STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-219	A. BUILDING: _____ B. WING _____	R-C 02/05/2019

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INSPIRATIONZ	607 HILLHAVEN DRIVE WINSTON-SALEM, NC 27107

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 2/5/2019. The complaint was substantiated (intake #NC147687). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children and Adolescents. A sister facility is identified in this report. The sister facility will be identified as sister facility A. Staff and/or clients will be identified using the letter of the facility and a numerical identifier.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need;	V 105		

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V 105	Continued From page 1 (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure client records were accessible to authorized users at all times. The findings are: Review on 2/1/2019 of the facility's "Records of the Person Served" policy revealed: - "It is the policy of Inspirationz, LLC to develop and maintain a complete and accurate record to ensure that all appropriate individuals have access to relevant clinical and other information regarding each person served ... - Individual records will be maintained at the home office. - All records will be maintained in a systematic fashion that follows a standard format for record organization established by Inspirationz, LLC ... - All information in the record will be current and complete ... - All program staff will be trained and authorized to document in the client's record ... - To ensure that records are maintained in a uniform manner, are secure, and are available to support continuity of care, the following guidelines apply: ... - Records are available for scheduled appointments, for documentation purposes, and for reviews upon request ..." Reviews from 1/25/2019 to 2/5/2019 of client #1's record revealed: - Admission date: 11/25/2018 - Diagnoses: Attention Deficit-Hyperactivity Disorder (ADHD); Adjustment Disorder with mixed disturbance of emotions and conduct; and	V 105		

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V 105	Continued From page 3 Borderline Intellectual Functioning; - Age: 12 - An unsigned, undated Screening/Intake form revealed client #1 was in middle school, needed medication management, an updated IEP (Individual Education Plan), testing for speech and vision, family and individual therapy; had a history of stress, anxiety, panic attacks; trauma, had been bullied because of her speech impairment, allegations of sexual abuse perpetrated by her father, "beating" her mother, severely strained familial relationships, was very manipulative, took no ownership for actions and had oppositional behavior; - The treatment plan was requested on 1/24/2019, but the crisis plan component only was provided on 1/25/2019; - The complete treatment plan was not available for review until 1/31/2019; - The treatment plan was originally dated 11/8/2018, with review dates of 12/16/2018 and 1/9/2019 and revealed: - "[Client #1] is very disrespectful and challenges staff with direction and causing conflict among peers and adults; She is very manipulative and was recently suspended for two days for fighting ... is picked on because of her speech impairment ..." - Goals: 1) will learn to manage ADHD symptoms, demonstrating marked improvements in impulse control ... 2) will consistently comply with rules and expectations in the home, school and community; and 3) will strengthen existing activities of daily living and develop independence with new activities of daily living; - No progress notes were available for review. Reviews from 1/24/2019 to 2/5/2019 of former client (FC) #2's record revealed: - Admission date: 8/31/2018	V 105		

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V 105	Continued From page 4 - Discharge date: 1/18/2019 - Diagnoses: Major Depressive Disorder; Post Traumatic Stress Disorder (PTSD); Generalized Anxiety Disorder; and Personal History of physical and sexual abuse in childhood; - Age: 17 - A Screening/Intake dated "8/2018" and signed by the Qualified Professional/Contracts Director (QP/CD) revealed a history of running away, cocaine, marijuana and opioid use, had a sister in the same city as the facility, family abuse, suspected molestation by step-father, and previous worker at another facility, and need for family therapy/reunification, individual therapy and medication management; - The treatment plan for FC #2 was requested on 1/24/2019, but was not available for review until 2/1/2019: - The treatment plan was originally dated 8/29/2018, with review dates of 9/19/2018 and 10/19/2018 for goals #1-4; and the addition/review of goals #5-7 on 10/19/2018 & 12/19/2018 and revealed: - A history of conflicts with peers, can be easily triggered, suspension from after school program, physical altercations with peers, communicating threats, unspecified "sexualized behaviors", very manipulative, lack of honesty, and lack of impulse control; - Progress notes related to incidents between 12/25/2018 to 12/27/2018 were requested on 1/24/2019, but were not available for review until 2/5/2019. Reviews from 1/25/2019 to 2/5/2019 of FC #3's record revealed: - Admission date: 4/18/2018 - Discharge date: 1/22/2019 - Diagnoses: Major Depressive Disorder, Recurrent Episode, Severe; and Oppositional	V 105		

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V 105	Continued From page 5 Defiant Disorder - Age: 13 - A Screening/Intake dated "03/18" and signed by the QP/CD revealed a history of depression/adjustment problems, stress/anxiety/panic attacks, and removal from the home of her mother due to neglect; - A request for FC #3's treatment plan was made on 1/24/2019; - The first copy of a treatment plan provided was provided on 1/31/2019 and was completed on 1/30/2019 for a different residential provider; - A second copy of FC #3's treatment plan provided on 2/5/2019 listed an original date of 2/20/2018, with the most recent review date of 10/15/2018 and revealed: - Behavioral issues including property destruction, attempting to destroy her 3rd cast (the reason for the cast was not specified), hitting a staff in the face, stealing butter knives and scratching her cast, cursing and threatening others, is hard to calm down when upset, lying about situations that lead up to her behaviors; challenging authority, disrespectfulness, causing conflict with peers, walking out of the home, throwing things, and tantrums; - Progress notes related to incidents between 12/25/2018 to 12/27/2018 were requested on 1/24/2019, but were not available for review until 2/5/2019. Requests for access to clients #1, FC #2 and FC #3's complete records were made throughout the course of the survey. Only paper records were available via fax or copies provided in person by the Qualified Professional/Contracts Director (QP/CD). The electronic client records were not available for review. Interview on 2/1/2019 with Associate Professional	V 105		

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V 105	Continued From page 6 (AP) #1 revealed: - Documentation in client records was done through an electronic record system; - The QP/CD was the person responsible for resolving any issues with the system; - In order to access clients' electronic record information, a copy of relevant files were stored on an on-line "Drive" and printouts were kept in binders for immediate access; - If facility staff were unable to log in to the electronic system to complete progress notes, they could write them out and the independent contract staff could scan them in. Interviews from 1/24/2019 to 2/5/2019 with the QP/CD revealed: - The facility utilized an internet-based electronic medical record system for client records that was backed up by an on-site server; - Facility staff had to log into the facility's system to enter client record information; - The system had been damaged during a storm in October of 2018 when the carpet near the server got wet and caused an electrical short in the server; - In order to prevent the loss of data, the client information on the server was merged into multiple years' worth of information stored together; - In order to locate specific information, such as progress notes for specific dates, an independent contract staff had to do "data mining" to pull each note individually; - The independent contract staff had to "data mine" the facility's system to locate specific progress notes for clients, but it was a lengthy process and would take multiple days; - The facility's camera surveillance system's alarm panels also backed up to the server and were not working correctly, either;	V 105		

