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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 000}	INITIAL COMMENTS A follow up survey to a Type A1 violation with the 23rd day of correction being July 7, 2018, was completed on August 20, 2018. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children and Adolescents.	{V 000}		
{V 108}	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 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 .5602(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,	{V 108}		

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{V 108}	Continued From page 1 reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure staff were trained to meet the treatment needs of the clients and failed to ensure that a staff member who was trained in first aid and CPR (cardiopulmonary resuscitation) was available at all times when clients were present in the facility effecting 5 of 6 audited staff (Behavioral Health Technicians #1, #2, #4, #7, #8). The findings are: Review on 8/16/18 of the personnel record for Behavioral Health Technician (BHT) #1 revealed: -Hired 4/9/18. -Training in Adolescent Depression, Bi-Polar Disorder in children and Adolescents, ADHD (attention deficit hyperactivity disorder), Mood Disorder, and Eating Disorders on 7/29/18, 7/30/18 and 7/31/18. -Training was provided 22 days following the due date for compliance. Review on 8/16/18 of the personnel record for Behavioral Health Technician (BHT) #2 revealed: -Hired 4/19/18. -Training in CPR (cardiopulmonary resuscitation) on 12/22/16 but no training in First Aid. -Training in Adolescent Depression, Bi-Polar Disorder in children and Adolescents, ADHD (attention deficit hyperactivity disorder), Mood Disorder, and Eating Disorders on 7/28/18 and 7/29/18.	{V 108}		

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{V 108}	Continued From page 2 Review on 8/16/18 of the personnel record for Behavioral Health Technician (BHT) #4 revealed: -Hired 5/11/18. -Training in Adolescent Depression, Bi-Polar Disorder in children and Adolescents, ADHD (attention deficit hyperactivity disorder), Mood Disorder, and Eating Disorders on 7/28/18 and 7/29/18. Review on 8/16/18 of the personnel record for Behavioral Health Technician (BHT) #7 revealed: -Hired 12/6/17. -Training in CPR (cardiopulmonary resuscitation) on 1/9/18 but no training in First Aid. -Training in Adolescent Depression, Bi-Polar Disorder in children and Adolescents, ADHD (attention deficit hyperactivity disorder), Mood Disorder on 7/26/18. Review on 8/16/18 of the personnel record for Behavioral Health Technician (BHT) #8 revealed: -Hired 12/10/17. -Training in CPR (cardiopulmonary resuscitation) on 1/9/18 but no training in First Aid. Review on 8/16/18 of documentation titled "In Service Training" dated 8/2/18 revealed: -Training was specific to the needs of Client #1 and Client #2. -Documentation was provided by the LPN (licensed practical nurse) and signed by all staff. -Training occurred on 8/2/18, 26 days after the date of compliance. Interview on 8/16/18 with the Corporate Nurse revealed: -All staff were provided client specific training on 8/2/18 for both Client #1 and Client #2.	{V 108}		

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{V 108}	Continued From page 3 Interview on 8/15/18 and 8/20/18 with the Executive Director revealed: -She replaced the prior Executive Director at the beginning of July. -The previous Director had failed to communicate the deficiencies cited in the June survey. -She did not see the report until 7/6/18 and at that time realized the magnitude of the violations. -Had reviewed job descriptions and developed supervision plans with each employee. -Participated in weekly treatment team meetings. -In each treatment team meeting the group reviews each specific client and their treatment needs. -Has met with the Human Resources Director on regular basis. -"Nothing was done toward corrections until 7/6/18." She had to come up with the presentations, line them up, make them available then implement for all staff. "That just took some time." She did not know why the previous Executive Director/Registered Nurse (ED/RN) had not worked on corrective actions. "Don't know if it was a misunderstanding or [ED/RN] just thought she could handle it." -Working toward corrections at the sister facility and managing current clients at all facilities also required her attention and support. This deficiency is cross referenced into 10A NCAC 27G .1301 Scope (V179) for a Failure to Correct Type A1 rule violation.	{V 108}		
{V 118}	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration:	{V 118}		

