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V 000	INITIAL COMMENTS An annual survey was completed April 10, 2019. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C, Supervised Living for Adults with Developmental Disabilities.	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; (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:	V 105		

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V 105	Continued From page 1 (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; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement adoption of standards that assure operational and	V 105		

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V 105	Continued From page 2 programmatic performance meeting applicable standards of practice for the use of a Glucometer instrument including the CLIA (Clinical Laboratory Improvement Amendments) waiver. The findings are: Review on 4/5/19 of client #3's record revealed: -41 year old female. -Admission date 11/2/17. -Diagnoses included Schizophrenia, Obsessive Compulsive Disorder, Diabetes Type A, Mild Intellectual Developmental Disorder; Hypertension, Gastroesophageal Reflux Disease (GERD), Enuresis. -Order dated 2/13/18 for fingerstick blood sugar testing (FSBS) two (2) times daily. -Interview on 4/5/19 the House Manager stated: -They checked client #3's blood sugar "every now and then." -She did not have a CLIA waiver certificate. -She was not aware of the requirement for a CLIA waiver. Interview on 4/9/19 the Chief Executive Officer/Qualified Professional stated: -She was not familiar with CLIA waiver requirements. -She would follow up to acquire the required waiver.	V 105		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following:	V 108		

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V 108	Continued From page 3 (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to provide staff training to meet client needs for 3 of 3 staff audited (House Manager, Staff #2, Staff #3). The findings are: Review on 4/5/19 of client #3's record revealed: -41 year old female. -Admission date 11/2/17.	V 108		

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V 108	Continued From page 4 -Diagnoses included Schizophrenia, Obsessive Compulsive Disorder, Diabetes Type A, Mild Intellectual Developmental Disorder; Hypertension, Gastroesophageal Reflux Disease (GERD), Enuresis. -Order dated 2/13/18 for fingerstick blood sugar testing (FSBS) two (2) times daily. Review on 4/9/19 of client #3's medical physician office visit summary dated 1/15/19 "Diabetes Self-Management Plan" revealed: -Monitor your blood sugars -Know the signs of low and high blood sugars Review on 4/9/19 of the House Manager's personnel file revealed: -Hire date was 8/21/02. She was a paraprofessional. -No documentation of training for care of clients with diabetes or performance of the fingerstick blood sugar (FSBS) procedure. Review on 4/9/19 of Staff #2's personnel file revealed: -Hire date was 10/9/18. -No documentation of training for care of clients with diabetes or performance of the FSBS procedure. Review on 4/9/19 of Staff #3's personnel file revealed: -Hire date was 4/1/19. -No documentation of training for care of clients with diabetes or performance of the FSBS procedure. Observation on 4/9/19 at 10:20 am revealed: -Client #3 was sitting at the kitchen table eating crackers. -Staff #2 put on gloves and performed a FSBS on	V 108		

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V 108	Continued From page 5 client #3 at the kitchen table. -The House Manager was standing and observing the procedure. The House Manager gave Staff #2 instructions on how to use the lancet device. -Staff #2 stated the result was 177. Interview on 4/9/19 Staff #2 stated: -She was a paraprofessional and usually worked evening hours and every Saturday from 8 am to 4 pm. -Client #3 was her "primary" client on week ends. -She had not received training on care of a client with diabetes. Diabetes was "touched on" in the computer based medication training course she had completed. -The House Manager showed her how to do a FSBS. She was shown this not long after she started her employment with the facility. -She documented the FSBS results on a paper the House Manager kept. -Usually she checked client #3's FSBS when "she (client #3) is not herself." -Examples of client #3 observations that would lead her to check her FSBS included "sluggishness, ... this thing she will do with her eyes, rolling them back, ... extra, extra sleepy." -She had done client #3's FSBS this morning because she was "sluggish." -She did not know of any parameters, high or low results, that would require any specific action to take. They had not had issues. Client #3's results were usually in the 90's. This morning when she performed the FSBS her result was 177 (10:20am) This was the highest it had been. -If she had concerns about client #3's FSBS results she would contact the House Manager. -She thought she took client #3's FSBS maybe once every 2 weeks.	V 108		

