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PRINTED: 01/14/2019
FORM APPROVED

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
	MHL011-204	A. BUILDING: _____ B. WING _____	C 12/21/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMMINGS COTTAGE	2 COMPTON DRIVE ASHEVILLE, NC 28806

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V 000	INITIAL COMMENTS A complaint survey was completed on December 21, 2018. One complaint was unsubstantiated (NC #00145299) and one complaint was substantiated (NC #00145744). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.	V 000	**10A NCAC 27G .1901 SCOPE** A clinical case review is completed for each client on a monthly basis, at a minimum. The review is facilitated by the assigned Clinician and includes all cottage staff. The document that guides this process was revised in October 2018, with implementation in November 2018. The revised document is designed to be a "living document": information is updated and added to the original document at each review to create a clear progression of treatment, emerging needs and implementation of intervention strategies. Additionally, the revised document includes detailed, comprehensive crisis planning. This document was revised again in December 2018 to include: 1. Prompt under each treatment goal for goal revision 2. Identification of additional treatment needs and immediate intervention strategies to address these needs. 3. Documentation of the next CFT Meeting, during which the identified goal revisions and treatment needs will be discussed and the PCP will be updated to reflect the recommendations. The clinical case review process is designed to elicit observations of client behaviors and efficacy of interventions from all staff who have engaged with each client and use this information to drive the formal treatment planning that occurs in the monthly Child and Family Team Meetings and is documented on the Person-Centered Plan.	11/7/2018
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (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.	V 112		12/31/2018

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

POI Director 2/1/19

STATE FORM 6899 — 08GC11 — If continuation sheet 1 of 35

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to develop and implement goals and strategies to address the behaviors effecting 1 of 3 audited clients (#1). The findings are: Record review on 11/28/18 for Client #1 revealed: -Admitted on 10/1/18 with diagnoses of Complex Post-Traumatic Stress Disorder, Major Depressive Disorder, and Oppositional Defiant Disorder (ODD). -Discharged on 12/11/18. -Age 15. -Referral Review Outline dated 7/24/18 indicated " ...while on the inpatient unit, [Client #1] has had self-injurious behaviors including cutting which required stitches and increased supervision 1:1. [Client #1] will require a high level of structure, supervision and clinical support ...Presenting Problems ...[hospital] (7/2/18-current) due to a history of multiple suicide attempts, depression, ODD and self-injurious behavior ...while in the hospital setting, she has had some cutting behaviors that have required stitches ...engages in verbal aggression multiple times per week ...she has endorsed SI (suicidal ideation) had has had two recent past attempts (cutting and overdosing on "Acetominophen, sleeping pills, and half a bottle of Ibuprofen") ...history of runaway attempts ...She has been the victim of severe bullying both physical and verbal ...Psychiatric Hospitalizations ...(7/2/18-Current) (5/25/18-6/11/18) ..." -Intake Summary indicated an additional psychiatric hospitalization at another hospital from	V 112	Eliada's Residential Director will review each Clinical Case Review document weekly to ensure thorough completion and appropriate use of this documentation tool. This responsibility will transfer to the Clinical Director for ongoing supervision effective February 2019. Person-Centered Plan development: Eliada's Clinical Director and PQI Director have revised Eliada's PCP Development Guide which includes specific interventions for each service delivered through the agency and guidance for how to individualize and document strategies on the PCP and respond to emerging needs and behavioral patterns. Training will be provided to all Clinicians and Cottage Supervisors on PCP development and documentation in January 2019. This training will be repeated with the hire of new clinicians and QPs as part of the onboarding process. The next training will occur in February. Eliada's Admission and Discharge Coordinator updates the Comprehensive Crisis Plan with the child and guardian during the admission meeting. This revised document is immediately emailed to the program staff for review. The program clinician presents the student's treatment needs, history of trauma demonstrated behavioral patterns and identified support and intervention strategies during the first Treatment Team Meeting following admission (within 7 days). During this review, the direct care staff shares observations of the student's behaviors in the cottage since arrival and	12/31/2018 2/1/2019 12/3/2018 1/22/2019 2/28/19 1/15/19

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V 112	Continued From page 2 8/7/18 until placement at Eliada. -Clinical Assessment update dated 6/14/18 indicated " ...Clt (client) was admitted to [hospital] on 5/23/18 after an attempt to commit suicide by cutting her thigh and then running away on 5/22/18 ...Clt continued to report SI until 6/7/18 ...running away, reports of loose of tempter, arguing with authority figures, anger and resentful, and actively refusing to comply with requests from authority ..." -Client #1 also had a history of participating with self-harm cutting groups, sexting, transmitting pornographic photos of herself, stealing, lying, verbal and physical aggression. -" ...Addendum, Reason for Continued Stay" indicated " ...[Client #1] was admitted to Eliada's all female locked PRTF (psychiatric residential treatment facility) ...on 8/16/18 ...since admission to [locked cottage-all female] [Client #1] has engaged in some self-harm as demonstrated by eating a piece of a wild mushroom, eating (amount unknown) pokeberries, scratching her arm with her finger nail, and head banging on two occasions ...continues to struggle with verbal aggression ...has been hit on several occasions by a student ...team agreed to move [Client #1] from [locked PRTF] to [unlocked co-ed PRTF] ...the move will also reduce bullying behavior toward this client ..." Review on 11/28/18 of the Treatment Plan for Client #1 revealed: -Treatment plan was created on 6/28/18 when Client #1 was involved in Intensive In Home Services and then updated on 8/3/18, 8/16/18, 9/19/18, 10/18/18 and 11/13/18. -" ...Clt struggles deeply with earlier trauma ...Clt reported that she was traumatized and bullied all the time at school ...Clt shared recurrent and persistent thoughts and impulses regarding	V 112	works with the staff to develop individualized strategies for engaging the student in treatment. Eliada is refining the student support plan development process to begin with a review of a visual/sensory strategies menu at admission and completed with the program clinician within 24 hours in the program. A new Safety and Prevention Plan is being developed. The form is trauma-focused and includes sections designated for self-harm risk assessment and run prevention strategies. Training will be provided to Cottage Supervisors, Clinicians and all Residential Staff on the use and implementation of the tools. The Safety and Prevention Plan is maintained in the student record, and copy is located in the cottage's Student Awareness Binder to be readily accessed and reviewed by staff. This binder is brought to the Treatment Team Meeting weekly to be referenced and updated by the Cottage Supervisor with full team input. Eliada's Child and Family Team Meeting document and transition plan are being revised to better guide interactive treatment planning and guardian input on the development of discharge plans.	2/15/19 2/15/19 2/19/19 2/20/19 2/27/19 2/1/19