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V 105	Continued From page 7 - Some documents in the clients' records, such as Child and Family Team (CFT) meeting notes, assessments and treatment plans, could be accessed through different electronic systems that were connected to the Local Management Entities/Managed Care Organizations' (LME/MCO's) authorization systems; - The LME/MCO's that the facility contracted with did not all utilize the same electronic system; - The QP/CD had attempted to securely fax client record information to the Division of Health Service Regulation (DHSR) as it was compiled, but had problems getting all of the faxes to send; - In order to provide access to clients' treatment plans and emergency information, facility staff had access to binders with that type of information printed out. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 105		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and	V 118		

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V 118	Continued From page 8 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 reviews and interviews, the facility failed to ensure MARs were kept up to date, the MAR included the time the drug was administered, and medications were administered as ordered by an authorized person affecting 1 of 1 audited current client (#1) and 2 of 2 former clients (FC) (FC #2 & FC #3). The findings are: (The facility was cited for a standard level deficiency for medication administration on 11/6/2018. The 60-day correction period for that citation ended on 1/11/2019.) Reviews from 1/25/2019 to 2/5/2019 of client #1's record revealed: - Admission date: 11/25/2018 - Diagnoses: Attention Deficit-Hyperactivity Disorder (ADHD); Adjustment Disorder with	V 118		

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V 118	Continued From page 9 mixed disturbance of emotions and conduct; and Borderline Intellectual Functioning; - Age: 12 - Physicians orders for the following medications: - Lamotrigine (used to treat seizures or mood disorders) 25 milligrams (mg), 1 tablet twice daily (BID), dated 1/22/2019; - Topiramate (used to treat seizures or to prevent headaches) 100 mg, 1 tablet BID, dated 1/22/2019; - Vyvanse (used to treat ADHD) 30 mg, 1 tablet every day (QD), dated 1/22/2019; - Escitalopram (Lexapro) (used to treat depression and generalized anxiety disorder) 20 mg, 1 tablet every morning (QAM), dated 1/22/2019. Review on 2/5/2019 of client #1's MARs dated 1/23/2019 to 2/5/2019 revealed: - The month, but not the year was listed on the MARs; - Other than "AM" or "PM" printed above the day of the month, no administration times were noted for any of the medications; - One of the AM medication columns did not include the name of the medication or dosage, rather, the only information was "tablet take 1 by mouth every morning"; - Escitalopram was not listed on the AM MAR. Reviews from 1/24/2019 to 2/5/2019 of FC #2's record revealed: - Admission date: 8/31/2018 - Discharge date: 1/18/2019 - Diagnoses: Major Depressive Disorder; Post Traumatic Stress Disorder (PTSD); Generalized Anxiety Disorder; and Personal History of physical and sexual abuse in childhood; - Age: 17 - Physicians orders for the following medications:	V 118		

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V 118	Continued From page 10 - Polyethylene glycol (Miralax) (used to treat constipation) 17 grams (gm) in 8 ounces (oz.) water or juice QD, dated 8/28/2018; - Patanase (Patanax) (used to treat allergic rhinitis) nasal spray 665 micrograms (mcg), 2 sprays in each nostril BID, dated 8/28/2018, with no discontinuation order present; - Lactaid (enzyme that breaks down lactose) 3,000 IU (international units), 1 tablet three times daily (TID) with meals, dated 8/28/2018; - Omeprazole DR (used to treat stomach conditions) 20 mg, 1 tablet QD, dated 10/4/2018; - Buspar (buspirone hydrochloride (HCL)) (used to treat anxiety disorders, and sometimes premenstrual syndrome) 10 mg, 2 tablet three times daily (TID), dated 10/10/2018, with no discontinuation orders; and - Seroquel (quetiapine fumarate) (atypical antipsychotic used to treat schizophrenia or depression and mania in people with Bipolar Disorder) 400 mg, 1 tablet every night at bedtime (QHS), dated 10/10/2018, with no discontinuation order present. Review on 1/31/2019 of FC #2's MARs dated 1/11/2019 to 1/18/2019 revealed: - The month, but not the year was listed on the MARs; - Other than "AM" or "PM" printed above the day of the month, no administration times were noted for any of the medications; - Polyethylene glycol was listed on the MAR, but there was no documentation that it had been administered; - Patanase was listed on the MAR, but there was no documentation that it had been administered; - Buspar and Seroquel were not listed on the MARs and there was no documentation that they had been administered.	V 118		

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V 118	Continued From page 11 Reviews from 1/25/2019 to 2/5/2019 of FC #3's record revealed: - Admission date: 4/18/2018 - Discharge date: 1/22/2019 - Diagnoses: Major Depressive Disorder, Recurrent Episode, Severe; and Oppositional Defiant Disorder - Age: 13 - Physician's orders for the following medications: - Sertraline (Zoloft) (Used to treat depression, obsessive-compulsive disorder, panic attacks, PTSD, and social anxiety disorder) 25 mg, 1 tablet QAM, dated 8/15/2018, with no discontinuation order; - Aripiprazole (Abilify) (atypical antipsychotic used to treat schizophrenia or depression and mania in people with bipolar disorder, autistic disorder, and Tourette's disorder) 15 mg, 1 tablet QAM, dated 8/15/2018, with no discontinuation order; - Vyvanse (used to treat ADHD) 40 mg, 1 tablet QAM, dated 1/8/2019; - Lexapro (used to treat depression and generalized anxiety disorder) 20 mg, 1 tablet QAM, dated 1/8/2019; - Trazodone (used to treat depression) 50 mg, 1 ½ (=75 mg) tablets every night (QPM), dated 1/8/2019; and - Clonidine (Catapres) (used in combination with other medications to treat ADHD) 0.1 mg, 1 tablet QPM, dated 1/8/2019; Review on 1/31/2019 of FC #3's MARs dated 1/11/2019 to 1/22/2019 revealed: - The month, but not the year was listed on the MARs; - Other than "AM" or "Bedtime" printed above the day of the month, no administration times were noted for any of the medications;	V 118		

