Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL010-081	A. BUILDING: _____ B. WING _____	02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALLBROWN HOME INC	99 HIGHPOINT ROAD SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual survey was completed on 02/21/19. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Alternative Family Living.	V 000	DHSR - Mental Health MAR 0 8 2019 Lic. & Cert. Section	
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 privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		

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V 118	Continued From page 1	V 118		

This Rule is not met as evidenced by:
Based on record reviews, observations, and interviews, the facility failed to administer medications as ordered by the physician and maintain an accurate MAR for 3 of 3 clients audited (clients #1, #2, #3). The findings are:

Finding #1:
Review on 2/20/19 of client #1's record revealed:
-26 year old male admitted 4/1/06.
-Diagnoses included moderate intellectual developmental disorder, attention deficit hyperactive disorder (ADHD), pervasive developmental disorder, hypothyroidism.
-Order dated 12/20/18 for Levothyroxine 0.025 mg (milligrams) daily. (Thyroid hormone replacement.)
-Order dated 2/4/19 for Mupirocin 2 % topical ointment to affected area 3 times daily. (Antibiotic)
-Order dated 2/4/19 to taper off Strattera over the next 2 weeks as directed, then will begin to taper off Ability. No order on hand to identify the taper doses/instructions for either medication. No prior orders on hand for Strattera 60 mg. (ADHD)

Review on 2/19/19 of client #1's December 2018, January 2019, and February 2019 MARs revealed:
-Transcription read to administer Valium 5mg PRN. "AM" and "PM" had been transcribed for dosing times. It as documented client #2 received Valium twice daily on 12/24/18, 12/30/18, 12/31/18, and 2/16/19.
-Mupirocin 2 % topical ointment was not

V118 - Medication Administration Registers will be done over. Prescription and non-prescription meds will be documented as required. The QP, M Wallbrown, will correct MAR's to include all meds currently ordered by all doctors. The QP will monitor this change weekly until certain that the MAR's are being kept up to date and followed. Particular attention will be paid to the doctors orders; proper transcription of the orders meaning all orders; and for failure to document. QP, M Wallbrown, will follow up on MAR's weekly until the deficiency survey and twice monthly thereafter to be certain that the policy is being implemented.

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V 118	Continued From page 2 transcribed to the February 2019 MAR. No documentation client #1 received any applications of the ointment. -No Levothyroxine 0.025 mg had been documented as administered in December 2018 or January 2019. -Strattera 60 mg was documented daily at 8 am from 12/1/18 - 2/7/19. Strattera 60 mg was documented as administered every other day from 2/9/19 - 2/19/19, then discontinued. Observations on 2/20/19 at 5:22 pm of client #1's medications on hand revealed the label for Valium 5 mg read to administer daily PRN. Finding #2: Review on 2/20/19 of client #2's record revealed: -34 year old male admitted 7/20/18. -Diagnoses included moderate developmental disability,fragile x syndrome, ADHD, Tardive Dyskinesia, psychotic disorder not otherwise specified, hypertension. -Order dated 10/3/18 for Risperidone 1 mg in the am and 2 in the pm. (Mental/mood disorders i.e. schizophrenia, bipolar disorder) -Order dated 9/20/18 for Desmopressin 0.2 mg 3 times daily. (Bed-wetting) -No order for Divalproex 500 mg twice daily. (Seizure medications; also used to treat manic episodes related to bipolar disorder.) Review on 2/20/19 of client #2's MARs for December 2018, January 2019, and February 2019 MARs revealed: -Transcription for Desmopressin from 1/16/19 - 1/31/19 and February 2019 read to administer 0.25mg at 8 am, 3 pm, and 8 pm. -Transcription for Risperidone 1 mg read to administer 1 tablet at 8 am, 3 pm, and 8 pm. Risperidone 1 mg had been documented as	V 118		