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V 112	Continued From page 3 negative images of self ...Clt self harms as evidenced by reportings from clt and visual extensive markings on clts arms. Clt's mom reports that clt has scares from self harming all over her legs ..." -" ...Due to clt's most recent attempt of SI, coupled with clt's report of low self-esteem and not liking herself, goal regarding SI to combat behaviors is significantly important ..." -Most of the treatment plan included goals specific to Intensive In Home services that had been provided prior to PRTF placement. -One goal was added to the treatment plan upon her admission into the PRTF which was "[Client #1] will demonstrate an improvement in post-traumatic stress as evidenced by: expression of wider range of emotions, increase in age appropriate behaviors, decrease in experiences of dissociation, depersonalization, de-realization, elimination of angry outbursts, elimination of nightmares, and elimination of intrusive recollections ..." -Strategies for the goal were" ...to teach coping, pro-social, decision making, problem solving and anger management skills. To provide behavioral and crisis management interventions. To monitor throughout sleeping hours. To facilitate therapeutic leave. One staff will provide transportation off campus as safety allows ..." -Goal was reviewed on 10/18/18 and indicated " ...Clinician shared with team ...much of [Client #1's] presentation since entry to [unlocked PRTF] has been behavioral ...possible revision of goals in future based on ongoing presentation in the residential milleu ..." -Goal was reviewed on 11/13/18 and indicated " ...[Client #1] has struggled with safety this month with self harming behaviors. She had to be IVC'd (involuntarily committed) today due to running into and standing in a major road and not responding	V 112	**10A NCAC 27G .0604** The Eliada Residential Treatment Care Coordination Protocols: Crisis Communication guide has been added to the New Employee Pre-Service Manual. During Eliada's 10-day on-boarding process, this protocol in introduced during the Residential Service Standards section and then reviewed during Eliada's Incident Response and Reporting Training. Eliada's Procedure for Contacting Law Enforcement and Procedure for Notifying Administration of Critical Incidents have been revised. These procedures have been distributed to Residential Leadership, reviewed with all residential staff and included in the new hire pre-service training manual. The Crisis Communication Protocol was developed and implemented. Eliada's Incident Debriefing Protocol has been reviewed and revised to ensure that every incident is reviewed with all staff involved, facilitated by the Cottage Supervisor, appropriately documented and reported, and individualized crisis planning occurs within 24 hours of the incident. Eliada's Director of Performance and Quality Improvement will revise Eliada's Incident Reporting Protocols and staff training to reflect the new roles established in the PRTF program and the reporting and documentation responsibilities for each role (specific to Cottage Supervisors, Clinicians, Residential Administrative Assistant and PQI).	12/21/18 12/24/18 1/7/19 1/3/19 2/19/19

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V 112	Continued From page 4 to police presence who were attempting to assist her ...she continues to struggle with emotion regulation and requires staff daily interventions ..." -No goals or strategies to address self-harm, suicidal ideation, elopement behavior, and aggressive behaviors. Review on 12/6/18 of the "Individual Crisis Management Plans" for Client #1 revealed: -Initial crisis plan dated 8/16/18 (when admitted to the locked PRTF) indicated " ...Safety Concerns-Warnings: Suicidal ideation, suicidal attempts, self-injurious behaviors (including cutting which required stitches) ...verbal aggression, physical aggression ...running behavior ..." Intervention strategies were listed as follows: Pre-crisis: staff checks in, positive reinforcement; Triggering: distraction techniques, music; Escalation: manage environment, remove trigger, remove the audience, redirection, directive statements; Outburst: manage environment, proximity; and Recovery: offer check ins, LSI (life space interview) processing. -Update to the crisis plan was not implemented until 11/28/18. The update indicated " ...Safety concerns-Warnings ...attempting to place herself in traffic, physically fighting staff ...head banging ...scratching herself with multiple items ...verbal and physical instigative behavior (threats, posturing), theft ...creating safety hazards (pulling fire alarms, exiting out of her window and setting off alarms), property destruction (pulling drywall away from wall, breaking a peer's reading glasses), assaultive behavior (assaulted a peer by striking them in the head, assaulted a staff member unprovoked bystriking them in the head, striking staff in the groin, biting staff) ...hoarding self harm items ..." Intervention strategies were listed as follows: Pre-crisis: staff checks in, positive reinforcement, validation, offer creative	V 112		

