STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-045	A. BUILDING: _____ B. WING _____	05/02/2019

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V 000	INITIAL COMMENTS An annual survey was completed on May 2, 2019. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .4100 Residential Recovery for Individuals with Substance Abuse Disorders and Their Children.	V 000		
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: (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	V 108		

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V 108	Continued From page 1 and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff were currently trained in first aid techniques provided by the Red Cross, the American Heart Association, or their equivalence for 1 of 3 staff audited (Staff #2). The findings are: Review on 5/01/19 of the Staff #2's personnel file revealed: - Hired 6/04/18. - Documentation of basic life support (BLS) training through American Heart Association dated 4/18/18 (does not include first aid). Interview on 5/01/19 the Human Resources Manager stated: -Facility CPR instructor had changed format to BLS in 2018. The current format being taught includes first aid instruction and first aid will be included in staff education moving forward.	V 108		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to	V 112		

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V 112	Continued From page 2 receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop a treatment plan and strategies based on client needs and assessment effecting 1 of 2 current clients (client #6) and 1 of 2 former clients (FC) audited (FC#10). The findings are: Finding #1: Review on 5/1/19 and 5/2/19 of client #6's record revealed: -19 year old female admitted 10/5/18. -Diagnoses included postpartum with infant, Opioid use disorder. -Referred to social services prior to admission due to self and infant testing positive to illicit drugs.	V 112		

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-Admission assessment documented client had legal issues and was homeless.
-Progress note dated 12/28/18 documented, "[Client #6] was caught shoplifting at [local retail store] and was placed on probationary period due to her behavior. [Client #6] states she does not know what she was thinking to make her want to steal and was very apologetic."
-Incarcerated 2/14/19 - 2/17/19 for shoplifting in December 2018.

Review on 5/1/19 and 5/2/19 of client #6's treatment plan revealed:
-No goals or strategies developed on admission to address shoplifting behaviors.
-No goals or strategies developed to address shoplifting behaviors following her shoplifting in December 2018.
-No goals or strategies addressing homelessness.

Interview on 5/1/19 client #6 stated:
-Was admitted in October with her baby.
-She was told by her social worker about this place and told they help you with recovery from drugs and help you stay clean.
-Has been told a little bit about parenting but the main focus was about drug use and recovery.
-She had attended parenting classes that were conducted at the corporate office.
-She attended the SACOT (Substance Abuse Comprehensive Outpatient Treatment) program. They mainly talk about goals and what they want to accomplish in those groups. Her goals have been about getting her GED (high school equivalency degree), staying clean, and getting house/car. Those were some of the goals that she was working on.
-Nobody really worked with clients on goals for independent living like housing, budgeting, etc.

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V 112	Continued From page 4 Finding #2: Review on 5/1/19 and 5/2/19 of FC #10's record revealed: -39 year old female admitted 9/6/18 and discharged 4/25/19. -Diagnoses included Opioid dependence, chronic back pain, high risk pregnancy, pending legal issues, homeless. -Comprehensive Clinical Assessment documented case management needs for coping skills, parenting skills, employment and housing and a history of depression. -Documentation dated 2/26/19 read, "[FC#10] had a serious relapse due to the stress of her incarcerated partner, her son's sickness, and not being able to find a place to relocate to after treatment." Review on 5/1/19 and 5/2/19 of FC #10's treatment plan revealed no goals or strategies addressing parenting skills, employment, housing, or depression. Interview on 5/2/19 the Clinical Counselor/Qualified Professional (QP) stated: -When admitted, client #6 was on probation for shoplifting that had occurred within 3 months of her admission. She had a goal about her probation and the strategy for this goal was to attend SACOT. -Client #6 was charged with shoplifting in December 2018 during a facility outing to allow clients to shop at a local retail store. -The facility transported clients weekly to the local retail store. This was the client's "free time." Staff would walk around the store to "keep tabs," but not stay with each client. Typically there would be only 1 staff with all the clients. -There had been discussion with client #6 to seek	V 112		

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V 112	Continued From page 5 out the staff if she felt the urge to shoplift. -Client #6 was not allowed to return to the large retail store where the shoplifting occurred, so they now would take her to much smaller stores to shop. -There had been no additions to client #6's treatment plan (goals or strategies) following her shoplifting charges in December 2018. -After reviewing the treatment plans for client #6 and FC#10 with the surveyor, the Clinical Counselor/QP stated she agreed it was difficult to follow all that was done for the clients' goals. Individual counseling sessions were difficult to identify in the client records. -SACOT was used for "everything" to include group, resources, individual counseling, and case management. -She did not realize SACOT was a separately licensed program.	V 112		
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.	V 114		