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V 118	Continued From page 12 - Sertraline and Aripiprazole were noted as "Discontinued" on the MAR, with no documentation that they were administration from 1/11/2019 until discharge on 1/22/2019; - The clonidine dosage was listed as changed from the ordered 0.2 mg to 0.1 mg on 1/8/2019 and documented as having been administered at the lower dose from 1/11/2019 until discharge on 1/22/2019. Interview on 1/31/2019 with client #1 revealed: - She took her morning medications after she finished her chores, and her evening medications at the Office if they were there around 7:00PM or at the facility around 8:00PM. Interview on 1/25/2019 with FC #2 revealed: - She had met with her physician on at least three occasions for medication management visits; - She was supposed to be taking Seroquel, but facility staff told her that her doctor had discontinued it; - Her Guardian had talked to FC #2's physician about the Seroquel, and the physician said he had not changed the medication; - " ... When they (facility staff) stopped giving me my Seroquel, that's when I put my hands on people ..." Interviews on 1/18/2019, 1/24/2019 and 1/25/2019 with FC #2's Guardian revealed: - FC #2 had told the Guardian that she was not getting her Seroquel; - The Pharmacy told the Guardian that the last time they had filled the Seroquel was on 11/15/2018; - The Qualified Professional/Contracts Director (QP/CD) told the Guardian that FC #2's doctor had stopped the Seroquel and ordered a different medication, Prazosin, which was for nightmares;	V 118		

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V 118	Continued From page 13 - The Guardian did not believe that FC #2 had been administered her Buspar because she still had 2 bubble pack cards worth of Buspar that had been filled in December, which should not have had that much left if she was taking it as ordered. Attempts were made on 1/31/2019 and 2/1/2019 to reach FC #3's Guardian and messages were left requesting a return call in order to coordinate interviews with FC #3 and the Guardian. No interviews were completed due to inability to reach the Guardian before the time of exit. Interview on 1/25/2019 with the Pharmacist revealed: - The pharmacy began supplying medications to the facility approximately 3-4 months ago; - FC #2's Seroquel was not refilled in December of 2018 because Medicaid required "safety documentation" from the prescriber before they would allow it to be refilled. Interview on 2/4/2019 with staff #1 revealed: - The facility was going to have a Registered Nurse (RN) start reviewing MARs next week. Interview on 2/1/2019 with Associate Professional (AP) #1 revealed: - The Qualified Professional/Contracts Director (QP/CD) was the person who made sure medications refills were obtained and reviewed MARs for accuracy; - Since she did not have the actual MARs in front of her, she could not answer questions about specific clients' medications. Interview on 1/23/2019 with the QP/CD revealed: - Staff #1 was responsible for ensuring MARs were accurate; - She would be writing up staff #1 due to the MAR	V 118		

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V 118	Continued From page 14 inaccuracies; - The MAR errors should have been corrected following the facility having been cited for medication administration issues on 11/6/2018; - An outside RN would begin reviewing the medication orders and MARs on Sundays in order to correct them. This deficiency constitutes a recited deficiency. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 118		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments.	V 120		

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V 120	Continued From page 15 This Rule is not met as evidenced by: Based on record reviews, observation, and interviews, the facility failed to store medications in a securely locked cabinet in a clean, well-lighted, ventilated room between 59° and 86° Fahrenheit (F) affecting 1 of 1 audited current client (#1). The findings are: Reviews from 1/25/2019 to 2/5/2019 of client #1's record revealed: - Admission date: 11/25/2018 - Diagnoses: Attention Deficit-Hyperactivity Disorder (ADHD); Adjustment Disorder with mixed disturbance of emotions and conduct; and Borderline Intellectual Functioning; - Age: 12 - Physicians orders for the following medications: - Lamotrigine 25 milligrams (mg), 1 tablet twice daily (BID), dated 1/22/2019; - Topiramate 100 mg, 1 tablet BID, dated 1/22/2019; - Vyvanse 30 mg, 1 tablet every day (QD), dated 1/22/2019; - Escitalopram (Lexapro) 20 mg, 1 tablet every morning (QAM), dated 1/22/2019. Observation at approximately 11:00AM on 2/5/2019 revealed: - Client #1's medications were stored in a soft-sided, zippered lunch box. Interview on 2/5/2019 with the Qualified Professional/Contracts Director (QP/CD) revealed: - Medications were transported in the trunks of facility staffs' vehicles when clients were out of the facility; - After clients got out of school, they went directly	V 120		

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V 120	Continued From page 16 to the Licensee's office for group therapy and other activities; - The medications were sometimes administered at the office, therefore, facility staff needed to keep the medications with them instead of stored at the facility; - She would purchase a new, lockable filing cabinet to place in a locked closet in order to store medications securely at the facility. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 120		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a	V 293		

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V 293	Continued From page 17 community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide intensive, active therapeutic services that included individualized supervision, minimized the occurrence of behaviors related to functional deficits, ensured safety, de-escalated out of control behaviors, and coordinated with other individuals and agencies within the adolescent's system of care affecting 1	V 293		

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V 293	Continued From page 18 of 1 audited current client (#1) and 2 of 2 former clients (FC) (FC#2 & FC#3). The findings are: Cross Reference: 10A NCAC 27G .0201 Governing Body Policies (V105). Based on record reviews and interviews, the facility failed to ensure client records were accessible to authorized uses at all times. Cross Reference: 10A NCAC 27G .0209 Medication Requirements (V118). Based on record reviews and interviews, the facility failed to ensure MARs were kept up to date, the MAR included the time the drug was administered, and medications were administered as ordered by an authorized person affecting 1 of 1 audited current client (#1) and 2 of 2 former clients (FC) (FC #2 & FC #3). Cross Reference: 10A NCAC 27G .0209 Medication Requirements (V120). Based on record reviews, observation, and interviews, the facility failed to store medications in a securely locked cabinet in a clean, well-lighted, ventilated room between 59° and 86° Fahrenheit (F) affecting 1 of 1 audited current client (#1). Cross Reference: 10A NCAC 27G .1702 Requirements of Qualified Professionals (V294). Based on record reviews and interviews, the facility failed to ensure that a qualified professional (QP) performed clinical and administrative responsibilities a minimum of 10 hours weekly, 70% of which time was when children and adolescents were awake and present in the facility. Cross Reference: 10A NCAC 27G .1703 Requirements for Associate Professionals	V 293		

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V 293	Continued From page 19 (V295). Based on record reviews and interviews, the facility failed to ensure that at least one full-time associate professional (AP) performed the responsibilities required by rule and policy. Cross Reference: 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367). Based on record reviews and interviews, the facility failed to report all level II incidents to the LME responsible for the catchment area within 72 hours of becoming aware of the incident. Interview on 1/31/2019 with client #1 revealed: - The amount of time clients were actually at the facility was limited; - She was picked up from school by facility staff at 2:00PM, and taken directly to the Licensee's Office to do homework and have groups; - Clients usually watched a movie, wrote a "group paper", and ate dinner at the Office; - " ... We stay there 'til 8 (PM) ..." - When clients arrived back at the facility, they took showers, and then went to bed; - Visits with her family only occurred at a Therapist's office in another city on Saturdays; - She had not been allowed to go on any home visits yet, but knew that families were allowed to pick clients up from the office for home visits; - She was supposed to be getting speech therapy, but that had not started yet; - She took her evening medications at the Office if they were there around 7:00PM or at the facility around 8:00PM; - The Police had not been to the facility that she was aware of. Interview on 1/25/2019 with client #1's Mother revealed: - "They (facility staff) won't tell me where she's at	V 293		