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V 112	Continued From page 5 outlets and leadership opportunities; Triggering: distraction techniques, music, proactive check ins, time and space away from potential target or situation, utilizing humor, neutral voice tones; Escalation: manage environment, remove trigger, remove the audience, redirection, directive statements, time and space; Outburst: manage environment, proximity, isolating her from the remainder of the milieu, attempt distraction techniques, reminders of her goals; and Recovery: neutral voice tone, check in, attempt a life space interview, increased checks, manage room, and real talk. Review on 11/28/18 of incident reports for 10/2018-12/2018 for Client #1 revealed: -On 10/28/18 " ...Staff directed [Client #1] to seclusion as she began to make aggressive threats toward her peer and bang on the window ...she began to run towards to the door to get to her peer ..." -On 11/2/18 " ...[Client #1] was in her room during a transition and on a check she informed staff that she had cut herself. She told staff that she did it with her nail ..." -On 11/5/18 " ...Staff provided proximity as [Client #1] socialized with her peers while in the gym and played a card game. Staff noted [Client #1] was in a negative space upon returning to the cottage. Staff began to pull the robe off of [Client #1's] neck as she attempted to choke herself. Staff followed [Client #1] into her room once the robe was removed. Staff provided real talk to [Client #1] as she began to pick up another article of clothing and wrap it around her neck ..." -On 11/12/18 " ...she (Client #1) came out of the bathroom holding her arm. Staff called nursing to check in ...she self harmed due to feeling afraid of her peer ..." -On 11/13/18 "...Staff transitioned [Client #1] to	V 112		

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V 112	Continued From page 6 English class. [Client #1] refused to sit down because she did not like her new seat ...began to yell at staff ...she refused to follow the prompt ...she threw a pencil at her target peer ...[Client #1] and her peer stood up and began to walk towards eachother ...[Client #1] stated that she was going home, and walked out of the academy ...walked off campus and along the highway. Staff used directive statements when [Client #1] walked into the middle of a lane and stopped. Staff observed cars swerve and nearly hit [Client #1] and another car as she did not move. Staff stepped into the road and used their bodies as barriers to attempt to keep [Client #1] from moving further into the highway. [Client #1] continued to push staff into on coming traffic as she attempted to push past staff to jump in front of moving vehicles. Police responded and helped staff by restraining [Client #1]. Staff and police used their bodies as a barrier together as [Client #1] continued to push into on coming traffic. Additional police responded and hand cuffed [Client #1] for her safety and others. [Client #1] was detained in the police vehicle while IVC was being submitted. Police transported [Client #1] to the hospital ..." -On 11/20/18 at 10:40am " ...[Client #1] threatened to slap her peer in the face ...[Client #1] stood up and hit her peer on the neck ..." -On 11/20/18 at 3:00pm " ...[Client #1] began to call her peer a b***h. Staff provided a barrier as [Client #1] and her peer began to slap each other in the face. Staff provided a barrier again as she attempted to charge at her peer once the peer had walked away ..." -On 11/20/18 at 4:00pm " ...Staff noted [Client #1] began to superficially self harm and then went to the bathroom. Staff conducted increased checks ...came out of the bathroom after self harming ..." -On 11/22/18 " ...she had a towel wrapped around	V 112		

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V 112	Continued From page 7 her left arm ...she harmed due to not being with her grandparents for thanksgiving ...she harmed herself by using her fingernail ..." -On 11/26/18 " ...[Client #1] raised her voice and began to target the teacher ...Staff used their bodies to separate [Client #1] from target staff as [Client #1] entered target staff's space ...Staff used their bodies to attempt to block [Client #1] as she reached around them to strike target staff with an open hand ...pushed against them to hit target staff again ...attempted to initiate a standing restraint as [Client #1] hit staff a third time ...Staff redirected [Client #1] when she picked up the teacher's grade book. Staff attempted to take the grade book from [Client #1] and provided a firm directive when [Client #1] bit their wrist ...she took a piece of plastic off the teacher's desk and attempted to self-harm with it ..." -On 11/27/18 " ...Staff blocked [Client #1] from her peer as she stated that "I'm going to go down there and punch him". Staff followed as [Client #1] ran past staff to grab her peer that was self harming. Staff directed [Client #1] to release her peer ...Staff then attempted to place a head board between [Client #1] and the wall as she began to head bang ...[Client #1] began to then hit staff with an open hand and grab their arms...[Client #1] sat down and began to self harm by reopening her wounds and sticking her fingers inside ..." -On 12/3/18 " ...[Client #1] became escalated during the nightly reflection with her peers. [Client #1] yelled instigative comments down the opposite hall. [Client #1] encouraged her peers to join. [Client #1] pushed against staff to get to her targeted peer. [Client #1] hit staff resulting in a restrictive intervention ..." -On 12/4/18 " ...Staff redirected [Client #1] for targeting a peer ...she began to scream and	V 112		

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V 112	Continued From page 8 posture at this peer ...got up and exited the cottage ...she approached the road ...transitioned to a standing restraint ...staff released the restraint when a staff member was hurt. Staff continued to follow [Client #1] and lost eye sight of her briefly when she darted across the road in to [drug store]. Staff re-gained eyesight of [Client #1] once entering [drug store]. Staff kept distant proximity when she yelled at staff to keep their distance. Staff lost eyesight of [Client #1] again briefly when she ran out of [drug store]. Staff re-gained eyesight ...Staff followed [Client #1] until [restaurant] before losing eyesight as she ran across the highway towards [liquor store]. Staff attempted to search for her within the area she was last sighted. Staff returned to campus and filed missing persons report. Staff returned [Client #1] to the cottage a few minutes later ..." Review on 11/28/18 of the Nursing notes from 10/1/18-12/4/18 for Client #1 revealed: -On 10/17/18 " ...[Client #1] was hit in the back of the head by a peer. She does not have a hematoma ...Neurological assessment WNL (within normal limits) ..." -On 10/20/18 " ...Student self harmed her R (right) inner arm on the 19th, has light brown abrasion. This evening 10/20 she self harmed her L (left) inner wrist by ripping off light outlet cover and has red opening area. Did not allow RN (registered nurse) to cleanse the area and apply antibiotic oint (ointment) ..." -10/29/18 " ...Student participated in mild head banging per staff and in the cafeteria ..." -11/1/18 " ...New superficial self harm to left forearm. I horizontal scratch in middle of anterior forearm, approximately 1.5 inches. Done with fingernail ..." -11/12/18 " ...Staff reported to this RN that she had self harmed. Upon assessment, student had	V 112		