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V 108	Continued From page 6 Interview on 4/5/19 the House Manager stated: -The facility had not provided training on diabetes or how to perform a FSBS procedure. -She was a diabetic and had been trained to do her own FSBS. -None of the staff had received training. Interview on 4/9/19 the Chief Executive Officer/Qualified Professional stated she would follow up to make sure staff received needed training. This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type A2 and must be corrected within 23 days.	V 108		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by:	V 114		

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V 114	Continued From page 7 Based on interviews and record reviews, the facility failed to hold disaster drills and fire drills that simulated fire emergencies at least quarterly on all shifts. The findings are: Interview on 4/4/19 the House Manager stated: -Staff worked 2 shifts Monday through Friday. The shift hours during the week were 12 am to 8:30 am (night shift) and 4 pm to 12 am (evening shift). -Typically there were no clients in the home from 8:30 am to 4 pm Monday through Friday. -There was 1 shift on the week end. The staff would come in on Friday night and work from midnight until Sunday night when the next shift started their shift at midnight. Review on 4/5/19 of fire drills from 4/1/18 through 3/31/19 revealed: -Quarter #1, 1/1/19 - 3/31/19: Fire drills documented 2/14/19 at "8:30" and 1/14/19 at "3:20." Documentation did not identify if the drills were done in "am" or "pm," therefore, could not determine if drills were done on both the evening and night shifts. -Quarter #3, 7/1/18 - 9/30/18: Fire drills documented 7/16/18 at "4:20" and 9/11/18 at "5:30." Documentation did not identify if the drills were done in "am" or "pm," therefore, could not determine if drills were done on both the evening and night shifts. Review on 4/5/19 of disaster drills from 4/1/18 through 3/31/19 revealed: -Quarter #1, 1/1/19 - 3/31/19: No disaster drills documented for the night shift between 12 am and 8:30 am. Staff documented they had a "discussion" and asked questions about what to do for an earthquake on 3/8/19 at 7:45 pm. No documentation a drill was performed to simulate	V 114		

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V 114	Continued From page 8 what actions to take in the event of an actual earthquake. -Quarter #2, 4/1/18 - 6/30/18: No disaster drills documented for the 2 week day shifts. -Quarter #3, 7/1/18 - 9/30/18: No disaster drills documented for the evening or week end shifts. -Quarter #4, 10/1/18 - 12/31/18: No disaster drills documented for the evening or week end shift. Continued interview on 4/4/19 the House Manager stated: -The facility had done drills for a communicable disease, power outage, medical emergency, and violent situation thinking these were disaster drills. -She did not realize these were not disaster drills. -She would make sure disaster drills were held quarterly on each shift. Interview on 4/9/19 the Chief Executive Officer/Qualified Professional stated: -The drills including power outage, medical emergency, and violent situation were done to meet the requirements for their CARF accreditation (Commission on Accreditation of Rehabilitation Facilities). -She would follow up to make sure a disaster drill was done on each shift each quarter. -She would follow up to make sure staff noted if the drill was done in the "am" or "pm."	V 114		
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	V 118		

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V 118	Continued From page 9 drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews, observation, and interviews, the facility failed to ensure medications were administered as ordered by the physician for 1 of 3 clients audited (client #3). The findings are: Cross Reference: 10A NCAC 27G .0202 Personnel Requirements (Tag V108). Based on record reviews, observations, and interviews, the facility failed to provide staff training to meet client	V 118		