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{V 118}	Continued From page 4 (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. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure medications were administered as ordered, failed to ensure that all medications administered were ordered by a person authorized by law to prescribe drugs, MARs were current for 2 of 2 current clients (#1, #2), and failed to ensure 1 of 1 former staff (Behavioral	{V 118}		

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{V 118}	Continued From page 5 Health Technician #9) and 5 of 8 current audited staff (Behavioral Health Technician's #2, #4, #5, #6 and the Behavioral Health Technician Supervisor) were trained to administer medications. The findings are: Record review on 8/16/18 for Client #1 revealed: -Admission date of 7/2/18 with diagnoses of Anorexia Nervosa, Obsessive Compulsive Disorder (OCD), Generalized Anxiety Disorder and Mild Major Depressive Disorder. -Age 11 years old. -There was no physician's order to start or change administration of the PediaSure supplement only recommendations by the dietician. The recommendation by the dietician was not dated. -Physician's order dated 7/31/18 to discontinue the Pediasure. Review on 8/16/18 of July-August 2018 MARs for Client #1 revealed: -The July 2018 MAR included PediaSure (nutritional supplement) with 3pm snack; then changed to twice daily and indicated "see new order". -The August 2018 MAR indicated that PediaSure had been discontinued on 7/31/18. -PediaSure was administered once daily only from 7/20/18-7/24/18. -No documentation of PediaSure being administered after 7/24/18. Interview on 8/16/18 with Client #1 revealed: -Met with the dietician weekly to discuss any urges or changes to meal plan. -She had PediaSure for a couple weeks but her vitamins were too high so they changed it to a milkshake every morning which was much better. -She saw the Nurse Practitioner on Mondays.	{V 118}		

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{V 118}	Continued From page 6 She started Zoloft and an Iron Supplement. The Zoloft started making her feel weird so he decreased it. She never missed any medication. Record review on 8/16/18 for Client #2 revealed: -Admission date of 7/2/18 with diagnoses of Anorexia Nervosa, Obsessive Compulsive Disorder (OCD), Anxiety Disorder and persistent Depressive Disorder. -Age 16 years old. -Physician's order dated 7/18/18 for Miralax (for constipation) 17gram packet, one packet daily. -Physician's order dated 7/6/18 for Ondansetron (for nausea) 4mg, one three times daily. -Physician's order dated 7/6/18 for Docusate (stool softner) 100mg, one twice daily. Review on 8/16/18 of July-August 2018 MARs for Client #2 revealed: -Administration of daily Miralax did not begin until 7/21/18, three days following the physician's order. -No administration of the noon or evening dose of Ondansetron on 7/7/18. -No administration of the night time dose of Docusate on 7/7/18. -Administration of Ondansetron on 7/9/18 and 7/10/18 did not follow the order of the physician. On 7/9/18 the midday dose was administered at 4:36PM followed by the evening dose that was administered at 5:00PM. On 7/10/18 the midday dose for Ondansetron was administered at 4:50PM followed by the evening dose at 5:37PM. Interview on 8/16/18 with Client #2 revealed: -She could name her medications and indicated how many times per day she took them. -She indicated that she received her medications daily. -She stated that she met with the Nurse	{V 118}		

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{V 118}	Continued From page 7 Practitioner and the nurse once per week. Review on 8/16/18 of the personnel record for Behavioral Health Technician (BHT) #2 revealed: -Hired 4/19/18. -Medication training completed on 8/1/18. Review on 8/16/18 of the personnel record for Behavioral Health Technician (BHT) #4 revealed: -Hired 5/11/18. -Medication training completed on 7/10/18. Review on 8/16/18 of the personnel record for Behavioral Health Technician (BHT) #5 revealed: -Hired 5/23/18. -Medication training completed on 8/1/18. Review on 8/16/18 of the personnel record for Behavioral Health Technician (BHT) #6 revealed: -Hired 5/15/18. -Medication training completed on 7/27/18. Review on 8/16/18 of the personnel record for former Behavioral Health Technician (BHT) #9 revealed: -Hired 5/31/18. -Date of separation was 7/16/18. -No medication training by a Registered Nurse (RN) prior to separation from employment. Review on 8/16/18 of the personnel record for the BHT Supervisor revealed: -Hired 4/30/18. -Medication training completed on 7/26/18. Review on 8/16/18 of July 2018 MARs for Client #1 and Client #2 revealed: -Medications were administered by BHT #2 on 7/17/18, 7/18/18, 7/26/18, 7/27/18, 7/29/18, and 7/30/18 prior to being trained on 8/1/18.	{V 118}		