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V 112	Continued From page 9 a cut ~1 " long. She had used a piece of plastic ..." -11/20/18 " ...[Client #1] was escalated and went to the bathroom ...she had several cuts to bilateral thighs, had pulled the scab off of a wound to her right forearm and several cuts to her left forearm ...[Client #1] stated she used a piece of plastic that she acquired while in school ...during med pass student reported that she had cut her left forearm 2 more times ...student also confessed that she stole a part from a gameboard and broke it then used the part to cut herself ..." -11/22/18 " ...Staff reported that [Client #1] had cut her left FA (forearm) again (on the lateral wrist area) ...1 " wound (which was new) was open ...This had been done on the same FA that she had cut on on 11/20/18 ..." -11/27/18 " ...student head banging ...picking at her old self harm scabs ...she is reopening scabs ...the wounds are not actively bleeding ...wounds approx. ½ in width and 1/2cm in depth." -12/4/18 " ...She banged the back of her head against a wall approximately 10-12 times ..." -12/4/18 "Student asked to have nursing check in with her when I arrived at the cottage to see another ...I checked in with [Client #1] at approx. 2:45pm. During this conversation, she stated that she ran from campus earlier today and went to [local pharmacy]. She stated that while in [local pharmacy] a man approached her and asked her if she was okay and asked her to step outside. [Client #1] stated that Eliada staff came at that time and she left [local pharmacy] with Eliada staff. [Client #1] then stated that once she left the [local pharmacy] she ran from staff and into a forest. She states that the man from the store followed her and raped her in the forest. Bruising and scratches were noted on the backs of [Client #1's] upper arms bilaterally. [Client #1] was	V 112		

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V 112	Continued From page 10	V 112		

informed that since she was reporting that she had been raped that she would likely be sent to the ER (emergency room) and that I needed to check with administration. She was also instructed to not take a shower, to which [Client #1] repolied, "But I feel icky". I explained to her the reason for not taking a shower due to collecting evidence since she stated that she was raped ...I left the cottage and reported this conversation to my supervisor, and then returned to [cottage] at approximately 3:30pm to find [Client #1] in the shower. While in the cottage I received a message that [Client #1] would be going to the ER, so staff and I collected her clothing and put the items in a bag. [Client #1] then refused to go to the ER and asked to speak with her mother. When [Client #1] was off the phone with her mother, I was asked to speak with [Client #1's] mother ...her mother asked me why I had not called the police. I explained all of the above as it started at 2:45pm and [Client #1] was going to the ER but now refusing. I explained to her that I would be glad to call the police, but had not yet had time ...I reported this entire incident to [Residential Director] and [Lead RN]."

Review on 12/4/18 of the daily service notes for Client #1 revealed:
-On 10/11/18 " ...a peer began to make instigative remarks ....threw her shoe at the peer...became escalated again when her peer began to instigate her again ...ran after the peer ...attempt to push past the teacher ...[Client #1] was attempting to get through the door to her peer while communicating verbal threats to "punch him in the face" and "beat his a*s" ...staff observed [Client #1] run behind staff to reach the target peer ...[Client #1] strike her peer in the head with a closed fist approximately 4 times ..."
-On 10/15/18 " ...[Client #1] became verbally

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V 112	Continued From page 11 aggressive and brought up previous crisis in which she hit the target peer. [Client #1] referenced the incident to threaten the target peer and made several instigative statements. [Client #1] struggled to disengage despite her peer disengaging ..." -On 10/17/18 " ...Staff transitioned [Client #1] to the cafeteria for lunch and heard her instigate peers from another cottage and was not receptive to redirection. Staff noted [Client #1] stood up and walked towards the other cottage's table and begin to yell ...Staff stood in between [Client #1] and her peers as she threw punches over staff at her peers ...her hair was pulled and she was punched in the head by a peer ..." -On 10/20/18 " ...she stated that she broke a faceplate off in her restroom ...she stated that herself harm did not do what she wanted, she expanded on this and said "she wanted to bleed out" ...she spat at staff. Staff redirected her negative relations with her peers and staff ..." -On 10/21/18 " ...Staff noted [Client #1] had ripped the drywall off of the wall and had pulled a screw out ...began to engage in property destruction in the interest of finding self harm items ..." -On 10/23/18 " ...Staff observed [Client #1] disrupt the milieu numerous times ...Staff observed [Client #1] tear apart a plastic cup ...proceeded to barricade in the rest room with a sharp piece of the plastic cup. Staff used their body to block the door from being shut completely and maintained eyesight ...neutral staff redirected [Client #1] for secretive behavior and listened as she cursed at staff and eluded becoming physically aggressive by referencing a past incident in which a student hit a staff ..." -On 10/28/18 " ...she began to make aggressive threats towards her peer and bang on the window ...pushed past staff to open the door ..."	V 112		