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V 118	Continued From page 3 administered 3 times daily. -No orders transcribed for Lamotrigine 25 mg twice daily. (Seizures, bipolar disorder) -No orders transcribed for Fluoxetine 20 mg daily. (Depression, panic attacks, obsessive compulsive disorder) -Divalproex 500 mg documented twice daily at 8 am and 8 pm from 1/16/19 - 2/12/19. Observations on 2/20/19 at 4:04 pm of client #2's medications on hand revealed: -Lamotrigine 25 mg, dispense date 2/13/19. -Fluoxetine 20 mg, dispense date 2/17/19. -Sample pack of Ingrezza 40 mg capsules. No label. (Tardive Dyskinesia) Finding #3: Review on 2/20/19 of client #3's record revealed: -37 year old female admitted 6/2012. -Diagnoses included moderate mental retardation, ADHD, insomnia, diabetes, gastroesophageal reflux disease (GERD). -Order dated 11/7/18 for Amethia Lo 0.1 mg/.02mg daily. (birth control pills, may be prescribed to regulate, decrease pain, and/or blood loss associated with menstrual cycle.) -Order dated 8/13/18 for Omeprazole 20 mg daily in am. (Decrease stomach acid, GERD) -Order dated 11/13/18 for Losartan 100 mg daily. (Treat high blood pressure.) -No order to taper Strattera in November 2018. Review on 2/20/19 of client #3's MARs for November 2018 through February 2019 revealed: -No Amethia Lo 0.1 mg/.02mg documented as administered 11/1/18 - 11/15/18. -No Omeprazole 20 documented as administered 11/1/18 - 11/15/18. -No Losartan 100 mg documented as administered in November. First dose	V 118		

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V 118	Continued From page 4 documented as administered was 12/19/18. -Strattera (Atomoxetine) 20 mg documented every other day from 11/15/18 - 11/23/18. Interview on 2/20/19 Staff #1 stated: -She did not have medication orders in the client records. She had never maintained medication orders on site. -She followed the MARs and labels to administer medications. -The MARs were prepared by the Qualified Professional/Licensee. She rarely had to make changes. -She had administered client #1's valium twice on the same day, but not often. She thought he could have the medication twice daily if needed because the MAR had 2 dosing times "AM" and "PM." -Client #2 had been prescribed Mupirocin 2% ointment on 2/4/19 for wounds on his head caused by head butting. She had administered the ointment on the same days she had administered the oral antibiotic given for the same reason (Bactrim 800 mg/ 160 mg administered twice daily 2/6/19 - 2/15/19). She had not transcribed the ointment onto the MAR; therefore, had not documented when it had been administered. -Staff #1 could not recall why the delay in starting the Levothyroxine for client #1. -She did not have an order on hand for client #1's tapering of Strattera. She followed the label instructions and had completed the medication on 2/19/19. The bottle had been discarded. -She had administered client #2's Risperidone 1 mg, 3 times daily at 8am, 3 pm, and 8 pm. She did not understand the order was to administer the 2 tablets at the same time in the pm. -She did not have an order for client #2's Divalproex 500 mg. The psychiatrist ordered the	V 118	V118 - Medication Administration Registers will be done over. Prescription and non-prescription meds will be documented as required. The QP, M Wallbrown, will correct MAR's to include all meds currently ordered by all doctors. The QP will monitor this change weekly until certain that the MAR's are being kept up to date and followed. Particular attention will be paid to the doctors orders; proper transcription of the orders meaning all orders; and for failure to document. QP, M Wallbrown, will follow up on MAR's weekly until the deficiency survey and twice monthly thereafter to be certain that the policy is being implemented.	

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V 118	Continued From page 5 medication in January 2019, but when they went back for the next visit in February the guardian terminated the physician. She took the client to his primary care physician and it was decided to not continue the medication. -Client #2's Desmopressin dose was transcribed in error. The medication he received was 0.2 mg as ordered. She had missed making the MAR corrections in January and February 2019. -There had been problems getting client #2's Ingrezza. The physician had given her a sample pack. -She had waited to pick up client #2's Lamotrigine and Fluoxetine when all his medications were ready. There was a delay in getting a couple of his medications authorized. This had delayed starting the medications. -She had made some errors on client #3's November 2018 MARs and had recopied them. She thought this may be why client #3's Amethia Lo 0.1 mg/.02mg and Omeprazole 20 mg had not been documented as administered 11/1/18 - 11/15/18. -She could not recall why the Losartan 100 mg was not started until 12/19/18. -She did not have an order to taper client #3's Strattera; she followed the label instructions. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician.	V 118	V118 - Medication Administration Registers will be done over. Prescription and non-prescription meds will be documented as required. The QP, M Wallbrown, will correct MAR's to include all meds currently ordered by all doctors. The QP will monitor this change weekly until certain that the MAR's are being kept up to date and followed. Particular attention will be paid to the doctors orders; proper transcription of the orders meaning all orders; and for failure to document. QP, M Wallbrown, will follow up on MAR's weekly until the deficiency survey and twice monthly thereafter to be certain that the policy is being implemented.	
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and	V 366		