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{V 118}	Continued From page 8 -Medications were administered by BHT #4 on 7/7/18, 7/8/18, and 7/9/18 prior to being trained on 7/10/18. -Medications were administered by BHT #5 on 7/18/18 prior to being trained on 8/1/18. -Medications were administered by BHT #6 on 7/18/18 and 7/19/18 prior to being trained on 7/27/18. -Medications were administered by former BHT #9 from 7/12/18 through midday on 7/16/18. She had not received medication administration training by an RN. -Medications were administered by the BHT Supervisor on 7/9/18 prior to being trained on 7/26/18. Interview on 8/16/18 with the Corporate Nurse revealed: -Medication Administration trainings were provided through the pharmacy RN or a RN employed by the Licensee beginning on 7/9/18 and went through 8/1/18. -Facility nurse came on site to observe medication passes 7/25/18-7/27/18, 8/2/18 and 8/3/18. -The LPN (licensed practical nurse) began routine review of the MARs on 7/27/18. She had completed this task on 7/27/18 and 8/2/18. Interview on 8/17/18 with the LPN (licensed practical nurse) revealed: -She had attended the medication training provided through the pharmacy on 7/9/18 and 7/10/18. -Former BHT #9 was never trained. She quit her job before the training was scheduled. -She indicated that she could not explain the delay in administration of Miralax for Client #2. -She was not aware of the medication errors identified in the June Survey. She had been	{V 118}		

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{V 118}	Continued From page 9	{V 118}		

instructed by the former RN/Executive Director to implement the electronic MAR and go to a medication class.
-The electronic MAR was very problematic and the issues were not getting resolved.
-She never saw the previous plan of correction and did not know the deficiencies.
-The facility brought in another nurse in mid-July to help implement corrections.
-New paper MARs were implemented on 7/14/18.
-She began review of the MARs for errors and completion on 7/27/18.

Interview on 8/15/18 and 8/20/18 with the Executive Director revealed:
-She replaced the prior Executive Director at the beginning of July.
-The previous Director had failed to communicate the deficiencies cited in the June survey.
-She did not see the report until 7/6/18 and at that time realized the magnitude of the violations.
-She had restructured management of each site location. Each site now had a Site Coordinator who would oversee operations at their site.
-Will be meeting with Site Coordinators bi-weekly.
-Participated in weekly treatment team meetings.
-A Corporate Nurse had been brought in to assist in the implementation of a new system for medication administration. This Nurse was not in place until the middle of July.
-"Nothing was done toward corrections until 7/6/18." She had to come up with the presentations, line them up, make them available then implement for all staff. "That just took some time." She did not know why the previous Executive Director/Registered Nurse (ED/RN) had not worked on corrective actions. "Don't know if it was a misunderstanding or [ED/RN] just thought she could handle it."
-Working toward corrections at the sister facility

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{V 118}	Continued From page 10 and managing current clients at all facilities also required her attention and support. This deficiency is cross referenced into 10A NCAC 27G .1301 Scope (V179) for a Failure to Correct Type A1 rule violation.	{V 118}		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record review and interview the facility failed to immediately notify a physician or pharmacy regarding drug administration errors affecting 1 of 2 audited clients (#2). The findings are: Record review on 8/16/18 for Client #2 revealed: -Admission date of 7/2/18 with diagnoses of Anorexia Nervosa, Obsessive Compulsive Disorder (OCD), Anxiety Disorder and persistent Depressive Disorder. -Age 16 years old. -Physician's order dated 7/18/18 for Miralax 17gram packet, one packet daily. -Physician's order dated 7/6/18 for Ondansetron	V 123		

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V 123	Continued From page 11	V 123		

4mg, one three times daily.
-Physician's order dated 7/6/18 for Docusate 100mg, one twice daily.