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V 114	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interview the facility failed to conduct fire and disaster drills on each shift at least quarterly. The findings are: Interview on 5/1/19 the Facility Manager stated the shift times were: -1st shift - 7:30 am - 4 pm -2nd shift - 3:30 pm - 12 am -3rd shift - 12 am - 8:30 am Review of fire and disaster drills documented between 4/1/18 - 3/31/19 revealed: -Quarter 7/1/18 - 9/30/18: No fire or disaster drills documented on the 3rd shift. -Quarter 10/1/18 - 12/31/18: No fire or disaster drills documented on the 1st shift. Continued interview on 5/1/19 the Facility Manager stated: -There was a schedule to make sure drills were done on each shift each quarter. -She monitored the drills. -There was some confusion at the end of 2018 and the staff did extra drills on some shifts and must have missed drills on other shifts.	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 drugs. (2) Medications shall be self-administered by	V 118		

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V 118	Continued From page 7 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 and interviews, the facility failed to administer medications as ordered by the physician and maintain an accurate MAR for 2 of 2 current clients and 1 of 1 former clients (FC) audited (clients #1, #6, and FC#10). The findings are: Finding #1: Review on 5/1/19 and 5/2/19 of client #6's record revealed: -19 year old female admitted 10/5/18. -Diagnoses included postpartum with infant,	V 118		

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V 118	Continued From page 8 Opioid use disorder. -Order dated 2/26/19 for Tylenol 500 mg (milligrams) 1-2 tablets 3 times a day as needed for fever. -Order dated 10/30/18 for Ibuprofen 400mg every 6 hours as needed for hand pain. Review on 5/1/19 of client #6's January and February 2019 MARs revealed: -Tylenol 500 mg, 2 tabs, had been administered for headache on 2/28/19 at 3:21 pm and 8:45 pm. No documentation the client had a fever. -Ibuprofen 400 mg had been administered 2/20/19 at 8:10 pm and 1/2/19 at 8:51 pm for headache. Finding #2: Review on 5/1/19 and 5/2/19 of FC #10's record revealed: -39 year old female admitted 9/6/18 and discharged 4/25/19. -Diagnoses included Opioid dependence, chronic back pain, high risk pregnancy, pending legal issues, homeless. -Order dated 2/5/19 for Labetalol 100 mg twice daily (treat high blood pressure). -Order dated 2/8/19 for Gabapentin 300 mg every 8 hours for chronic pain. Review on 5/1/19 of FC #10's February, March, and April 2019 MARs revealed: -Labetalol 100 mg was administered 2/1/19 at 6:59 am. There ending inventory count documented was"0" (tablets remaining). The next dose documented was on 2/6/19 at 7:05 am. The starting inventory count was "60." (A total of 9 doses of Labetalol 100 mg over 4 1/2 days were not documented as administered.) -Labetalol 100 mg was administered once on 3/7/19 at 8:26 pm (no am dose documented). On	V 118		

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V 118	Continued From page 9 3/6/19 at 8:25 pm the ending inventory count documented was"0." The starting inventory count on 3/7/19 at 8:26 pm was "60." -Labetalol 100 mg was administered once on 4/3/19 at 6:09 am (no pm dose documented). The ending inventory count documented was 7 doses on hand. The next dose documented was on 4/4/19 at 6:06 am with a starting inventory of 7 doses on hand. -2/19/19 Gabapentin 300 mg was documented as given twice at 7 am and 8 pm (ordered 3 times daily). -2/20/19 Gabapentin 300 mg was documented as given once at 8:30 pm. Interview on 5/1/19 staff stated it was likely the reason for missed doses following an ending inventory count of "0" was because they were waiting for the precription to be refilled. Finding #3: Review on 5/1/19 and 5/2/19 of client #1's record revealed -27 year old female admitted 12/18/18. -Diagnoses included Opioid dependence, depression, anxiety, high risk pregnancy, post-traumatic stress disorder (PTSD), and attention deficit hyperactivity disorder (ADHD). -Order dated 1/09/19 for Iron 65mg one tablet, once daily. -Order dated 4/24/19 for saline mist two sprays in each nostril 6 times daily for 10 days. -Order dated 4/25/19 for Abilify 10 mg 1 tablet by mouth once daily (antipsychotic). -Typed letter from Physician dated 5/01/19 stating patient was prescribed "Abilify 10mg." Patient requested a reduction in dosage and physician stated "It is my recommendation that patient remain on prescribed dosage of Abilify and Lamictal titration due to mood lability/anxiety."	V 118		