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V 112	Continued From page 12 -On 11/1/18 " ...when a peer then began to engage her about her behaviors, [Client #1] once again became escalated. She began to make very aggressive statements and insult both staff and her peers ..." -On 11/7/18 " ...[Client #1] struggled with boundaries while throwing books at her peer ...struggled with unfamiliar staff when they pronounced her name wrong multiple times, beginning to snap and threaten them if they called her name wrong one more time ...struggled throughout the shift with inappropriate, vulgar, sidebar conversations with her peers ..." -On 11/10/18 " ...She became upset with a peer after being called a b***h ...she quickly transitioned to her room brought glasses out and bent them in half and threw them on the floor ...staff quickly stood between her and a peer as she became escalated by throwing markers at the peer ..." -On 11/12/18 " ...Staff redirected her for poor physical boundaries and being passive aggressive toward a peer ...she demonstrated verbal aggression toward a peer receiving help from the teacher as she struggled to wait ..." -On 11/14/18 " ...[Client #1] struggled with boundaries with her peers ...struggled when her peer was in crisis at the end of the night, yelling and screaming on the hallway ..." -On 11/19/18 " ...Staff heard [Client #1] make instigative statements to her peer ...with statements such as "if you have something to say to me, say it to my face" ...showed poor impulse control by once again indulging in her peers negativity ..." -On 11/20/18 " ...Staff used directive statements when [Client #1] invaded a peers boundaries and hit them ...[Client #1] argued and called staff a "b***h" ...Staff redirected [Client #1] as she began to call her peer a "b***h". Staff provided a barrier	V 112		

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V 112	Continued From page 13 as [Client #1] and her peer began to slap each other in the face. Staff provided a barrier again as she attempted to charge at her peer once the peer had walked away ...[Client #1] began to superficially self harm ...came out of the bathroom after self harming ...expressed suicidal ideation ..." -On 11/21/18 " ...[Client #1] made negative comments about a certain peer which amounted to bullying behaviors. She was not very receptive to redirection ...when redirected [Client #1] began to talk back to staff and even threaten to slap them in the face ..." -On 11/26/18 " ...Staff redirected [Client #1] for bullying behaviors towards a specific peer ...staff redirected [Client #1] for calling staff a "b***h" ...staff used directive statements when [Client #1] continued to engage in bullying behaviors ...began to make threats ...[Client #1 began to target a specific staff ...make aggressive threats toward this staff ...continued to call this peer names like "squirrely b***h" ...engaged in practicing restraints with her peers ..." Interview on 11/28/18 with Client #1 revealed: -She saw the nursing staff twice daily. She had seen the Physician's Assistant as needed. -Most nights the nurses checked her skin for cuts. -She got along pretty well with her peers. -She had hit a peer. -She stated that Client #2 made sexual remarks to her and she slapped him. She added that Client #2 had hit her first. -She stated that she had advocated for the boundary plan that was put in place for her and Client #2. -She had to restrain another client because staff would not help him. -She stated that on the day she ran into the road	V 112		

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V 112	Continued From page 14 she did so because Client #2 was threatening to kill her and she had to leave. She would not discuss details of that incident. Interview on 11/29/18 with Client #2 revealed: -He had been a resident of the cottage for one and half months. -He stated it "was not the best" and that there "was a lot of bullying". -He stated that there was a crisis every day. -He had engaged in one fight with Client #1. Client #1 called him a name, he called her a name, she slapped him and he hit her. She hit him again. Staff were actively trying to break it up. -He stated that he did not feel safe around her now. -Staff had implemented a boundary plan for he and Client #1 which restricted their contact and kept them separate. -He stated that Client #1 hit one other client and almost fought another. Interview on 11/29/18 with Client #3 revealed: -She had been a resident of the cottage for 4 months. -She had been targeted and bullied. She indicated that staff do what they can. -She did not feel safe around some peers. -Client #1 had hit her in the head. Client #1 made threats and followed through on her threats. Interview on 12/4/18 with Residential Counselor #1 revealed: -She worked second shift. -Client #1 had poor boundaries with everyone. -A boundary plan was implemented for her and Client #2 due to concerns regarding their interactions. The plan limited contact, proximity and activities. Client #1 was consistently	V 112		

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V 112	Continued From page 15 non-compliant with the boundary plan. -Client #1 "had created a culture where no one likes him (Client #2)." -There were times that Client #1 and Client #2 threatened each other. There was a lot of verbal aggression. -Having Client #1 in the milieu was extremely negative and had caused a "great deal of anxiety" for other clients. She stated that the other clients did not know how to separate themselves from her. She further added that she thought that some of the clients were afraid of being targeted by her. -In the cottage, Client #1 would pick her target and instigate arguments with them. She had managed to pull other peers into a negative space even when they have tried to stay on task. -Increased supervision was implemented for Client #1 at times when she self-harmed. -Strategies used in the milieu were isolation from peers, boundary plans, taken choice time, and real talk approach. -She was present during the incident that occurred on 11/5/18. Client #1 was upset about Client #2. She thought "he looked sad." She was present and intervened when Client #1 used clothing items to try and choke herself. She redirected Client #1 who immediately stopped. She was not injured and immediately wanted to rejoin her peers. -She was present for the incidents that occurred on 11/20/18. Client #1 tried to provoke Client #2. She initiated verbal aggression and then it turned physical. Staff were acting as a barrier. Client #2 disengaged. Later on the same date Client #1 engaged in self-harm. She had stolen and hid a piece of a game and used it to cut herself. Nursing staff were involved and her room was searched.	V 112		

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V 112	Continued From page 16 Interview on 11/29/18 with Residential Counselor #2 revealed: -She worked second shift. -On shift there were 4 staff unless a code was called which would reduce their staffing to 3 temporarily. -Client #1 changed the milieu. She had poor boundaries and acts out when she doesn't get her way. -She was non-compliant with the boundary plan put in place with Client #2. The boundary plan was established when inappropriate notes of a sexual nature were found. -Since in the cottage she had punched Client #3 four times in the head, almost fought Client #2 and had threatened to hit staff. -Client #1 participated in bullying, did a lot of whispering and was "influential in the milieu." She stated that Client #1 would make a big deal out of anything. -The behaviors of Client #1 changed the milieu and "added drama." -Other clients were afraid to go against her. -"She made it hard for a lot of people to focus on their treatment." -Staff would isolate Client #1 and engage in "real talk" or take her choice time for bullying behaviors. -The clients were checked every 10 minutes and checks were increased when self-harm occurred. Staff also sat in hallways with eyes on if needed. -Nurses checked in with Client #1 for her self-harm. -Rooms were searched randomly once per week. Interviews on 11/28/18 and 12/4/18 with the Cottage Supervisor revealed: -Life Space Interviews were attempted with Client #1 in response to her self-harm but many times she refused. Staff would present alternative	V 112		