Review on 8/16/18 of July-August 2018 MARs for Client #2 revealed:
-Administration of daily Miralax did not begin until 7/21/18, three days following the physician's order.
-No administration of the noon or evening dose of Ondansetron on 7/7/18.
-No administration of the night time dose of Docusate on 7/7/18.
-Administration of Ondansetron on 7/9/18 and 7/10/18 did not follow the order of the physician. On 7/9/18 the midday dose was administered at 4:36PM followed by the evening dose that was administered at 5:00PM. On 7/10/18 the midday dose for Ondansetron was administered at 4:50PM followed by the evening dose at 5:37PM.
-Medication errors were made on 7/7/18, 7/9/18, 7/10/18, 7/19/18 and 7/20/18. These medication errors were not documented either on a level I incident report or the "Medical Error Form".

Review on 8/16/18 of incident reports and Medical Error Forms since the date of correction of 7/7/18 revealed no level I incident reports documented. Two Medical Error Forms were completed on 7/18/18 for errors that occurred on 7/17/18. The forms did not indicate when the Nurse Practitioner was notified so there was no way to determine if the Nurse Practitioner was immediately notified of the errors as the rule required. The Nurse Practitioner signed both forms but that was 17 days after the error occurred.

Interview on 8/16/18 and 8/17/18 with the LPN (licensed practical nurse) revealed:

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V 123	Continued From page 12 -The Medical Error form is the form used to document medication errors. This is the only documentation for that purpose. -She could not explain the medication errors for Client #2 on 7/7/18, 7/9/18, 7/10/18, 7/19/18, and 7/20/18 and there were no Medical Error forms for those dates. -She notified the Nurse Practitioner immediately about medication errors.	V 123		
{V 179}	27G .1301 Residential Tx - Scope 10A NCAC 27G .1301 SCOPE (a) The rules of this Section apply only to a residential treatment facility that provides residential treatment, level II, program type service. (b) A residential treatment facility providing residential treatment, level III service, shall be licensed as set forth in 10A NCAC 27G .1700. (c) A residential treatment facility for children and adolescents is a free-standing residential facility which provides a structured living environment within a system of care approach for children or adolescents who have a primary diagnosis of mental illness or emotional disturbance and who may also have other disabilities. (d) Services shall be designed to address the functioning level of the child or adolescent and include training in self-control, communication skills, social skills, and recreational skills. Children or adolescents may receive services in a day treatment facility, have a job placement, or attend school. (e) Services shall be designed to support the child or adolescent in gaining the skills necessary to return to the natural, or therapeutic home setting. (f) The residential treatment facility shall	{V 179}		

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{V 179}	Continued From page 13 coordinate with other individuals and agencies within the client's system of care. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to operate within the scope of their program which is to provide a structured living environment within a system of care approach for adolescents who have diagnoses of mental illness, emotional disturbance or other disabilities, affecting 2 of 2 clients (#1, #2). The findings are: Cross reference: 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (V108) Based on record review and interviews the facility failed to ensure staff were trained to meet the treatment needs of the clients and failed to ensure that a staff member who was trained in first aid and CPR (cardiopulmonary resuscitation) was available at all times when clients were present in the facility effecting 7 of 7 audited staff (Behavioral Health Technicians #1, #2, #4, #5, #6, #7, #8). Cross reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (V118) Based on record review and interviews the facility failed to ensure medications were administered as ordered, failed to ensure that all medications administered were ordered by a person authorized by law to prescribe drugs, MARs were current for 2 of 2 current clients (#1, #2), and failed to ensure 1 of 1 former staff (Behavioral	{V 179}		

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{V 179}	Continued From page 14 Health Technician #9) and 5 of 8 current audited staff (Behavioral Health Technician's #2, #4, #5, #6 and the Behavioral Health Technician Supervisor) were trained to administer medications. Cross reference: 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (V366) Based on record reviews and interviews the facility failed to implement their written policy governing their response to level I incidents. Cross reference: 10A NCAC 27E .0107 TRAINING ON ALTERNATIVE TO RESTRICTIVE INTERVENTIONS (V536) Based on record review and interviews the facility failed to ensure that 2 of 6 audited staff (Behavioral Health Technician #1 and Therapist #1) were trained in alternatives to restrictive interventions prior to the delivery of services. Review on 8/20/18 of the Plan of Protection signed and dated by the Executive Director on 8/20/18 revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? -"10A NCAC 27G .0209 Med Req (V118) All employees have been trained by a state approved trainer as of 8/3/18. All medications will be given/administered only with an appropriate physician's order. All med errors will be documented on a med error form and all appropriate treatment team members will be notified, including the physician. Time, nature and plan of correction will be documented on form, kept in clients MAR (medication administration record), and uploaded into ECR (electronic client record). 10A NCAC 27G .0202	{V 179}		