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

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V 366	Continued From page 7 (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to	V 366		

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V 366	Continued From page 8 Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to develop and implement written policies including all requirements for governing their response to level I, II or III incidents. The findings are: Review on 2/20/19 of client #1's record revealed: -26 year old male admitted 4/1/06. -Diagnoses included moderate intellectual developmental disorder, attention deficit hyperactive disorder (ADHD), pervasive developmental disorder, hypothyroidism. -9/24/18 Psychiatric Evaluation documented client #1 had a history of destructive behaviors before moving into group home and continued to have self-injurious behaviors. Observations on 2/20/19 at approximately 4:00 pm revealed Staff #1 put client #1 into a restrictive intervention for self injurious behaviors (head butting).	V 366	V366 - Policy 346.1 will be updated to assign the person responsible in the specific home to document restrictive interventions. Likewise,the requirements to attend to the health and safety needs of the individual(s) involved. Documenttation to include obvious or possible causes as well as corrective and/or preventable measures that might be used. QP, M Wallbrown, will follow up on incident reporting along with MAR's weekly until the deficiency survey and twice monthly thereafter to be certain that the policy is being implemented.	

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V 366	Continued From page 9 Review on 2/21/19 of the facility Incident Reporting policy #346.1 revealed the policy did not include all response requirements to include attending to the health and safety needs of the involved client(s), determining the cause, developing and implementing corrective and preventive measures within required timeframes, and assigning person(s) to be responsible for implementation of the corrections and preventive measures. Interview on 2/20/19 Staff #2 stated: -Client #1's aggressive and self injurious behaviors happened frequently and required a restrictive hold to prevent him from hurting himself. -Staff did not document these restrictive interventions or complete an incident report. -Staff would notify the Qualified Professional/Licensee and he would take care of documentation and incident reporting. Interview on 2/21/19 the Qualified Professional/Licensee stated: -Staff #2 had reported the restrictive intervention on 2/20/19. -He was not aware of other restrictive interventions. -Client #1's behaviors seemed to have increased since a 3rd client was admitted in July 2018.	V 366	V366 - Policy 346.1 will be updated to assign the person responsible in the specific home to document restrictive interventions. Likewise,the requirements to attend to the health and safety needs of the individual(s) involved. Documenttation to include obvious or possible causes as well as corrective and/or preventable measures that might be used. QP, M Wallbrown, will follow up on incident reporting along with MAR's weekly until the deficiency survey and twice monthly thereafter to be certain that the policy is being implemented.	
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	V 367		

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V 367	Continued From page 10 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; (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	V 367		

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V 367	Continued From page 11 (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 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:	V 367	V367 - QP, M Wallbrown will develop an onsite incident report that will include date, time, and description of the event. Also to include possible cause as well as injuries and/or property damage. Report can be emailed, delivered in person to QP as soon as possible, but within 24 hours to prevent incidents from going unreported. QP will then do a Level I report internally, or report to IRIS as is required. The onsite report will be coupled with the QP Level I or IRIS report as an original document of the incident. QP, M Wallbrown, will follow up on incident reporting along with MAR's weekly until the deficiency survey and twice monthly thereafter to be certain that the policy is being implemented.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 12 Based on record reviews and interviews, the facility failed to report all Level II incidents as required. The findings are: Review on 2/20/19 of client #1's record revealed: -26 year old male admitted 4/1/06. -Diagnoses included moderate intellectual developmental disorder, attention deficit hyperactive disorder (ADHD), pervasive developmental disorder, hypothyroidism. -9/24/18 Psychiatric Evaluation documented client #1 had a history of destructive behaviors before moving into group home and continued to have self-injurious behaviors. Review on 2/20/19 of the North Carolina Incident Response Improvement System from 11/1/18 - 2/20/19 revealed no facility level 2 incident reports. Interview on 2/20/19 Staff #1 stated: -During the facility tour Staff #1 stated the overhead ceiling fan light cover had been removed from client #1's room due to his aggressive behaviors. -She was concerned about him breaking his bedroom window when he had these behaviors. -His behaviors occurred during the night and occurred frequently. -Her spouse, Staff #2, often had to put him in a restraint for behaviors to keep him from hurting himself. Observations on 2/20/19 at approximately 4:00 pm revealed Staff #1 put client #1 into a restrictive intervention for self injurious behaviors (head butting). Interview on 2/20/19 Staff #2 stated: -Client #1's self injurious behaviors happened	V 367	V367 - QP, M Wallbrown will develop an onsite incident report that will include date, time, and description of the event. Also to include possible cause as well as injuries and/or property damage. Report can be emailed, delivered in person to QP as soon as possible, but within 24 hours to prevent incidents from going unreported. QP will then do a Level I report internally, or report to IRIS as is required. The onsite report will be coupled with the QP Level I or IRIS report as an original document of the incident. QP, M Wallbrown, will follow up on incident reporting along with MAR's weekly until the deficiency survey and twice monthly thereafter to be certain that the policy is being implemented.	