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V 118	Continued From page 10 needs for 3 of 3 staff audited (House Manager, Staff #2, Staff #3). Finding #1: Review on 4/5/19 of client #3's record revealed: -41 year old female. -Admission date 11/2/17. -Diagnoses included Schizophrenia, Obsessive Compulsive Disorder, Diabetes Type A, Mild Intellectual Developmental Disorder; Hypertension, Gastroesophageal Reflux Disease (GERD), Enuresis. -Order dated 2/13/18 for fingerstick blood sugar testing (FSBS) two (2) times daily. -No order documented to clarify when FSBS testing should be done. -Order dated 11/6/18 for Metformin 500 mg (milligrams) ER (extended release) daily. Metformin 500 mg ER was documented daily at 8 am. (Lowers the amount of sugar in the blood.) -Order dated 11/6/18 for Mylanta 5 ml (milliliters) 4 times daily as needed for indigestion. -No order for "Family Wellness Daytime Severe Cold & Cough." (Non-prescription medication for cold symptom relief) Review on 4/5/19 of client #3's MARs for January, February, March, and April 2019 revealed: -Mylanta was documented as administered 15 of 31 days in January 2019, 11 of 28 days in February, 14 of 31 days in March, and 3 of the first 5 days in April 2019. No times were documented when the medication had been administered. -"Family Wellness Daytime Severe Cold & Cough," 30 ml (milliliters) every 4 hours had been transcribed onto the March 2019 MAR. Documentation the medication had been administered 3/5/19, 4:10 pm; 3/6/19, 8 am, 3/6/19, 2:38; 3/7/19, 8 am; 3/8/19, 8 am; 3/9/18,	V 118		

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V 118	Continued From page 11 9:55 am; 3/10/19, 8 am; 3/11/19, 4 pm; 3/17/19, 9 pm; and, 3/18/19,8 am. Review on 4/9/19 of client #3's FSBS log results from 1/1/19 - 4/9/19 revealed: -FSBS results were documented once daily. Forty eight (48) results were documented at 8 am and the other 53 results were documented between 3:30 pm and 8 pm. -Results ranged from 49 to 177. -Results less than 60 were documented on 7 occasions as follows: -1/16/19, 8 am = 54; next FSBS documented 1/17/19, 4 pm = 119 -2/1/19, 8 am = 49; next FSBS documented 2/2/19, 4 pm = 107 -2/5/19, 8 am = 54; next FSBS documented 2/6/19, 6 pm =100 -2/15/19, 8 am = 54; next FSBS documented 2/16/19, 4 pm = 99 -2/17/19, 8 am = 49; next FSBS documented 2/18/19, 3:47 pm = 97 -3/6/19, 8 am = 54; next FSBS documented 3/7/19, 5 pm = 126 -3/19/19, 8 am = 54; next FSBS documented 3/20/19, 6 pm = 98 -Results less between 60 and 70 were documented on 14 occasions as follows: -1/10/19, 8 am = 67; next FSBS documented 1/11/19, 3:30 pm = 102 -1/22/19, 8 am = 63; next FSBS documented 1/23/19, 4 pm = 97 -1/28/19, 8 am = 67; next FSBS documented 1/29/19, 6 pm = 98 -1/30/19, 8 am = 67; next FSBS documented 1/31/19, 3:30 pm = 103 -2/3/19, 8 am = 67; next FSBS documented 2/4/19, 4 pm = 98 -2/11/19, 8 am = 68; next FSBS documented	V 118		

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V 118	Continued From page 12 2/12/19, 7 pm = 134 -2/23/19, 8 am = 67; next FSBS documented 2/24/19, 6 pm = 99 -2/27/19, 8 am = 69; next FSBS documented 2/28/19, 3:56 pm = 78 -3/10/19, 8 am = 64; next FSBS documented 3/11/19, 8 pm = 110 -3/15/19, 8 am = 62; next FSBS documented 3/16/19, 7 pm = 132 -3/21/19, 8 am = 62; next FSBS documented 3/22/19, 3:30 pm = 98 -3/25/19, 8 am = 67; next FSBS documented 3/26/19, 7 pm = 142 -3/27/19, 8 am = 66; next FSBS documented 3/28/19, 5 pm = 98 -4/1/19, 8 am = 69; next FSBS documented 4/2/19, 3:30 pm = 124 Finding #2: Review on 4/9/19 of Staff #2's personnel file revealed: -Hire date was 10/9/18. -Documentation Staff #2's medication training completed on 2/7/19 and 10/15/18 was a computer based instruction, "Group Home Medication Administration," www.southrx.com. Interview on 4/9/19 Staff #2 stated: -She did medication administration training "on line." -She did this on her computer at home. The staff were given their own password to access the course. There was no "live person" doing the training. -The course format was reading and then taking a test at the end of the course. Review on 4/9/19 of Staff #3's personnel file revealed: -Hire date was 4/1/19.	V 118		