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V 112	Continued From page 17 options to self-harming but she did not want other options. Staff would attempt to process with her when she was in a negative space but she would resort to self-harm. -A boundary plan was implemented for Client #1 and Client #2 after they had passed notes of a sexual nature. -Client #1 and Client #2 had assaulted each other. Staff have had to block Client #1 from engaging physically with Client #2. -Client #1 tried to draw other clients in her negative space and would instigate negative behavior in the cottage. -Client #1 was moved from another campus cottage due to safety. She had been targeted by a peer in that cottage. -Client #1 would try to add "gas on the flame of anything." Most of the time Client #1 was the aggressor in the cottage. He indicated that for the first week in the cottage she flourished but after that she "asserted herself as the alpha" and tried to instigate multiple peers. He indicated that Client #1 had a completely negative effect in the cottage. She encouraged peers not to talk to staff and hurt the staff's ability to build rapport with other clients. -He indicated that the milieu had "become nearly unmanageable." The majority of the clients were experiencing depression and anxiety. He added that Client #1 encouraged a culture of being non-compliant with staff. He stated that he wasn't sure where to go with her. -He indicated that usually when clients entered the cottage a support plan/safety plan was created and signed by the client. -The system in the cottage was strength based and motivators/rewards were put in place. Staff tried to nurture positive coping skills and teach new skills. -Client #1 would hoard items to use for self-harm.	V 112		

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V 112	Continued From page 18 -In the cottage, clients were monitored every 10 minutes or more frequently if self-harm had occurred. -Random search and seizures were conducted weekly and staff monitored and tried to process with Client #1. She was kept in eyesight if she had any object to use for self-harm and staff would try to remove the item. Interviews on 11/29/18, 12/5/18, and 12/6/18 with the Clinical Director revealed: -When admitted to the current cottage Client #1 had a therapist assigned. He was injured and was no longer employed at the agency. Client #1 had a temporary therapist assigned to her while the agency hired another therapist. -When a student engaged in self-harm the Clinician was notified. The Clinician would assess the need for increased supervision and review strategies with staff. -Support/Safety plans identified what was needed to support each client and what the client would also do. These plans were kept in the cottage. She did not know how this was implemented for Client #1. -Every week the team addressed the behaviors exhibited by each client to include triggers and strategies to address the behaviors. -If a client was non-compliant with a boundary plan that was in place then the Leadership team can meet with that client to review. Next steps would be considered to ensure safety. She did not know if this was done for Client #1. -Intensive in home (IIH) services were in place for Client #1 prior to her admission to the PRTF (psychiatric residential treatment facility). The agency that provided the IIH service revised the treatment plan and added the goal to be addressed when she was admitted to the PRTF. The initial therapist that worked with Client #1	V 112		

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V 112	Continued From page 19 completed the first update to the treatment plan and then she completed the most recent update. -Neither time the treatment plan was updated were goals or strategies added to address the self-harm, aggression or elopement behaviors of Client #1. -Her understanding was that goals in the treatment plan were related to diagnosis only. -She indicated that she had been instructed that the treatment plan could not be individualized because of how it was set up in their computer system. -The treatment plan was treated as an authorization form only. -She stated that neither the staff nor the therapist saw the treatment plans. -The Licensee was currently in the process of changing the entire person centered plan process to ensure interventions were more individualized. She indicated that their entire system was being revised. Interview on 12/5/18 with the Lead RN revealed: -For any clients who self-harmed random or daily body checks were conducted. -Body checks were documented on the MAR (medication administration record) and conducted by nursing staff. If there was a history of self-injurious behavior body checks were implemented upon admission. Frequency of body checks were conducted on an individualized basis. -Daily body checks were determined to be necessary for Client #1 due to significant self-harm. The body checks were conducted and documented for Client #1. Interview on 12/5/18 with RN #1 revealed: -On 12/4/18 she was contacted at approximately 2:45PM by cottage staff and informed that Client	V 112		

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V 112	Continued From page 20 #1 wanted to check in with her. -Client #1 informed her that she had run away and gone into a local pharmacy. She indicated that after walking out of the pharmacy with staff that she ran off and a man who had spoken to her in the pharmacy followed her into the forest and raped her in the forest. -She indicated that she told Client #1 that she needed to look at the policy but that she would need to go to the emergency room and have a rape kit conducted. She advised Client #1 not to shower and had Client #1 agree not to shower. -She consulted the Lead RN who stated that she would notify the Administration. She was instructed to take Client #1 to the emergency room. -She returned to the cottage at 3:30pm and Client #1 was in the shower. She collected her clothing to the take to the emergency room. Client #1 was refusing at this time to go to the emergency room and wanted to call her mother. Client #1 then called her mother. -At approximately 4:00PM when Client #1 was on the phone her mother requested to speak to the RN and questioned why the local police had not been contacted. The nurse indicated that she informed Client #1's mom about the entire scenario and that they planned to take Client #1 to the emergency room. She indicated that she also informed Client #1's mother that Client #1 had destroyed any possible evidence by showering. She indicated that she talked to the Residential Director following her phone call with Client #1's mother. -After the phone call Client #1 agreed to go to the emergency room. She called ahead to the emergency room to inform them of the situation. -She indicated that the emergency room collected evidence and informed the police at that time. -She did not make a police report.	V 112		