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V 293	Continued From page 20 ...When we have our visits, we don't meet at the group home ..." - The family was supposed to have a visit with client #1 during Christmas, but "She was disrespecting staff ... They waited 'til the day before and I had to ask before they told me we couldn't visit on Christmas Day ..." - The family was not allowed to visit client during Christmas; - Facility staff were supposed to coordinate with client #1's Mother regarding her medication management visits, but she was not called; - The Mother did not know if client #1's medications had been changed; - " ... They told me about the appointment the day of. She (the QP/CD) told me she (client #1) has her appointment today and be available ... I waited all day and no one called ... I messaged her at 4 o'clock ..." - Client #1 had a second part of the appointment scheduled for the next day, but the Mother was never called about that one, either; - Another concern client #1's Mother had was that client #1 should have been set up with speech therapy, but the facility never made those arrangements; - " ... I told [the QP/CD] she (client #1) had to have speech therapy in school and out of school ... I gave her the piece of paperwork for [the speech therapy agency that client #1 used to receive services from]. She told me she would get her in a program ... [Client #1] says she's not getting any speech anywhere ...." - " ... We only get to meet with her at the office. They won't tell us what house she is at ..." - " ... When they don't tell me what's going on, I worry ..." - " ... [Client #1's stepfather] says he worries because they won't tell us where she's at ..."	V 293		

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V 293	Continued From page 21 Interviews on 1/18/2019, 1/24/2019 and 1/25/2019 with FC #2's Guardian revealed: - FC #2 had been admitted to the facility on 8/31/2018; - The Guardian had been told by facility staff that FC #2 remained at the facility, but found out from FC #2 in January of 2019 that she had been moved to the level 2 sister facility A; - When she asked FC #2 about why she did not discuss the move with the Guardian, FC #2 told her that the QP/CD had telephone calls to the Guardian on speaker phone and told FC #2 not to tell the Guardian information; - " ... [FC #2] didn't say anything because she was scared ..." - The Guardian had obtained Police reports for 11/16/2018, 12/4/2018, and 12/27/2018 that listed FC #2's residence as the level 2 sister facility A instead of the level 3 facility; - "We never talked about her moving to the other home ..." - The Guardian had only attended CTF meetings at the Licensee's office, and had not visited the facility itself; - Billing invoices submitted by the Licensee to the Guardianship agency listed the facility address that services were provide at as the address for sister facility B; - The Guardian also had concerns that FC #2's medical and dental appointments had not been coordinated as they should have been, and that FC #2 had missed scheduled dental appointments on two occasions. Attempts were made on 1/31/2019 and 2/1/2019 to reach FC #3's Guardian and messages were left requesting a return call in order to coordinate interviews with FC #3 and the Guardian. No interviews were completed due to inability to reach the Guardian before the time of exit.	V 293		

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V 293	Continued From page 22 Interview on 2/4/2019 with staff #1 revealed: - Staff #1 worked at both the level 2 sister facility A and the level 3 facility; - Regarding the Police-involved incident on 12/25/2018, " ... There was no fight... We were giving back to the homeless ... We had went do the event at the shelter and then after that one of the kids said there was going to be Christmas caroling on [a local street] ... On [the local street] the old van broke down and we had to give it a jump... And then [FC #3]'s nose started bleeding... She had a cold ... She started asking about going to see her mother ... She got mad and walked by and knocked the stuff off the stand ... She walked up the street ... [Staff #A-2] called the police..." - On 12/26/2018, FC #3 again got upset about her mother and broke a table that was outside of sister facility A, was "ranting and raving", and pushed a neighbor's mailbox; - FC #3 "got it together", then left the facility with staff; - The reason that clients from the facility were at sister facility A was because they were gathering to go into the community to do a "community giving back to the homeless" activity together; - FC #3 did not hit staff #A-2; - On 12/27/2018, client #A-4 had been talking about a fight she had gotten into with FC #2 at a facility they were at together prior to their admissions to Licensee facilities; - Clients from the Licensee's sister facilities were together at the office 2-3 days a week for group therapy; - Clients from sister facilities arrived at the office around 5:00PM and left around 7:00PM; - "We do everything as a whole to give back to the clients and for support as well ..." - FC #2 never resided at sister facility A.	V 293		

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V 293	Continued From page 23 Interview on 1/25/2019 with staff #A-2 revealed: - Staff #A-2 worked on varying shifts at the facility; - On 12/25/2018, " ... We (the facility and sister facility A) got together to go give Christmas cards to the homeless ... One of the clients (FC #3), she was waiting in the car and she started to act out ...I called the police because she was acting out ... We called them to calm her down ... [The QP/CD] and the staff from [the facility] were out there with her... They were waiting out there so we could go together ..." - " ... The next day (12/26/2018), we were dealing with the same girl (FC #3) ... This time she was hitting the van ... we called the police. We were getting together to go back out... It was around the time we were giving out Christmas cards ... We went and picked up trash at the park ..." - Staff #A-2 did not remember the time of the incident on 12/26/2018; - On 12/27/2018, client #A-4 walked away from the facility after getting angry about not being able to go home for the holiday; - The Police were called; - The QP/CD, along with one other staff came to the facility with FC #2 and FC #3 after they finished at a medication management appointment to assist; - " ... They (facility clients) don't come over to the (sister facility A) house... They were only over there to meet up... It wasn't even a time where they went in ...They never spent the night there ..." Interview on 2/4/2019 with FS #A-3 revealed: - On 11/16/2018, FC #2 had been at sister facility A because staff from the facility was bringing medications that FS #A-3 had left at the office earlier that evening;	V 293		