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	MHL010-081	A. BUILDING: _____ B. WING _____	02/21/2019

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V 367	Continued From page 13 frequently and required a restrictive hold to prevent him from hurting himself. -Staff did not document these restrictive interventions or complete an incident report. -Staff would notify the Qualified Professional/Licensee and he would take care of documentation and incident reporting. Interview on 2/21/19 the Qualified Professional/Licensee stated: -Staff #2 had reported the restrictive intervention on 2/20/19. He had submitted a Level 2 incident report. -He was not aware of other restrictive interventions. He looked in his incident reporting book back to July 2018 and had no incident reports for putting client #1 in a restrictive intervention. -Client #1's behaviors seemed to have increased since a 3rd client was admitted in July 2018.	V 367	V367 - QP, M Wallbrown will develop an onsite incident report that will include date, time, and description of the event. Also to include possible cause as well as injuries and/or property damage. Report can be emailed, delivered in person to QP as soon as possible, but within 24 hours to prevent incidents from going unreported. QP will then do a Level I report internally, or report to IRIS as is required. The onsite report will be coupled with the QP Level I or IRIS report as an original document of the incident. QP, M Wallbrown, will follow up on incident reporting along with MAR's weekly until the deficiency survey and twice monthly thereafter to be certain that the policy is being implemented.	
V 521	27E .0104(e9) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum: (A) notation of the client's physical and psychological well-being; (B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior;	V 521		

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V 521	Continued From page 14 (C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used; (D) a description of the intervention and the date, time and duration of its use; (E) a description of accompanying positive methods of intervention; (F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions; (G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and (H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to document restrictive interventions in the client's record as required affecting 1 of 3 audited clients (#1). The findings are: Review on 2/20/19 of client #1's record revealed: -26 year old male admitted 4/1/06. -Diagnoses included moderate intellectual developmental disorder, attention deficit hyperactive disorder (ADHD), pervasive developmental disorder, hypothyroidism. -9/24/18 Psychiatric Evaluation documented client #1 had a history of destructive behaviors before moving into group home and continued to have self-injurious behaviors.	V 521	V521 - QP, M Wallbrown will review and update current incident reporting policy to include reporting in the client record any incidents involving that client. The policy will include placement in the client record of the onsite incident report along with QP follow up via a Level I report or IRIS report. The policy will also direct that follow ups, debriefings, and the client or guardian input be included. QP, M Wallbrown, will follow up on incident reporting along with MAR's weekly until the deficiency survey and twice monthly thereafter to be certain that the policy is being implemented.	