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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 118	Continued From page 13 -Documentation Staff #3's medication training completed on 3/7/19 was a computer based instruction, "Group Home Medication Administration," www.southrx.com. Interview on 4/9/19 the House Manager stated: -She administered client #3's Mylanta in the morning. She would ask the client how her stomach felt, and if she complained her stomach was "weak" she would administer the medication with her other 8 am meds. She did not realize she needed to document the time when she administered the medication. -Client #3 purchased the "cough/cold" medication for her cold in March, 2019. She did not know she needed an order if the client bought the medication over the counter. -Client #3's FSBS was checked "from time to time." They had been told to check it from time to time. She got her instructions from the doctor. -She had no order other than the order dated 2/13/18 ordering checks to be done twice daily. -There was no policy, guideline, or orders from client #3's physician for staff to follow for results that were too high or too low. -When FSBS results less than 60 were reviewed, the House Manager stated the client would eat breakfast. She might have rechecked the client's blood sugar in the afternoon. Review on 4/9/19 of the Plan of Protection dated 4/9/19 and completed by the Chief Executive Officer(CEO)/Qualified Professional revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Schedule an doctor appt (appointment) for consumer so that the doctor can provider a baseline of high and low blood sugars, and staff will follow the doctors order. When to preform Blood sugar level for consumers. Complete In	V 118		

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	MHL040030	A. BUILDING: _____ B. WING _____	04/10/2019

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V 118	Continued From page 14 Service Training for Diabetic Care and figure stick Blood Sugars. Describe your plans to make sure the above happens. CEO and QM/TD (Quality Manager) will document the appt time and date of the appt and findings. Doctors orders will be implemented by CEO and QM/TD." Client #3 was a diabetic with blood sugars not checked as ordered. The client took Metformin 500 mg ER daily at 8 am to lower her blood sugar, and was ordered to have FSBS checks twice daily. None of the staff had training on diabetes and how to care for someone with diabetes, to include recognizing the signs and symptoms of low blood sugar. Between 1/10/19 and 4/1/19 Client #3's blood sugars ranged from 49 - 177, with results between 60 and 70 on 14 occasions, and less than 60 on 7 occasions. Normal fasting blood sugars would range from 80-130. There was no documentation the staff notified the physician, or took any actions to address the low FSBS results. For each occasion the FSBS was documented to be less than 70, the next documented FSBS was documented the following day in the afternoon. Client #3's low blood sugar results, her FSBS not checked as ordered, staff not reporting low results to the physician, and staff not rechecking client #3's FSBS until the following day in the afternoon when the results were less than 70, put client #3 at risk of developing other medical problems caused by low blood sugar levels. Potential problems included mental confusion, antagonistic behaviors, unconsciousness, or seizures if severe, to name a few. This deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and must be corrected within 23 days. An administrative penalty of $500.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of	V 118		

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V 118	Continued From page 15 $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 118		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by:	V 291		