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V 293	Continued From page 24 - FC #2 began running around houses in the neighborhood and was in and out of sight of facility staff; - The Police were called when FC #2 got out of sight; - The QP/CD was on site the entire time; - FC #2 had not been inside of the facility that day; - The QP/CD had left, but returned to the facility when the Police brought FC #2 back; - FC #2 gave false information to the Police; - When asked how often clients from the facility went to sister facility A, FS #A-3 stated: "They don't at all. The only time we see them is if they are doing group... That's the only time they come together..." - The only time clients from sister facilities were together at the Office was when they were having group therapy two days a week; - FC #2 had never stayed at sister facility A. Interview on 2/1/2019 with Associate Professional (AP) #1 revealed: - She worked at both the level 3 facility and the level 2 sister facility A, but was the acting AP at the level 2 sister facility A; - The QP/CD was the primary staff who coordinated with families and Guardians; - AP #1 was sick with strep throat and requested to cut the interview short to go to an appointment; - AP #1 did not call the Surveyor back later on 2/1/2018 as planned, and did not answer her phone when called on 2/5/2019. Interview on 2/5/2019 with AP #2 revealed: - On 11/16/2018, FC #2 was in the van at sister facility A, got out of the van, and began running around the yard; - The reason facility staff and clients were at sister facility A was because they were delivering	V 293		

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medications to the facility that had been left at the Office, and there had been issues with the group home van;
- Clients from the sister facilities did not gather at the office often: " ... It's a meet up location. If there is an outing planned."
- Clients may be at the office from 4 pm until 6 pm, but no later than 7 pm;
- On 12/25/2018, all of the clients got together to "give back to the community."
- The activity was a "random event," and was not coordinated with the homeless shelter;
- Staff were very familiar with the surrounding community centers and shelters, and took clients from the sister facilities out to give Christmas cards to homeless individuals there;
- Staff and the clients felt safe doing the activity;
- Facility staff and clients followed the sister facility A van back to sister facility A because their van was having problems;
- AP #2 did not recall FC #2 and FC #3 getting into a fight;
- FC #3 had "random" nosebleeds;
- On 12/26/2018, all AP #2 knew was that FC #3 broke a table outside of sister facility A, but knew no other details;
- AP #2 could not recall any details about the incident on 12/27/2018.

Interviews from 1/23/2019 to 2/5/2019 with the QP/CD revealed:
- On 11/16/2018, the QP/CD, AP #2 and staff #1 were working at the facility;
- The reason that the staff and clients were at sister facility A was because FS #A-3 had left the sister facility A clients' medications at the office, and the facility staff were dropping them off in order to provide support to FS #A-3;
- After the clients from the facility finished their showers at their own facility, the medications

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were picked up at the office and taken to sister facility A;
- FC #2 was not showing oppositional behavior, rather, she stepped out of the car and began walking through the yards and between houses in the neighborhood;
- FC #2 behaved in this manner for approximately 45 minutes;
- 911 was called when FC #2 got out of eyesight of staff;
- The Police brought a dog to help in the search for FC #2;
- When the Police called to inform the QP/CD that FC #2 had been found, the QP/CD returned to sister facility A;
- On 12/25/2018, clients from the facility were at sister facility A following a community service activity in which they gave Christmas cards, fruit and other items to homeless individuals at a nearby shelter;
- The activity was not organized in consultation with the shelter, but was one in which the facility went to the shelter and started giving out Christmas cards and other items on its own;
- Facility staff were very familiar with homeless individuals in the community and clients were safe during the activities;
- FC #3 was feeling depressed because it was Christmas and she was not with her family;
- FC #3 walked away from the facility;
- The QP/CD was not aware of any assault that happened between FC #2 and FC #3;
- FC #3 had a history of nosebleeds, and that is why EMS was called;
- On 12/26/2018, clients from the facility were at sister facility A to meet together to do another community activity;
- FC #3 was upset because she wanted to see her mother;
- FC #3 destroyed property at sister facility A,

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V 293	Continued From page 27 "bumped up" against staff #A-2, then walked away from the facility; - On 12/27/2018, client #A-4 walked away from the facility, and the Police were called when she got out of eyesight; - Client #A-4 had told the Police about an incident that had happened with FC #2 prior to their admission to Inspirationz facilities; - Clients #A-4 and FC #2 had not gotten into a fight since their admissions to the sister facilities; - Clients from sister facilities met at the office for group therapy and to provide for their educational needs; - Each group of clients had their own room and staff while at the office; - The clients from each sister facility attended therapy sessions in a neighboring city, and met at the office for transport to the sessions; - Clients from each facility were not combined with clients from sister facilities during transport; - Tuesdays, Thursdays and Saturdays were therapy days; - On Mondays, Wednesdays and Fridays, clients in middle school were picked up and arrived at the office around 3:00PM: - Clients in high school and who were 17 or 18 years old were involved in an independent living program that met at the office; - By the time the high school clients arrived at the office around 4:45PM, their evening meal had been prepared for them there; - Facility staff tried to leave the office by 6:00PM; - It was easier to have all the clients meet at the office and then disperse the clients to their individual homes following school on weekdays; - FC #2 had never been moved to the level 2 sister facility A from the level 3 facility; - FC #2 had made up false allegations about where she was staying; - FC #2 had said she was in a fight on	V 293		

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V 293	Continued From page 28 12/27/2018, but could not have been because she was at a medication management appointment; - There were not any problems with coordination of care between the facility and others involved in clients' care. Review on 2/5/2019 of the Plan of Protection written by the QP/CD and dated 2/5/2019 revealed: - What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? - Describe your plans to make sure the above happens. - "Quality Assurance and QP (Qualified Professional) will follow up to assure all components are being met. - Medication Administration Record-Inspirationz will assure that all components of the record are present and will implement writing the time on the current record that the medication has been administered effectively immediately. Inspirationz has identified Nurse, [Nurse's name] to come in weekly to review the records for accuracy as they relate to administration of the med according to the order. - Inspirationz LLC will immediately purchase a working file cabinet today to assure medications are stored properly in the medication closet to assure medications are locked and secure. Unless there is a need to transport medications, medications will remain on site. - All incidents as of right now will be immediately reported in IRIS (Incident Response Improvement System) that involve Police or emergency personnel by staff/QP reviewed by agency LPC (Licensed Professional Counselor) to assure all components are met. The agency will have an immediate staff meeting/training 6/6/19 to	V 293		

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implement the current plan of action.
- Inspirationz will implement immediately a leger to identify duties of the QP provide that will include date, time and purpose to assure duties are trackable and identified as to when completed with purpose.
- The AP will document daily duties performed on staff checklist to indicate date and time and duties performed effective today 2/5/19. AP duties will be distinguished from QP duties to determine the roles of each daily checklist and duties."