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V 521	Continued From page 15 -No documentation of restrictive interventions. Interview on 2/20/19 Staff #1 stated: -During the facility tour Staff #1 stated the overhead ceiling fan light cover had been removed from client #1's room due to his aggressive behaviors. -She was concerned about him breaking his bedroom window when he had these behaviors. -His behaviors occurred during the night and occurred frequently. -Her spouse, Staff #2, often had to put him in a restraint for behaviors to keep him from hurting himself. Unable to interview client #1 on 2/20/19 at 4:00 pm due to his communication deficits and behaviors. Observations on 2/20/19 at approximately 4:00 pm revealed: -Client #1 sat down on the kitchen floor as Staff #2 started to prepare dinner. -Staff #1 and #2 attempted to redirect client #1 and get him to stand. Client #1 refused. -Client #1 suddenly hit his head on the hard wood floor. -Client #1 hit his head again and Staff #2 squatted to the client's level and proceeded to put him in a therapeutic wrap from behind. -Client #1 resisted and began to slap at himself and Staff #2. Staff #2 instructed client #1 to not bite. -The client was held for no more than 1 minute. Client #1 became calm, was released by staff #2, stood. and went to his room. Interview on 2/20/19 Staff #2 stated: -This behavior happened frequently and required a restrictive hold to prevent him from hurting	V 521	V521 - QP, M Wallbrown will review and update current incident reporting policy to include reporting in the client record any incidents involving that client. The policy will include placement in the client record of the onsite incident report along with QP follow up via a Level I report or IRIS report. The policy will also direct that follow ups, debriefings, and the client or guardian input be included. QP, M Wallbrown, will follow up on incident reporting along with MAR's weekly until the deficiency survey and twice monthly thereafter to be certain that the policy is being implemented.	

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V 521	Continued From page 16 himself. -Staff did not document these restrictive interventions or complete an incident report. -Staff would notify the Qualified Professional/Licensee and he would take care of documentation and incident reporting. Interview on 2/21/19 the Qualified Professional/Licensee stated: -Staff #2 had reported the restrictive intervention on 2/20/19. -He was not aware of other restrictive interventions. -Client #1's behaviors seemed to have increased since a 3rd client was admitted in July 2018. Review on 2/21/19 of the facility police revealed no directions for documentation of restrictive interventions in the client record.	V 521	V521 - QP, M Wallbrown will review and update current incident reporting policy to include reporting in the client record any incidents involving that client. The policy will include placement in the client record of the onsite incident report along with QP follow up via a Level I report or IRIS report. The policy will also direct that follow ups, debriefings, and the client or guardian input be included. QP, M Wallbrown, will follow up on incident reporting along with MAR's weekly until the deficiency survey and twice monthly thereafter to be certain that the policy is being implemented.	
V 524	27E .0104(e12-16) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (12) The use of a restrictive intervention shall be discontinued immediately at any indication of risk to the client's health or safety or immediately after the client gains behavioral control. If the client is unable to gain behavioral control within the time frame specified in the authorization of the intervention, a new authorization must be obtained. (13) The written approval of the designee of the	V 524		

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V 524	Continued From page 17 governing body shall be required when the original order for a restrictive intervention is renewed for up to a total of 24 hours in accordance with the limits specified in Item (E) of Subparagraph (e)(10) of this Rule. (14) Standing orders or PRN orders shall not be used to authorize the use of seclusion, physical restraint or isolation timeout. (15) The use of a restrictive intervention shall be considered a restriction of the client's rights as specified in G.S. 122C-62(b) or (d). The documentation requirements in this Rule shall satisfy the requirements specified in G.S. 122C-62(e) for rights restrictions. (16) When any restrictive intervention is utilized for a client, notification of others shall occur as follows: (A) those to be notified as soon as possible but within 24 hours of the next working day, to include: (i) the treatment or habilitation team, or its designee, after each use of the intervention; and (ii) a designee of the governing body; and (B) the legally responsible person of a minor client or an incompetent adult client shall be notified immediately unless she/he has requested not to be notified. This Rule is not met as evidenced by: Based on interview the legally responsible person for an incompetent adult client had not been notified immediately following a restrictive intervention affecting 1 of 3 clients audited (client #1). The findings are: Review on 2/20/19 of client #1's record revealed: -26 year old male admitted 4/1/06. -Diagnoses included moderate intellectual developmental disorder, attention deficit	V 524	V524 - The onsite incident review form will include notifications block including the time of notification. Likewise, the Incident reporting policy will include the requirement to notify the legally responsible party as soon as possible and in less than 24 hours. QP, M Wallbrown, will follow up on incident reporting along with MAR's weekly until the deficiency survey and twice monthly thereafter to be certain that the policy is being implemented.	