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{V 179}	Continued From page 15 Personnel Req (V108)-All staff have been trained in population specific and client specific education/treatment as of 8/1/18. Employees will be trained in First Aid by 9/1/18. 10A NCAC 27G .0603 Incident Response Req (V366)-all medication errors will be reported to NP (nurse practitioner) and/or pharmacy immediately in accordance with policy and procedure. All medication errors will be documented on "Medical Incident Report Form". " Describe your plans to make sure the above happens. -"Compliance with medication req is the responsibility of the program nurse. Program and oversight. Nurse and Executive Director will meet weekly to review MARs and medication protocol. All new hires that will participate in medication protocol will be appropriately trained in med admin prior to administering medications. Program nurse will participate in monthly medical supervision meetings with Regional medical team. Medical Director and Executive Director are responsible for oversite of medical P&P (policy and procedure). (RN (registered nurse) hired with start date of 9/3). Compliance and oversight of initial training is the responsibility of HR (human resources) Director. Client specific and population specific training is the responsibility of the Clinical Director and Site Coordinator (prior to new hire of Clinical Director). Compliance and oversight is the responsibility of the Program Nurse. Please see above for continued oversite related to medication policy. All staff will be trained in NCI (North Carolina Interventions) at time of hire and prior to working with clients. Oversite of this rule is the responsibility of the HR director and Site Coordinator." On 6/14/18 this facility, which is licensed as a	{V 179}		

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{V 179}	Continued From page 16 residential program for adolescents who have eating disorders, received an A1 rule violation for serious neglect and harm due to systemic failures within the scope of the program. Upon follow up it was determined that the facility failed to have corrective measures in place to ensure compliance with medication administration, staff training and incident reporting until 8/3/18. Physician orders for 3 medications that treat constipation and nausea were not followed for Client #2 which resulted in 7 medication errors. These errors were not documented on incident reports or medical error forms and went unaddressed. A physician's order was not obtained for a dietary supplement recommended by the Dietician and that Client #1 was given for 5 days. Due to the failure to accurately document the supplement there is no way to determine if Client #1 received the supplement as it was recommended. Six staff continued to administer medications to clients with no training throughout the month of July. All staff were not fully trained to administer medications until 8/1/18, 25 days following the date of compliance. All staff were not fully trained in the specific treatment needs of each client, mental health and eating disorders, and NCI until 8/2/18, 26 days following the date of compliance. This deficiency constitutes a Failure to Correct the Type A1 rule violation for serious neglect and harm. An administrative penalty of $500.00 per day is imposed for failure to correct within 23 days.	{V 179}		
{V 366}	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and	{V 366}		

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{V 366}	Continued From page 17 implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and	{V 366}		

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{V 366}	Continued From page 18 (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to	{V 366}		

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{V 366}	Continued From page 19 Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to implement their written policy governing their response to level I incidents. The findings are: Review on 8/17/18 of the policy entitled "REPORTING OF ANY INCIDENTS, UNUSUAL OCCURRENCES OR MEDICATION ERRORS" revealed: -" ...Purpose: To establish written procedures that address ...documentation of medication administration, errors and reactions ..." -" ...Policy: It shall be the [licensee] practice to: ...Maintain documentation (written and/or digital) of errors and reactions and a written plan to address and correct/prevent these issues ...The members of the Clinical Staff involved in the overall process of medications will diligently and accurately maintain written and/or digital documentation of: ...Errors occurring in the medications process ..."	{V 366}		