This facility is a residential staff secure treatment facility which serves clients requiring continuous supervision, behavioral interventions and a high level of support to meet their needs. Clients audited were ages 12, 13 and 17 with histories significant for property destruction, oppositional behavior, running away, physical altercations with peers, communicating threats, unspecified sexualized behaviors and lack of impulse control. Due to a reported electrical surge in October 2018, client and facility records were very difficult to access by both administrative staff and surveyors. This brought into question facility records being readily available to staff for service documentation and reporting.
Issues continued (from the Nov. 2018 survey) with the medication administration records system. MARs lacked documentation that 16 different medications were actually given and did not have administration times or dates. This made it difficult to determine if clients were receiving medications used to treat disorders such as PTSD, ADHD, ODD, anxiety, mania and depression. Also, medications were frequently transported in the trunks of staff vehicles rather than being securely locked and accessible for use in the facility.

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V 293	Continued From page 30 Program regulations identify very specific requirements for the roles of QPs and APs. The facility had multiple people identified as QP and AP, with no clear indication of who was actually fulfilling the required responsibilities of each position. QPs and APs made joint decisions to co-mingle clients from the level 2 and level 3 facilities. Clients were together at the facility office, group home and in the community without authorization or Guardian knowledge. Police reports indicated at least 5 different incidents involving clients from both programs. Incidents included episodes of running away, physical aggression/assault, property destruction and felony possession of cocaine. These incidents were not documented nor reported as required to the LME/MCO responsible for the catchment area. These multiple systems issues resulted in neglect of client needs and constitutes a Type A1 rule violation for serious neglect which must be corrected within 23 days. An administrative penalty of $2,000.00 is imposed. If the violation is 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 293		
V 294	27G .1702 Residential Tx. Child/Adol -Req. for Q P 10A NCAC 27G .1702 REQUIREMENTS OF QUALIFIED PROFESSIONALS (a) Each facility shall utilize at least one direct care staff who meets the requirements of a qualified professional as set forth in 10A NCAC 27G .0104(18). In addition, this qualified professional shall have two years of direct client	V 294		

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V 294	Continued From page 31 care experience. (b) For each facility of five or less beds: (1) the qualified professional specified in Paragraph (a) of this Rule shall perform clinical and administrative responsibilities a minimum of 10 hours each week; and (2) 70% of the time shall occur when children or adolescents are awake and present in the facility. (c) For each facility of six or more beds: (1) the qualified professional specified in Paragraph (a) of this Rule shall perform clinical and administrative responsibilities a minimum of 32 hours each week; and (2) 70% of the time shall occur when children or adolescents are awake and present in the facility. (d) The governing body responsible for each facility shall develop and implement written policies that specify the clinical and administrative responsibilities of its qualified professional(s). At a minimum these policies shall include: (1) supervision of its associate professional(s) as set forth in Rule .1703 of this Section; (2) oversight of emergencies; (3) provision of direct psychoeducational services to children or adolescents; (4) participation in treatment planning meetings; (5) coordination of each child or adolescent's treatment plan; and (6) provision of basic case management functions.	V 294		

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V 294	Continued From page 32 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that a qualified professional (QP) performed clinical and administrative responsibilities a minimum of 10 hours weekly, 70% of which time was when children and adolescents were awake and present in the facility. The findings are: Review on 1/23/2019 of the QP/Contracts Director's (QP/CD) employee file revealed: - Hire date: 4/21/2008 as the Contracts Director; - Documentation of education and experience working with the population served to meet the credentials and qualification requirements for the QP role as specified in 10A NCAC 27G .0104 Staff Definitions. Access to the complete client records was limited due to the electronic record system and server having been damaged by an electrical surge in October of 2018. There was no clear documentation of the times, location or duties performed by the QP/CD or any other QP present in any reviewed records. Interview on 1/31/2019 with client #1 revealed: - The amount of time clients were actually at the facility was limited; - She was up every morning at 5:30AM because the bus for other clients arrived at that time, and then she was transported to her own school which was out of the district; - She was picked up from school by facility staff at 2:00PM, and taken directly to the Licensee's Office to do homework and have groups; - Clients usually watched a movie, wrote a "group paper", and ate dinner at the Office;	V 294		

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V 294	Continued From page 33 - " ... We stay there 'til 8 (PM) ..." - When clients arrived back at the facility, they took showers, and then went to bed. Interview on 1/25/2019 with former client (FC) #2 revealed: - She had been admitted to the facility on 8/31/2018, but was moved to the level 2 sister facility A the next day due to issues with the facility's heating system; - She remained at the sister facility A until 1/4/2019. Attempts were made on 1/31/2019 and 2/1/2019 to reach FC #3's Guardian and messages were left requesting a return call in order to coordinate interviews with FC #3 and the Guardian. No interviews were completed due to inability to reach the Guardian before the time of exit. Interview on 2/4/2019 with staff #1 revealed: - Clients from the Licensee's sister facilities were together at the office 2-3 days a week for group therapy; - Clients from all sister facilities arrived at the office around 5:00PM and left around 7:00PM to return to their own facilities. Interview on 2/5/2019 with Associate Professional (AP) AP #2 revealed: - Clients from the Licensee's sister facilities did not gather at the office often: " ... It's a meet up location. If there is an outing planned." - Clients may be at the office from 4 pm until 6 pm, but no later than 7 pm. Interviews from 1/23/2019 to 2/5/2019 with the QP/CD revealed: - There were a total of 3 people, including herself, who were qualified to be QP's working at the	V 294		

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V 294	Continued From page 34 facility; - The other two QP's were independent contractors who had other jobs and were not available on week days; - One of the other QP's role was focused on maintaining the electronic records for clients; - The third QP only worked on weekends; - Clients from sister facilities met at the office for group therapy and to provide for their educational needs; - Each group of clients had their own room and staff while at the office; - The clients from each sister facility attended therapy sessions in a neighboring city, and met at the office for transport to the sessions; - Tuesdays, Thursdays and Saturdays were therapy days; - On Mondays, Wednesdays and Fridays, clients in middle school were picked up and arrived at the office around 3:00PM: - By the time the high school clients arrived at the office around 4:45PM, their evening meal had been prepared for them there; - Facility staff tried to leave the office by 6:00PM to return to the facility with clients; - It was easier to have all the clients meet at the office and then disperse the clients to their individual homes following school on weekdays; - The facility's electronic record system had been damaged during a storm in October of 2018; - It was a time-consuming and complicated process to retrieve documentation from client records; - There was not a means to locate clear documentation of when, where and what clinical and administrative duties the QP's performed at the facility; - The facility used to complete log sheets detailing the QP's activities, but it had not been used in a long time;	V 294		