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V 524	Continued From page 18 hyperactive disorder (ADHD), pervasive developmental disorder, hypothyroidism. Observations on 2/20/19 at approximately 4:00 pm revealed: -Client #1 sat down on the kitchen floor. -Staff #1 and #2 attempted to redirect client #1 and get him to stand. Client #1 refused. -Client #1 suddenly began to hit his head on the hard wood floor. -Staff #2 squatted to client #1's level and proceeded to put him in a therapeutic wrap from behind. Interview on 2/21/19 the Qualified Professional/Licensee stated: -Staff #2 had reported the restrictive intervention on 2/20/19. -No one had notified client #1's mother/guardian of the restrictive intervention. -He would notify the guardian today.	V 524	V524 - The onsite incident review form will include notifications block including the time of notification. Likewise, the Incident reporting policy will include the requirement to notify the legally responsible party as soon as possible and in less than 24 hours. QP, M Wallbrown, will follow up on incident reporting along with MAR's weekly until the deficiency survey and twice monthly thereafter to be certain that the policy is being implemented.	
V 525	27E .0104(e17) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (17) The facility shall conduct reviews and reports on any and all use of restrictive interventions, including: (A) a regular review by a designee of the governing body, and review by the Client Rights Committee, in compliance with confidentiality rules as specified in 10A NCAC 28A; (B) an investigation of any unusual or possibly	V 525		

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V 525	Continued From page 19 unwarranted patterns of utilization; and (C) documentation of the following shall be maintained on a log: (i) name of the client; (ii) name of the responsible professional; (iii) date of each intervention; (iv) time of each intervention; (v) type of intervention; (vi) duration of each intervention; (vii) reason for use of the intervention; (viii) positive and less restrictive alternatives that were used or that were considered but not used and why those alternatives were not used; (ix) debriefing and planning conducted with the client, legally responsible person, if applicable, and staff, as specified in Parts (e)(9)(F) and (G) of this Rule, to eliminate or reduce the probability of the future use of restrictive interventions; and (x) negative effects of the restrictive intervention, if any, on the physical and psychological well-being of the client. This Rule is not met as evidenced by: Based on interview the facility failed to follow policy and procedures to conduct reviews of restrictive interventions and document/maintain a log meeting documentation requirements. The findings are: Observations on 2/20/19 at approximately 4:00 pm revealed: -Client #1 sat down on the kitchen floor. -Staff #1 and #2 attempted to redirect client #1 and get him to stand. Client #1 refused and demonstrate defiance toward staff. -Staff #2 had started preparing dinner. -Client #1 suddenly began to bang his head on the hard wood floor. -Client #1 banged his head again and Staff #2	V 525	V525 - QP, M Wallbrown, will include in Policy 341.1 on Restrictive Intervention that incidents will be reviewed on a timely basis. Likewise the modified policy on Incident reporting. There will be an Incident Tracking form attached to the onsite incident report in each case so that follow up is documented. This will include follow up with staff invloved in an incident as well as the person or their guardian. All incidents will be reviewed quarterly so as to note trends or patterns. QP, M Wallbrown, will follow up on incident reporting along with MAR's weekly until the deficiency survey and twice monthly thereafter to be certain that the policy is being implemented.	

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V 525	Continued From page 20 squatted to client #1's level and proceeded to put him in a therapeutic wrap from behind. -Client resisted and began to slap at self and staff. Staff #2 instructed client #1 to not bite. -The client was held for less than 1 minute. He became calm, was released by staff #2, stood. and went to his room. Interview on 2/20/19 Staff #2 stated: -This behavior happens frequently and required a restrictive interventions to prevent him from hurting himself. -Staff did not document these restrictive interventions or complete an incident report. -Staff would notify the Qualified Professional/Licensee and he would take care of documentation and incident reporting. Interview on 2/21/19 the Qualified Professional/Licensee stated: -Staff #2 had reported the restrictive intervention on 2/20/19. -He was not aware of other restrictive interventions. -It was difficult to convene a group to review restrictive interventions. -He did not maintain a log of restrictive interventions.	V 525	V525 - QP, M Wallbrown, will include in Policy 341.1 on Restrictive Intervention that incidents will be reviewed on a timely basis. Likewise the modified policy on Incident reporting. There will be an Incident Tracking form attached to the onsite incident report in each case so that follow up is documented. This will include follow up with staff invloved in an incident as well as the person or their guardian. All incidents will be reviewed quarterly so as to note trends or patterns. QP, M Wallbrown, will follow up on incident reporting along with MAR's weekly until the deficiency survey and twice monthly thereafter to be certain that the policy is being implemented.	