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{V 366}	Continued From page 20 Review on 8/16/18 of incident reports since the date of correction of 7/7/18 revealed no level I incident reports documented. Review on 8/16/18 of documentation titled "Medical Error Form" dated 7/18/18 revealed two medication errors documented on 7/18/18 both of which occurred on 7/17/18. The Medical Error form included that date, time, staff member, error that was made, notification to the nurse, notification to the physician, and follow-up plan of action. Record review on 8/16/18 for Client #2 revealed: -Admission date of 7/2/18 with diagnoses of Anorexia Nervosa, Obsessive Compulsive Disorder (OCD), Anxiety Disorder and persistent Depressive Disorder. Review on 8/16/18 of July-August 2018 MARs for Client #2 revealed medications errors were made on 7/7/18, 7/9/18, 7/10/18, 7/19/18 and 7/20/18. These medications errors were not documented either on a level I incident report or the "Medical Error Form". Interview on 8/16/18 and 8/17/18 with the LPN (licensed practical nurse) revealed: -The Medical Error form is the form used to document medication errors. This is the only documentation for that purpose. She reviewed every form as well as the Nurse Practitioner. -She could not explain the medication errors for Client #2 on 7/7/18, 7/9/18, 7/10/18, 7/19/18, and 7/20/18 and there were no Medical Error forms for those dates. Interview on 8/15/18 and 8/20/18 with the Executive Director revealed:	{V 366}		

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{V 366}	Continued From page 21 -She replaced the prior Executive Director at the beginning of July. -The previous Director had failed to communicate the deficiencies cited in the June survey. -She did not see the report until 7/6/18 and at that time realized the magnitude of the violations. -Medication errors were not seen as incidents unless something occurred. "Simple missed meds should not be an incident." -"An incident report should be about something BIG. If staff completed incident reports for all missed or just errors in meds, they might not see the significance of a big incident." -"Nothing was done toward corrections until 7/6/18." She had to come up with the presentations, line them up, make them available then implement for all staff. "That just took some time." She did not know why the previous Executive Director/Registered Nurse (ED/RN) had not worked on corrective actions. "Don't know if it was a misunderstanding or [ED/RN] just though she could handle it." Working toward corrections at the sister facility and managing current clients at all facilities also required her attention and support. -All staff had been trained in incident reporting. -No medication errors beyond 7/31/18 and no other incidents had occurred. This deficiency is cross referenced into 10A NCAC 27G .1301 Scope (V179) for a Failure to Correct Type A1 rule violation.	{V 366}		
{V 536}	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS	{V 536}		

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{V 536}	Continued From page 22 (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). (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	{V 536}		

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{V 536}	Continued From page 23	{V 536}		

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 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

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{V 536}	Continued From page 24	{V 536}		

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.
(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
(C) 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

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{V 536}	Continued From page 25 the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (I) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure that 2 of 6 audited staff (Behavioral Health Technician #1 and Therapist #1) were trained in alternatives to restrictive interventions prior to the delivery of services. The findings are: Review on 8/16/18 of the personnel record for Behavioral Health Technician (BHT) #1 revealed: -Hired 4/9/18. -Trained in NCI (North Carolina Interventions) on 7/12/18, 5 days following the date for compliance. Review on 8/16/18 of the personnel record for Therapist #1 revealed: -Hired 5/8/18. -Trained in NCI (North Carolina Interventions) on 7/23/18, 16 days following the date for compliance. -No documentation of attestation. Interview on 8/15/18 and 8/20/18 with the Executive Director revealed: -She was not aware that no attestation statement had been completed for Therapist #1. -"Nothing was done toward corrections until 7/6/18." She had to come up with the	{V 536}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL045-133	A. BUILDING: _____ B. WING _____	R-C 08/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{V 536}	Continued From page 26 presentations, line them up, make them available then implement for all staff. "That just took some time." She did not know why the previous Executive Director/Registered Nurse (ED/RN) had not worked on corrective actions. "Don't know if it was a misunderstanding or [ED/RN] just though she could handle it." -Working toward corrections at the sister facility and managing current clients at all facilities also required her attention and support. -She knew that the training in alternatives to restrictive interventions was required prior to delivery of services and the Human Resources Director was ensuring compliance with that requirement. She would continue to meet with the Human Resources Director on regular basis. This deficiency is cross referenced into 10A NCAC 27G .1301 Scope (V179) for a Failure to Correct Type A1 rule violation.	{V 536}		