Rule is not met as evidenced by: Based on interview, record review and observation the facility was not maintained in a safe manner. The findings are: Observation on 5/22/18 at approximately 10:30am revealed: -Upon entry to the facility's administration building, a posted sign indicated no weapons allowed.	V 736	Anderson Health Services will ensure the facility is maintained in a safe manner. All staff members will continue to be trained in health and safety. Residential supervisors will monitor staff to ensure no weapons are bought on the grounds. QA/QI will monitor for compliance monthly. Residential Counselor #4 and Residential Supervisor Counselor #5 are no longer employed with Anderson Health Services and not subject for rehire.	5/30/18

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ANDERSON HEALTH SERVICES-WALFUS	1915-A HASTY ROAD MARSHVILLE, NC 28103

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V 736	Continued From page 1 29 Observation on 5/22/18 at approximately 11:00am revealed: -Residential Counselor Supervisor #4 (RCS #4) entered a conference room at the facility to interview with surveyors; -RCS #4's badge and gun were visible and worn during the interview. Observation on 5/22/18 at approximately 11:53am revealed: -RCS #4 and Residential Counselor #5 (RC #5) standing and talking in the doorway of the facility cafeteria approximately 25-30 feet away from the male clients who were eating lunch; -RCS #4's badge and gun were visible while standing and talking in the doorway of the facility cafeteria with RC #5. Review on 5/17/18 and 5/22/18 of the facility's Incident Reports revealed: -On 4/21/18 (client #4) hit roommate in the face several times. (Client #4) went outside to attack roommate. He (client #4) picked up a board and ran after him. He (client #4) then turned and attempted to destroy staff members cars but stopped at the main building. Interview on 4/17/18 with client #2 revealed: -He stole a knife from the cafeteria, stole a staff's cell phone and got a hammer from a peer. After Residential Counselor #1 (RC #1) came and talked with him about whether or not he had the stolen items, he voluntarily gave the items to RC #1, because staff would have never found the items. -He had seen Residential Counselor Supervisor #4 (RCS #4) at the facility wearing a badge and gun.	V 736	Responsible Person: Health and Safety Coordinator Areas with associate responsibilities: Staff Training and Development Coordinator Qualified Professionals Clinical Director and Qualified Designee QA/QI Department Direct Care Staff Residential Supervisor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL090-193	A. BUILDING: ~~~~~~~~~~~~~~~~~~~~~~ B. WING ##########################	06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 736	Continued From page 130 Interview on 5/17/18 with Residential Counselor (RC #2) revealed: -He had seen RCS #4 a couple of times at work (the facility) with his "gear on," specifically his gun and his badge; This deficiency is cross referenced into 10A NCAC 27G .1901 Scope (V314) fora Type A1 rule violation.	V 736		