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V 112	Continued From page 21 -At approximately 5:00PM Client #1 went to the emergency room. -She stated that when Client #1 eloped she was barefoot and in her pajamas. Upon her return she did not observe Client #1 to have any leaves or debris on her clothing to indicate she had been on the ground in the forest. She observed scratches on her upper arms but indicated Client #1 self-harmed. -She stated that she had 20 years' experience in the emergency room and had worked with rape victims. Interview on 12/19/18 with the Local Law Enforcement Detective revealed: -On 12/4/18 at 4:25PM the guardian of Client #1 reported to law enforcement that Client #1 had run away from the facility and had been raped. -He indicated that no one from the facility had contacted law enforcement. He stated that the allegation should have been reported to local law enforcement. -He stated the allegation was very vague and in order to move forward with the investigation a forensic interview with the victim (Client #1) would have to be conducted. He indicated that the guardian of the victim was afraid to have that interview conducted due to her prior self-injurious behavior. Interviews on 11/29/18 and 12/5/18 with the Residential Director revealed: -He received the call from RN #1 about the allegations of rape made by Client #1 on 12/4/18. At that time RN #1 was getting things in place for her to be taken to the hospital. This RN had a lot of emergency room experience and experience working with rape victims. She had directed Client #1 not to remove clothing or shower before going to the emergency room. The nurse also	V 112		

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V 112	Continued From page 22 advised the staff of those procedures, however, Client #1 was non-compliant and took a shower. -The RN advised that the police would be called upon her admission to the emergency room. -It was his understanding that Client #1's mother contacted the police around 5:30-6:00PM and told the police that Eliada was refusing to report a rape. -Local law enforcement came to the campus after receiving the call from Client #1's mother. The officer questioned why Eliada had not called to make a police report and he advised the officer that they were following nursing protocols. -The Officer stated that law enforcement should have been immediately notified because a child was involved. -He indicated that he felt it was a medical issue and followed the nursing recommendation. They wanted to get Client #1 in one place so that all needed professionals could evaluate the situation. This deficiency is cross referenced into 10A NCAC 27G .1901 Scope (V314) for a Type A1 rule violation and must be corrected within 23 days.	V 112		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare	V 132		

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V 132	Continued From page 23 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. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to report the results of their internal investigation of abuse by a staff member to the Health Care Personnel registry within five working days of the initial notification to the Department.	V 132		

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V 132	Continued From page 24 The findings are: Review on 11/28/18 of the incident reports for Client #1 revealed: -On 10/31/18 " ...The consumer attended Eliada's Halloween event. During the event she engaged in off-task and disruptive behavior with her peers. Staff reviewed the behavioral expectations for the activity and provided verbal redirection to the consumer to engage appropriately. The consumer reacted with defiance and yelled, "Well, you are a pedophile so I don't have to listen to you" in front of staff and peers ...Residential Director was notified of her statement and met with the consumer. She reported to the Residential Director at this time that the targeted staff allegedly "rubbed his penis on her butt" on several occasions ..." -Level III Incident report was submitted through the IRIS (Incident Response Improvement System) system. This report included notification to the Health Care Personnel Registry. Review on 11/28/18 of the Internal Investigation report revealed: -Residential Counselor #4 was sent home from his shift immediately following the allegation. -Administration met with Residential Counselor #4 the next morning, obtained his statement and he was removed as a direct care staff and assigned administrative duties. -DSS report made 11/1/18. -Internal investigation completed. Interview on 12/13/18 with the Director of Performance/Quality Improvement revealed: -She indicated this notification was her responsibility and she had failed to submit their findings. -She knew that the 5 day report should have been	V 132		

Division of Health Service Regulation

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V 132	Continued From page 25 submitted but it was simply an oversight.	V 132		
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 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,	V 314		

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V 314	Continued From page 26 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 interviews the facility failed to ensure services were designed to provide therapeutic interventions to address the functional deficits associated with the child or adolescents diagnosis and failed to coordinate with other agencies within the child or adolescents catchment area, effecting 1 of 3 audited clients (#1). The findings are: Cross Reference: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) Based on record review and interviews the facility failed to develop and implement goals and strategies to address the behaviors effecting 1 of 3 audited clients (#1). Review on 12/7/18 and 12/21/18 of the Plan of Protection signed and dated by the Director of Performance/Quality Improvement on 12/7/18 revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk? "-The identified student has been admitted to an inpatient psychiatric hospital. If the student returns to Eliada, the Residential Director and Clinical Director will complete a new safety	V 314		

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V 314	Continued From page 27 contract and boundary plan with the student prior to her re-entry to Cummings Cottage. The Residential Director and Chief Operating Officer will evaluate and determine necessary staffing patterns to provide increased supervision and monitoring to prevent behaviors that might be injurious to the student or others. This student's needs, treatment and transition planning will be a priority throughout the action steps detailed below. -A strategic intervention and crisis planning training will provided to the Cottage Supervisors and Clinicians during the Residential Leadership Meeting on Tuesday, 12/11/18. This will include clear directives on how to engage the cottage treatment team in identifying individualized intervention strategies and therapeutic support for each student during the weekly team supervision meetings; thorough and descriptive documentation of these strategies on both the Treatment Team Minutes and individual student Clinical Case Reviews. -The students identified in this survey (3) have been reviewed through the process of a Clinical Case Review. This has been documented on Eliada's revised Clinical Case Review document, which now has an embedded Individual Crisis Management Plan/Strategies for the Comprehensive Crisis Plan. The Clinical Director will lead a review of these plans with all Cummings Cottage staff during the Treatment Team Meeting on Wednesday, 12/12/18, using the revised the Clinical Case Review process and documentation, which now has an embedded Individual Crisis Management Plan/Strategies for the Comprehensive Crisis Plan. This plan includes student-specific details for: a. Pre-Crisis: What is the student's baseline? What does it look like when the student is doing well?	V 314		