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V 291	Continued From page 16 Based on record reviews, observations, and interviews the facility failed to coordinate care between the facility and the qualified professionals who are responsible for treatment/habilitation affecting 1 of 3 clients audited (client #3). The findings are: Review on 4/5/19 of client #3's record revealed: -41 year old female. -Admission date 11/2/17. -Diagnoses included Schizophrenia, Obsessive Compulsive Disorder, Diabetes Type A, Mild Intellectual Developmental Disorder; Hypertension, Gastroesophageal Reflux Disease (GERD), Enuresis. -Consultation form dated 8/30/18 documented client #3 was seen by an Optometrist. Client #3 and diagnosed with "Myopia/Astigmatism." Glasses were recommended. -On 1/15/19 client #3's primary care physician documented on the Consultation Form, "Pt (patient) c/o (complained of) urinary incontinence, UA (urinalysis) neg (negative), sounds behavioral. Plans/Recommendation Scheduled voiding so that pt doesn't urinate on herself." -No documentation of a voiding schedule for client #3. -No order to clarify "scheduled voiding" ordered by the physician on 1/15/19. -Documentation client #3 was seen 1/25/19 by the Psychologist. The Psychologist documented she would create a behavior plan based on issues discussed that day. -Client #3 received Zolpidem (Ambien) 5 mg every night at 8 pm (sleep medication). Observations of client #3 on 4/5/18 at 3:20 pm and on 4/9/19 at 10:20 am revealed client #3 was not wearing glasses.	V 291		

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V 291	Continued From page 17 Interview on 4/9/19 the House Manager stated: -There was not a specific schedule to prompt client #3 to void. Client #3 was very independent in going to the bathroom. -Staff reminded client #3 to void before leaving the home. -Incontinence was not a major problem during waking hours. She only recalled one time client #3 voided on herself because they were in the car and could not get to a bathroom facility quickly enough. -The staff tried to awaken client #3 during the night to void, but the client refused to get up. She would pretend to be sleeping and you would see her eyes move but not open. The client had asked that she (staff) touch her to awaken her, but she (House Manager) informed the client this was not permitted. -When asked about the recommendation for glasses, the House Manager stated that Medicaid was not paying for glasses in 2018, but had started paying again as of January 2019. The House Manager called the optometrist and was told her next appointment was scheduled for September, 2019. Interview on 4/9/19 the Chief Executive Officer/Qualified Professional stated: -She was not sure if the physician who ordered Ambien was aware of the primary care physician's order for scheduled voidings and the staff's efforts to awaken client #3 during the night to void. -The Psychologist was in the process of developing a behavior plan for client #3. This could be addressed in the plan. -She would pursue an earlier eye appointment prior to the September 2019 appointment if the client complained or they saw an issue with her vision.	V 291		

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V 291	Continued From page 18 Telephone Interview on 4/10/19 the Psychologist stated: -She saw client #3 and staff on 1/25/19. The behaviors that were the focus for the behavior plan included behaviors such as her being argumentative and staying on task. -The incontinence behaviors were not discussed to be part of the behavior plan. -Staff made her aware client #3 had incontinence issues and that the client had been cleared medically. -It was not shared that the staff had an order for scheduled voidings and staff's efforts to awaken the client in the middle of the night after having received Ambien for sleep. Telephone interview on 4/10/19 the Optometrist staff stated: -Client #3 was given a prescription for glasses when seen on 8/30/18. -The script would have been given at the time the client checked out. -At any time the facility could obtain a copy of the prescription to obtain glasses. Telephone interview on 4/10/19 the Chief Executive Officer/Qualified Professional stated: -She had called the House Manager and discussed the eye glasses order. -At the time of the appointment in August 2018 Medicaid did not pay for eye glasses. -The facility was not obligated to acquire eye glasses if there was no payor source. -She would follow up with the optometrist office.	V 291		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT	V 366		

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V 366	Continued From page 19 RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and 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:	V 366		

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V 366	Continued From page 20 (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (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	V 366		

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V 366	Continued From page 21 (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement a written policy governing their response to Level II incidents. The findings are: Review on 4/5/19 and 4/9/19 of client #1's record revealed: -56 year old female admitted 9/3/08. -Diagnoses included Schizophrenia, Paranoid Type; Nicotine dependence; Severe Mental Retardation; Gastroesophageal Reflux Disease (GERD); Diabetes; Cholesterol Dysfunction; Benign Chest Lumps, lung area; Anemia. -8/10/18 physician consultation form documented client had fallen and was to wear a boot for a toe fracture. -1/15/19 client #1 was seen in the Emergency Room (ER) and diagnosed with a Second-Degree	V 366		