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V 118	Continued From page 10 -Order dated 3/28/19 for Olazapine 2.5mg "1 tablet by oral route 1 time per day. Take 1-2 tablets PO [taken by mouth] at night for mood stabilization." -Order dated 4/05/19 to discontinue Zyprexa (Olazapine). Review on 5/2/19 of client #1's February, March, April, and May 2019 MARs revealed: -Iron 65 mg - Missing signatures for 2/15/19 - 2/17/19, 4/24/19, and 5/01/19. -Saline Mist - Missing signatures for 4/26/19 (x4), 4/27/19 (x4), 4/29/19 (x6), 4/30/19 (x6) and no May MAR available for review. -Abilify 10mg - April MAR transcribed as Abilify 5mg- Take 1 tablet by mouth daily. No May MAR for review and no medication on hand for review. -Olazapine 2.5mg - No clarification obtained on order. Missing signatures on 4/02/19, 4/03/19, and 4/04/19. 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		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. .	V 123		

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V 123	Continued From page 11 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to notify the physician or pharmacist of medication errors and refusals for 1 of 2 current clients and 1 of 1 former client (FC) audited (client #1, FC #2). The findings are: Finding #1: Review on 5/1/19 and 5/2/19 of client #1's record revealed: -27 year old female admitted 12/18/18. -Diagnoses included Opioid dependence, depression, anxiety, high risk pregnancy, post-traumatic stress disorder (PTSD), and attention deficit hyperactivity disorder (ADHD). -Order dated 1/09/19 for Iron 65mg one tablet, once daily. According to client #1's February, March, April, and May 2019 Medication Administration Records (MARs) Iron was not administered 2/15/19 - 2/17/19, 4/24/19, and 5/01/19. -Order dated 4/24/19 for saline mist two sprays in each nostril 6 times daily for 10 days. According to client #1's April 2019 MARs saline mist was not administered for 20 doses between 4/26/19 and 4/30/19. May MAR was unavailable for review. -Order dated 4/25/19 for Abilify 10 mg 1 tablet by mouth once daily (antipsychotic). Typed letter from Physician dated 5/01/19 stating patient was prescribed "Abilify 10mg." Patient requested a reduction in dosage and physician stated "It is my recommendation that patient remain on prescribed dosage of Abilify and Lamictal titration due to mood lability/anxiety." May 2019 MAR was unavailable for review and medication was not on hand. -Order dated 3/28/19 for Olanzapine 2.5mg "1	V 123		

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V 123	Continued From page 12	V 123		

tablet by oral route 1 time per day Take 1-2 tablets PO [taken by mouth] at night for mood stabilization." According to client #1's April 2019 MARs Olanzapine was not administered 4/02/19 - 4/04/19.
-There was no documentation a pharmacist or physician had been notified of missed medications in February, March, April, or May 2019.

Interview on 5/2/19 staff stated client #1 had not received abilify or saline mist due to medication refusals.

Interview on 5/02/19 client #1 stated she had refused saline mist but had not refused abilify. She had requested a reduction in medication dosage but Physician had recommended dosage not be reduced on 5/01/9. She stated she had not taken abilify due to medication not being on hand.

Finding #2:
Review on 5/1/19 and 5/2/19 of FC #10's record revealed:
-39 year old female admitted 9/6/18 and discharged 4/25/19.
-Diagnoses included Opioid dependence, chronic back pain, high risk pregnancy, pending legal issues, homeless.
-Order dated 2/5/19 for Labetalol 100 mg twice daily (treat high blood pressure).
-Order dated 2/8/19 for Gabapentin 300 mg every 8 hours for chronic pain.
-There was no documentation a pharmacist or physician had been notified of missed medications in February, March, or April 2019.

