STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-371	A. BUILDING: _____ B. WING _____	R-C 02/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN LEVEL III	2 COMPTON DRIVE ASHEVILLE, NC 28806

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V 000	INITIAL COMMENTS A complaint and limited follow up survey was completed on February 6, 2019. The complaint was unsubstantiated (#NC00147475). This was also a limited follow up survey, only 10A NCAC 27G .0404 Operations (V138), 10A NCAC 27G .1708 Transfer or Discharge (V300), 10A NCAC 27G .1701 Scope (V293) and 10A NCAC 27G .0205 Assessment and Treatment, Habilitation or Service Plan (V112) were reviewed for compliance. The following were brought back into compliance: 10A NCAC 27G .0404 Operations (V138), 10A NCAC 27G .1708 Transfer or Discharge (V300), 10A NCAC 27G .1701 Scope (V293) and 10A NCAC 27G .0205 Assessment and Treatment, Habilitation or Service Plan (V112). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate	V 110		

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V 110	Continued From page 1 professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record review and interviews, 1 of 5 audited paraprofessionals (Staff #2) failed to demonstrate knowledge, skills and abilities required by the population served. The findings are: Review on 1/31/19 of the personnel record for Staff #2 revealed: -Hired on 6/4/18 as a Residential Counselor. -On 12/26/18 Staff #2 met with the Residential Director and assistant residential director for coaching. They met to address appropriate student/staff boundaries. Dress code and ratio expectations were reviewed. The documentation indicated that reports were made about inappropriate dress and for playing inappropriate music in front of students. Interview on 1/31/19 with Staff #2 revealed:	V 110		

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V 110	Continued From page 2 -She wore leggings and knew she wasn't supposed to. -The residential director had met with her and had her sign a "boundary plan". -Client #1 had a pre-planned visit with his family scheduled for Christmas. She had to supervise the visit because there were no other staff to facilitate the visit. She indicated she had no idea how to do that. -The other students of the facility had to gone to a sister facility. She remained in the facility from 8:00PM to approximately 10:00Pm alone with Client #1. Interview on 1/31/19 with Staff #3 revealed: -Staff #2 did not display good boundaries with the students. Students would request music that she would play for them. -A student had reported to her the Staff #2 wore tight clothing and would sit with her legs open. Interview on 2/4/19 with Staff #4 revealed: -Client #1 was alone in the cottage with Staff #2 for a couple of hours. -Staff were never to be alone with students. -Staff #2 would play music in the van that "was filthy and racist". He indicated she was in the back of the van dancing like "one of them". He reported this behavior to leadership. -Staff #2 would hang out with 2 students like "hanging out with her buddies". He felt her interactions with students was like "buddies" -There were "a lot of red flags". Interview on 2/5/19 on Staff #5 revealed: -Staff #2 seemed hyper focused on Client #1. She felt that Staff #2 showed favoritism to Client #1. -Staff #2 always wore leggings. She was told not to wear them.	V 110		

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V 110	Continued From page 3 -Other students reported to her that Staff #2 wore "see through leggings" and would sit with her legs open. The students also said that she would play inappropriate music in the van. Interview on 2/4/19 with the Cottage Supervisor revealed: -She wore exercise pants to work which was against policy. This was addressed with her but she continued to wear them. -If music is not played on the radio then it should not be played in front of students. -Client #1 had a visit with family but they did not show up. Staff #2 remained in the cottage with Client #1. No other staff were present. No supervisor was notified of this event. Staff #2 was counseled about this event. Interview on 2/1/19 with the Residential Director revealed: -It was reported to him that Staff #2 played sexually explicit music in front of students. He and the assistant director addressed this with her. They reviewed the boundary protocol with students and had her sign it. Staff #2 said that "they are in the real world" and would hear that kind of music. This issue was included in the boundary plan. -He stated that Staff #2 pushed the envelope to do things. Limits were set with her and she was redirected. -He was not aware at the time that Staff #2 was alone in the cottage with Client #1. She should have called a supervisor.	V 110		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING	V 296		

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V 296	Continued From page 4 REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and	V 296		