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V 294	Continued From page 35 - The facility would begin using log sheets or checklists to clearly show QP's activities at the facility. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 294		
V 295	27G .1703 Residential Tx. Child/Adol - Req. for A P 10A NCAC 27G .1703 REQUIREMENTS FOR ASSOCIATE PROFESSIONALS (a) In addition to the qualified professional specified in Rule .1702 of this Section, each facility shall have at least one full-time direct care staff who meets or exceeds the requirements of an associate professional as set forth in 10A NCAC 27G .0104(1). (b) The governing body responsible for each facility shall develop and implement written policies that specify the responsibilities of its associate professional(s). At a minimum these policies shall address the following: (1) management of the day to day day-to-day operations of the facility; (2) supervision of paraprofessionals regarding responsibilities related to the implementation of each child or adolescent's treatment plan; and (3) participation in service planning meetings. This Rule is not met as evidenced by:	V 295		

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V 295	Continued From page 36 Based on record reviews and interviews, the facility failed to ensure that at least one full-time associate professional (AP) performed the responsibilities required by rule and policy. The findings are: Review on 1/23/2019 of AP #1's employee file revealed: - Hire date: 4/7/2007 as an AP; - Documentation of education and experience working with the population served to meet the credentials and qualification requirements for the AP role as specified in 10A NCAC 27G .0104 Staff Definitions. Review on 2/5/2019 of AP #2's employee file revealed: - Hire date: 6/17/2008 as an AP; - Documentation of education and experience working with the population served to meet the credentials and qualification requirements for the AP role as specified in 10A NCAC 27G .0104 Staff Definitions. There was no clear documentation of the times, location or duties performed by the AP's present in any reviewed record. Review on 2/1/2019 of the facility's policies and procedures revealed: - Day to day oversight for direct care staff would be the responsibility of a Licensed Professional (LP) rather than an AP as required by rule; - " ... The Associate Professional can act as Agency Representative to monitor day to day operations of Inspirationz, LLC; provide supervision of regarding responsibilities related to each client's treatment plan and participation in service plan meetings. - Duties will also include, but are not limited to	V 295		

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V 295	Continued From page 37 responsibilities related to the implementation of each child or adolescent's treatment plan, participation in service planning meetings, conduct initial assessment upon entrance into an Inspirationz, LLC Facility and program orientation session with teen/parents which includes identifying strength and needs of client; strengths and needs of family; review of medications; assessment of scheduling of assessment and contact with collateral agencies; - Participate in development of new Individualized Treatment Plans. Conduct one-on-one bi-weekly meetings with administration to update administrative changes or updates to policies with recommendations as they relate to the Department of Health and Human Services and the LME (local management entity). Complete program reports and documentation. Perform Quality Assurance and Quality Improvement. - It is the requirement that the Associate Professional contractor work a minimum of 40 hours per week ..." Interview on 2/1/2019 with AP #1 revealed: - She worked at both the facility and the level 2 sister facility A, but was the acting AP at the level 2 sister facility; - The AP duties included ensuring all of the needs of clients are met, scheduling for direct care staff, and "make sure everybody is successful ..." - AP #1 attended Child and Family Team (CFT) meetings if the Qualified Professional/Contracts Director (QP/CD) or AP #2 could not attend; - Supervision of direct care staff was done monthly by the QP who worked on weekends rather than the AP; - Oversight of clients' medication administration records (MARs) was not done by AP #1; - AP #1 was sick with strep throat and requested to cut the interview short to go to an appointment;	V 295		

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V 295	Continued From page 38 - AP #1 did not call the Surveyor back later on 2/1/2018 as planned, and did not answer her phone when called on 2/5/2019. Interview on 2/5/2019 with AP #2 revealed: - AP #2 did work 40 hours per week at the facility, but could not provide specific days or times that she worked; - AP #2's shifts rotated, but were mostly during 3rd shift; - AP #2 worked a second job, but was able to manage her own schedule and only worked that job 20 hours per week; - The AP duties included "...ensure the group home is running within the guidelines it is required to follow, ensuring the staff have what is needed at the group home, making staff schedule, making sure everything runs smoothly ..." - Direct care staff could ask questions of the AP if needed, but received their supervision from the QP that worked on weekends; - AP #2 was not present for all CFT meetings, but the QP/CD or other staff did attend them on a monthly basis; - AP #2 had nothing to do with addressing medication issues; - The QP/CD was responsible for coordination of care with clients' Guardians. Interviews from 1/23/2019 to 2/5/2019 with the QP/CD revealed: - The facility had two AP's working there regularly; - The facility's electronic record system had been damaged during a storm in October of 2018; - It was a time-consuming and complicated process to retrieve documentation from client records; - There was not a means to locate clear documentation of when, where and what duties the APs' performed at the facility;	V 295		

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V 295	Continued From page 39 - There was not a schedule readily available to show the dates and times the APs' were working; - The facility used to complete log sheets detailing the AP activities, but it had not been used in a long time; - The facility would begin using log sheets or checklists to clearly show APs' activities at the facility. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 295		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 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;	V 367		

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V 367	Continued From page 40 (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (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	V 367		

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V 367	Continued From page 41 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 reviews and interviews, the facility failed to report all level II incidents to the LME responsible for the catchment area within 72 hours of becoming aware of the incident. The findings are: (Police Incident/Investigation Reports were originally obtained and reviewed on 1/22/2019 as part of the annual and complaint survey for sister facility A. The reports listed the location of incidents involving former client (FC) #2 and FC #3 as sister facility A's address, and were therefore relevant to the complaint and follow up survey initiated at the facility on 1/24/2019.) Review on 1/22/2019 of the local Police Incident/Investigation Reports revealed:	V 367		

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V 367	Continued From page 42 - At 19:00 hours (7:00PM) on 11/16/2018, Police responded to a "Runaway" call in which FC #2 " ... who left the premises and keeps hiding behind houses ... Upon my arrival, I made contact with the reporting party, [former staff (FS) #A-3]. She advised me that one of the residents of the group home at this location (sister facility A), [FC #2], ran away earlier this same evening. [FS #A-3] is an employee of Inspirationz, which runs the home at this location. [FS #A-3] told me that [FC #2] was upset for much of the day leading up to this incident for an unknown reason. At approximately 7:00PM [FC #2] said she wanted to go outside, and exited the residence at this location. She then began walking away from the residence, and was last seen heading northwest, cutting through the back yards of nearby houses ... A K-9 track was conducted but [FC #2] was not located. [The local Fire Department] responded to the scene and used thermal imaging camera to attempt to locate [FC #2] with negative results ...Later on the evening, I responded to [a house two streets away from sister facility A], in response to a Police Service ... 16 year old female (FC #2) has shown up at her (the neighbor's) house stating that her father has kicked her out of the house ... I took her back to [sister facility A], where Inspirationz personnel confirmed that she was, in fact, [FC #2]. They took custody of her ..." - At 22:14 hours (10:14PM) on 12/25/2018, Police responded to an "Assault" call in which " ... Upon my arrival I made contact with [staff #A-2] who advised that [FC #2] was in a fight with [FC #3]. [Staff #A-2] advised me that [FC #3] just walked away from the residence and her nose was bleeding. Other officers located [FC #3] further up [the street that sister facility A was located on] and requested EMS to respond to care for her nose ... [Staff #A-2] advised me that she was	V 367		