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V 366	Continued From page 22 Burn of her face and ordered to follow up with the burn clinic. -Client #1 was treated at the burn clinic on 1/17/19, 1/24/19, and 2/8/19. Review on 4/9/19 of facility incident reports from 8/1/18 through 4/9/19 revealed: -No incident report for client #1's fractured toe in August 2018. -No Level 2 incident report for client #1's burn on 1/15/19. -Level 1 incident report dated 1/15/19 documented, "At approximately 6:00 pm Staff was assisting member [client #1] with washing and blow drying her hair...Member asked if she could take a break and go smoke a cigarett... staff moistorized, blow dried and plaited members hair... Staff in formed member that she could go smoke at this time. It was approximately 6:40 pm. Staff went to wash her hands and observed member rocking back and forth while trying to light her cigarett. Staff began washing her hands and monitoring member. Staff looked up in time to see that member had accidentally sat her hair on fire. Staff pick up the towel and ran towards member... rapped the towel around her head to put out the flame... She was treated at Med-Direct and returned to group home at approximately 10:20 pm. -No documentation corrective measures were developed or implemented to prevent similar incidents in the future for either incident (fall or burn). Interview on 4/5/19 client #1 stated: -She fell in her room, hit her toe on the table, broke her toe, and had to wear a boot until it healed. She no longer needed the boot. -She accidentally set her hair on fire while smoking.	V 366		

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V 366	Continued From page 23 Interview on 4/5/19 the House Manager stated: -In August 2018 client #1 said she had stumped her toe. She took her to the Sports Medicine physician. She had a fractured toe. Client #1 told the doctor she fell but she (House Manager) did not believe this because she did not hear her fall. She believed client #1 hit her foot against the bed post. She could not locate an incident report. -Client #1 burned herself on 1/15/19. She was taken to the ER that night and was referred to burn center. Client #1 received a tetanus booster injection in addition to wound care while in the ER. -She does not enter incident reports into IRIS. These are submitted to the Qualified Professional. Interview on 4/9/19 the Chief Executive Officer/Qualified Professional stated: -She thought there was an incident report for client #1's toe injury. -These incidents had not been identified as meeting Level 2 criteria.	V 366		
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	V 367		

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V 367	Continued From page 24 becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III	V 367		

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V 367	Continued From page 25 incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure Level II incident reports were submitted to the Local Management Entity (LME) within 72 hours as required. The findings are: Review on 4/5/19 of the North Carolina Incident	V 367		

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LUCILLE'S BEHAVIORAL, INC. #2	351 HOLLOMAN ROAD WALSTONBURG, NC 27888

(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 26 Response Improvement System (IRIS) reports between August 2018 and April 2019 revealed no Level II incident reports had been submitted by the facility. Review on 4/5/19 and 4/9/19 of client #1's record revealed: -56 year old female admitted 9/3/08. -Diagnoses included Schizophrenia, Paranoid Type; Nicotine dependence; Severe Mental Retardation; Gastroesophageal Reflux Disease (GERD); Diabetes; Cholesterol Dysfunction; Benign Chest Lumps, lung area; Anemia. -8/10/18 physician consultation form documented client had fallen and was to wear a boot for toe fracture. -1/15/19 client #1 was seen in the Emergency Room (ER) and diagnosed with Second-Degree Burn of her face and ordered to follow up with the burn clinic. -Client #1 was treated at the burn clinic on 1/17/19, 1/24/19, and 2/8/19. Interview on 4/9/19 the Chief Executive Officer/Qualified Professional stated: -Because there was no police involvement she had not thought about these incidents being Level II incidents. -No Level II incidents had been submitted for client #1's 2 injuries in August 2018 or second degree burn in January 2019. Refer to V366 for additional details.	V 367		