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V 296	Continued From page 5 needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure that two direct care staff are present for one, two, three, or four children. The findings are: Review on 1/31/19 of video tape for 12/25/18 revealed: -Staff #2 was in the cottage at 8:30PM with Client #1. There were no other staff present. At 10:06PM the 2nd staff member was observed to enter the facility. Review on 1/31/19 of the personnel record for Staff #2 revealed: -Hired on 6/4/18 as a Residential Counselor. Record review on 1/31/19 for Client #1 revealed: -Admitted on 12/5/18 with diagnosis of Conduct Disorder, adolescent onset type. Interview on 1/31/19 with Staff #2 revealed: -Client #1 had a pre-planned visit with his family scheduled for Christmas. She had to supervise the visit because there were no other staff to facilitate the visit. She indicated she had no idea how to do that. -The other students of the facility had to gone to a sister facility. She remained in the facility from 8:00PM to approximately 10:00Pm alone with Client #1. -She did not contact leadership to indicate that	V 296		

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V 296	Continued From page 6	V 296		

she was alone in the facility with a student.
-She indicated that the cottages "combine pretty consistently". Cottages combined on first shift when school was out and around the holidays.

Interview on 1/31/19 with Staff #3 revealed:
-She was working recently when cottages had combined and had 6 students and 3 staff. This had occurred for a couple of hours.

Interview on 2/4/19 with Staff #4 revealed:
-He had worked alone in the cottage for short time periods if his co-worker was late.
-He had transported students alone while his co-worker was alone in the cottage with other students.
-There were holes in staffing that happened a lot.
-Nurses were pulled to do shifts and then if a medical emergency occurred they would have to leave which would leave the facility out of ratio.
-They were told not to combine cottages, then told could combine if 6 students or less, and then told could combine if kept at 4 students.
-Combining cottages was frequent on weekends and after school.
-Client #1 was alone in the cottage with Staff #2 for a couple of hours.
-Staff were never to be alone with students.

Interview on 2/5/19 on Staff #5 revealed:
-There were times she worked alone with 3 or 4 students. This would be for an hour or so.
-Staff may be pulled out of ratio temporarily which made her feel uncomfortable.

Interview on 2/4/19 with the Cottage Supervisor revealed:
-Client #1 had a visit with family on Christmas but they did not show up. Staff #2 remained in the cottage with Client #1. No other staff were

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V 296	Continued From page 7 present. -Cottages combined of the census was down in a cottage. For example, if one level 3 had 3 students and another level 3 had 3 students they may take 2 students from another level 3 to add to each facility census to make 4 in each cottage. This occurred during the day shift on weekends and after school until approximately 8:30PM. -The only reason they combined cottages was due to a lack of staff. -At times they would combine and have 5 students at the weight barn with 3 staff. Interview on 2/1/19 with the Residential Director revealed: -He was not aware at the time that Staff #2 was alone in the cottage with Client #1. She should have called a supervisor. -There is never 1 student with 1 staff.	V 296		
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	V 367		

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V 367	Continued From page 8 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 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	V 367		

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V 367	Continued From page 9 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 2 of 3 audited clients (#1, #2). The findings are: Record review on 1/31/19 for Client #1 revealed: -Admitted on 12/5/18 with diagnosis of Conduct Disorder, adolescent onset type. -Age 17. Record review on 1/31/19 for Client #2 revealed:	V 367		

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V 367	Continued From page 10 -Admitted on 9/13/18 with diagnoses of Post-Traumatic Stress Disorder and Adjustment Disorder with mixed anxiety and depressed mood. -Age 16. Review on 1/31/19 of incident reports revealed: -On 1/22/19 " ...Staff arrived at [local high school] a couple of minutes late to pick up [Client #2]. Staff continued to wait around ...Staff notified administration at school ...had them page [Client #2] ...Staff informed [Client #2's] guardian that she was missing from school and that they had filed a report with [local law enforcement] ..." -On 1/6/19 " ...Staff did the 12:20am check and [Client #1] was in his room. At 12:31am staff checked in with [Client #1] then left his room. At 12:37am staff went back to ask [Client #1] a question. When staff open the door [Client #1] appeared to be in his bed sleep, but staff called his name 2 times and he didn't answer ...staff went in [Client #1's] room to check on him and realized he was not in his bed ...Supervisor made a report with [local police] ...at 5:15am, staff did a check in [Client #1's] room and noticed he was back in his bed ..." IRIS (Incident Response Improvement System) report completed and submitted on 1/11/19. Review on 1/31/19 of reports in the IRIS system revealed: -No IRIS report for the incident on 1/22/19. -Incident on 1/6/19 was submitted on 1/11/19. Interview on 2/6/19 with the Director of Performance/Quality Improvement revealed: -She was aware that the IRIS reports were submitted late for the level II incidents. This was an oversight.	V 367		