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V 314	Continued From page 28 b. Triggering: (events and early signs that student is not doing well) c. Prevention and Early Intervention Strategies: (Engagement and calming strategies: what works well, doesn't work well) d. Escalation and Outburst: (strategies for crisis response and stabilization) e. Recovery: (specific needs or supports after crisis) -The developed intervention strategies for each student will be communicated by the residential staff through the Cottage Update emails that are completed daily at the end of each shift. -The Clinician will review the individualized strategies developed by the treatment team with the Child and Family Team. Each student's progress, needs and intervention strategies will be included in the monthly Person-Centered Plan updates and the corresponding Comprehensive Crisis Plan. -Cummings Residential Counselors will facilitate one psycho-educational group with the students daily, beginning on Tuesday, 12/11/18. Staff have been provided with manualized group therapy workbooks and will address topics related to self-esteem, positive decision-making, managing emotions, resisting peer influences and coping strategies. The daily group topic and therapeutic activities will be detailed in each students progress note. Group topics completed will be selected during each weekly Treatment Team Meeting, then reviewed and documented on the minutes for the following week. -Eliada's PQI (Performance/Quality Improvement) Director will revise the critical incidents reporting procedures and send out an email communication with the procedures by 12/24/18. This will include clear guidance on when to file police reports and the designated Eliada	V 314		

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V 314	Continued From page 29 personnel responsible." Describe your plans to make sure the above happens: "-The intervention training, conducted on 12/11/18, will be documented in the Residential Leadership Meeting Minutes. -**The Clinical Director will facilitate the Clinical Case Reviews with the Cummings Treatment Team on 12/12/18. The Clinical Director will document all updates to the Clinical Case Reviews and will share with the team. The Cottage Supervisor will provide coaching to direct care staff for implementation and will review each shift update email to ensure that the individualized intervention strategies are included for each student. -A therapeutic group weekly schedule will be maintained for the cottage. The schedule will be developed by the Cottage Supervisor during the weekly Residential Leadership Meeting. The group facilitation will be monitored at least one time per week by the Residential Director." Client #1 had a history of sexual trauma, and suspected physical and verbal abuse. Just prior to her placement in the PRTF she was hospitalized twice for depression, self-harm, and suicidal behavior. The facility failed to have a system in place to meet the complex treatment needs and manage the behaviors of Client #1. She was admitted initially to the locked PRTF with the knowledge of her extensive cutting behaviors, suicidal attempts, and runaway attempts. Her treatment goals and strategies upon admission failed to address her self-injurious behavior. When targeted and bullied by another client she was moved into an unlocked PRTF to ensure her safety. Following the transition to the new cottage, her self-harm and elopement behaviors	V 314		

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V 314	Continued From page 30 began to escalate. The facility failed to develop goals or strategies in her treatment plan at the time of this transition or as the behaviors continued to increase. Client #1 engaged in self-harm to include scratching, cutting and head banging 11 times. There were some days when the self-harm occurred more than once. There were 11 incidents of verbal and/or physical aggression to peers, staff, and one teacher. Client #1 eloped on 2 dates, one of which resulted in an involuntary commitment when she was running into traffic on a busy road. When she eloped the second time she ran from staff across traffic and ultimately into an area out of their sight. This incident ended when Client #1 reported an alleged rape by a stranger in the community. Failure to design services to meet the therapeutic needs of Client #1 constitute a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $1500.00 is imposed. If the violation if not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 314		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY AAND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where	V 367		

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V 367	Continued From page 31 services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A	V 367		

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V 367	Continued From page 32 providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure Level III incidents were reported to the Local Management Entity (LME) within 72 hours of becoming aware of the incident effecting 1 of 3 audited clients (#1). The findings are:	V 367		

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V 367	Continued From page 33 Review on 11/28/18 of incident reports for 10/2018-12/2018 for Client #1 revealed: -Level II incident report completed on 12/4/18 indicated " ...Staff redirected [Client #1] for targeting a peer ...she began to scream and posture at this peer ...got up and exited the cottage ...she approached the road ...transitioned to a standing restraint ...staff released the restraint when a staff member was hurt. Staff continued to follow [Client #1] and lost eye sight of her briefly when she darted across the road in to [drug store]. Staff re-gained eyesight of [Client #1] once entering [drug store]. Staff kept distant proximity when she yelled at staff to keep their distance. Staff lost eyesight of [Client #1] again briefly when she ran out of [drug store]. Staff re-gained eyesight ...Staff followed [Client #1] until [restaurant] before losing eyesight as she ran across the highway towards [liquor store]. Staff attempted to search for her within the area she was last sighted. Staff returned to campus and filed missing persons report. Staff returned [Client #1] to the cottage a few minutes later ..." -No level II incident report completed when Client #1 reported that she was allegedly raped by a stranger in the community. Review on 11/28/18 of the Nursing notes from 10/1/18-12/4/18 for Client #1 revealed: -12/4/18 "Student asked to have nursing check in with her when I arrived at the cottage to see another ...I checked in with [Client #1] at approx. 2:45pm. During this conversation, she stated that she ran from campus earlier today and went to CVS. She stated that while in CVS a man approached her and asked her if she was okay and asked her to step outside. [Client #1] stated that Eliada staff came at that time and she left CVS with Eliada staff. [Client #1] then stated that once she left the CVS she ran from staff and into	V 367		

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V 367	Continued From page 34 a forest. She states that the man from the store followed her and raped her in the forest ..." Interview on 12/13/18 with the Director of Performance/Quality Improvement revealed: -No IRIS (Incident Response Improvement System) report submitted for the allegation of rape only the events leading up to that which included an elopement and restrictive intervention. -Client #1 kept changing details of what allegedly occurred. -She indicated that the Program Supervisor should have submitted the report but most likely was not directed to do so.	V 367		