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V 367	Continued From page 43 watching a movie with the girls in the residence and she paused the movie because one of the girls asked a question about the movie. [FC #3] became upset and began to yell at [staff #A-2]. [Staff #A-2] advised me that she attempted to speak with [FC #3] about her attitude and she left and went to her room. [FC #3] eventually stormed out of her room and knocked several items off a table and walked outside ... [FC #3] then opened the door to the residence and hit [FC #2] with the door. [FC #3] and [FC #2] began to fight and punch each other. [Staff #A-2] separated the two females and [FC #3] walked down the street. [Staff #A-2] advised me that [FC #3] causes a lot of problems at this residence and is known to break things and cause fights. [Staff #A-2] advised me that her boss, [the QP/CD] was on her way ...I then responded to [the street intersection that FC #3 was located at] where officers were standing by with [FC #3] and [the QP/CD]. EMS (emergency medical services) responded and cared for [FC #3]'s injuries. [The QP/CD] advised me that she had watched the security footage of the incident and she observed the girls fighting as [Staff #A-2] described. [The QP/CD] advised me that the group home managers are meeting to have [FC #3] relocated to a different home in the near future ..." - At 14:05 hours (2:05PM) on 12/26/2018, Police responded to a "Simple Assault-non Aggravated Assault" call in which "On this date I responded to a group home owned by Inspirationz LLC at [sister facility A] with the following call details: ... 13 YO (year old) armed with shovel causing dis (disturbance) ... Once we turned onto [the street the facility was located on] and began heading toward the given address, we noticed a black female teenager picking up a stick out of a pile of leaves. She was later identified as the suspect, [FC #3]. We continued on to the address and met	V 367		

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V 367	Continued From page 44 with a [Staff #A-2] who is a counselor at the group home. She informed us that one of the children living at the home, [FC #3], had become angry and started smashing things in the house ... had gone to the van parked in the back driveway, and struck it multiple times ... [FC #3] had gone inside the van and was kicking the dashboard where the airbag was housed. [Staff #A-2] was able to get [FC #3] out of the van and back into the house. [Staff #A-2] told us that [FC #3] damaged a table and lamp before heading onto the front porch and hitting the house with a large stick. [Staff #A-2] attempted to get [FC #3] to calm down and that's when [FC #3] struck [staff #A-2] multiple times in the face ... She (Staff #A-2) stated that [FC #3] also slammed the door on her (staff #A-2's) hand as she left. It was at this time that [FC #3] left the home and headed up the street. [The director of the group home, [the QP/CD] then arrived at the scene and informed us that [FC #3] has had multiple incidents similar to this. [The QP/CD] then told us that she had been at the home 20 minutes earlier and [FC #3] was in the street yelling and hitting mailboxes with stick. [The QP/CD] told us she thought [FC #3] had calmed down, and so she left the home to pick up medications for some of the children living there ..." - At 13:01 hours (1:01PM) on 12/27/2018, Police responded to a "Simple Assault-non Aggravated Assault" in which " ... 16 YOA (year old adolescent) - [client #A-4] who has walked away from the group home reported to be at a service station in the area ... We (Police Officers) attempted to locate [client #A-4], who had left a group home at [facility's address], owned by Inspirationz, LLC. Once we arrived at the top of the street we spoke to [the QP/CD] ... She advised us that [client #A-4] was most likely at one of the service stations nearby. [The Police	V 367		

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V 367	Continued From page 45 Corporal] located her at the [local gas station] on [an intersection near the facility]. [The Police Officers] were able to get [client #A-4] into their patrol vehicle and bring her back to the group home. Once there [the QP/CD] told us that yesterday [client #A-4] had assaulted another 16 year old female living at the group home, [FC #2]. [The QP/CD] said she learned about the assault while overhearing [client #A-4] talk about it to one of the other girls who lives at the home ..." Review on 1/22/2019 of the online North Carolina Incident Response Improvement System (IRIS) revealed: - The only level 2 incident that had been submitted to IRIS by the Licensee agency since 10/1/2018 was dated 12/4/2018 for FC #2 related to felony legal charges for possession of drugs while at the Licensee's office location; - There were no incident reports entered into IRIS for the Police-involved incidents on 11/16/2018, 12/25/2018, 12/26/2018 or 12/27/2018. Interview on 1/25/2019 with FC #2 revealed: - The local Police were called to sister facility A "back-to-back three times until they (the Police) said 'If you pass the mailbox, you'll be arrested' ..." - The dates Police were at the facility were 12/25/2018, 12/26/2018 and 12/27/2018. Interviews on 1/18/2019, 1/24/2019 and 1/25/2019 with FC #2's Guardian revealed: - FC #2 had been admitted to the facility on 8/31/2018; - The Guardian found out from FC #2 in January 2019 that she had been moved to the level 2 sister facility A; - The Guardian had obtained Police reports for 11/16/2018, 12/4/2018, and 12/27/2018 that listed	V 367		

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V 367	Continued From page 46	V 367		

FC #2's residence as the level 2 sister facility A;
- The incident on 12/4/2018 was related to FC #2 being charged with possession of cocaine while at the Licensee's office location.

Attempts were made on 1/31/2019 and 2/1/2019 to reach FC #3's Guardian and messages were left requesting a return call in order to coordinate interviews with FC #3 and the Guardian. No interviews were completed due to inability to reach the Guardian before the time of exit.

Interview on 1/23/2019 with client #A-3 revealed:
- She did not remember the last time that the local Emergency Services number/Police were called to sister facility A;
- When asked about whether there had been any physical fights at the facility, client #A-3 reported: "We really don't have them ... Before anything starts, they (facility staff) send us to our room ..."
- She had never run away from the facility.

Interview on 2/4/2019 with staff #1 revealed:
- IRIS reports were completed by the QP.

Interview on 2/4/2019 with Associate Professional #2 revealed:
- IRIS reports were completed by the QP/CD;
- AP #2 did not complete incident reports.

Interviews from 1/23/2019 to 2/5/2019 with the QP/CD revealed:
- Police had been called to sister facility A on multiple days due to incidents in which clients from the facility had destroyed property or ran away;
- Clients and staff had been in the area of sister facility A in order to drop off medications or meet to go to community activities together;
- The QP/CD did not think that IRIS reports had to

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V 367	Continued From page 47 be made if the client was not missing for more than 3 hours. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 367		