Review on 5/1/19 of FC #10's February, March, and April 2019 MARs revealed:
-Labetalol 100 mg was not documented as

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V 123	Continued From page 13 administered for 9 doses between 2/1/19 and 2/6/19. -Labetalol 100 mg was not documented as administered in the morning on 3/7/19. -Labetalol 100 mg was administered once on 4/3/19 at 6:09 am (no pm dose documented). -2/19/19 Gabapentin 300 mg was documented as given twice at 7 am and 8 pm (ordered 3 times daily). Interviews on 5/1/19 the Facility Manager stated there was no documentation the physician or pharmacist had been notified of medication omissions or refusals. Refer to V118 for additional information.	V 123		
V 364	G.S. 122C- 62 Additional Rights in 24 Hour Facilities § 122C-62. Additional Rights in 24-Hour Facilities. (a) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-61, each adult client who is receiving treatment or habilitation in a 24-hour facility keeps the right to: (1) Send and receive sealed mail and have access to writing material, postage, and staff assistance when necessary; (2) Contact and consult with, at his own expense and at no cost to the facility, legal counsel, private physicians, and private mental health, developmental disabilities, or substance abuse professionals of his choice; and (3) Contact and consult with a client advocate if there is a client advocate. The rights specified in this subsection may not be restricted by the facility and each adult client may exercise these rights at all reasonable times.	V 364		

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V 364	Continued From page 14 (b) Except as provided in subsections (e) and (h) of this section, each adult client who is receiving treatment or habilitation in a 24-hour facility at all times keeps the right to: (1) Make and receive confidential telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party; (2) Receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over therapies; (3) Communicate and meet under appropriate supervision with individuals of his own choice upon the consent of the individuals; (4) Make visits outside the custody of the facility unless: a. Commitment proceedings were initiated as the result of the client's being charged with a violent crime, including a crime involving an assault with a deadly weapon, and the respondent was found not guilty by reason of insanity or incapable of proceeding; b. The client was voluntarily admitted or committed to the facility while under order of commitment to a correctional facility of the Division of Adult Correction of the Department of Public Safety; or c. The client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; A court order may expressly authorize visits otherwise prohibited by the existence of the conditions prescribed by this subdivision; (5) Be out of doors daily and have access to facilities and equipment for physical exercise several times a week; (6) Except as prohibited by law, keep and use personal clothing and possessions, unless the	V 364		

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V 364	Continued From page 15 client is being held to determine capacity to proceed pursuant to G.S. 15A-1002; (7) Participate in religious worship; (8) Keep and spend a reasonable sum of his own money; (9) Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes; and (10)Have access to individual storage space for his private use. (c) In addition to the rights enumerated in G.S. 122C-51 through G.S. 122C-57 and G.S. 122C-59 through G.S. 122C-61, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to have access to proper adult supervision and guidance. In recognition of the minor's status as a developing individual, the minor shall be provided opportunities to enable him to mature physically, emotionally, intellectually, socially, and vocationally. In view of the physical, emotional, and intellectual immaturity of the minor, the 24-hour facility shall provide appropriate structure, supervision and control consistent with the rights given to the minor pursuant to this Part. The facility shall also, where practical, make reasonable efforts to ensure that each minor client receives treatment apart and separate from adult clients unless the treatment needs of the minor client dictate otherwise. Each minor client who is receiving treatment or habilitation from a 24-hour facility has the right to: (1) Communicate and consult with his parents or guardian or the agency or individual having legal custody of him; (2) Contact and consult with, at his own expense or that of his legally responsible person and at no cost to the facility, legal counsel, private physicians, private mental health, developmental	V 364		

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disabilities, or substance abuse professionals, of his or his legally responsible person's choice; and
(3) Contact and consult with a client advocate, if there is a client advocate.
The rights specified in this subsection may not be restricted by the facility and each minor client may exercise these rights at all reasonable times.
(d) Except as provided in subsections (e) and (h) of this section, each minor client who is receiving treatment or habilitation in a 24-hour facility has the right to:
(1) Make and receive telephone calls. All long distance calls shall be paid for by the client at the time of making the call or made collect to the receiving party;
(2) Send and receive mail and have access to writing materials, postage, and staff assistance when necessary;
(3) Under appropriate supervision, receive visitors between the hours of 8:00 a.m. and 9:00 p.m. for a period of at least six hours daily, two hours of which shall be after 6:00 p.m.; however visiting shall not take precedence over school or therapies;
(4) Receive special education and vocational training in accordance with federal and State law;
(5) Be out of doors daily and participate in play, recreation, and physical exercise on a regular basis in accordance with his needs;
(6) Except as prohibited by law, keep and use personal clothing and possessions under appropriate supervision, unless the client is being held to determine capacity to proceed pursuant to G.S. 15A-1002;
(7) Participate in religious worship;
(8) Have access to individual storage space for the safekeeping of personal belongings;
(9) Have access to and spend a reasonable sum of his own money; and

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V 364	Continued From page 17 (10)Retain a driver's license, unless otherwise prohibited by Chapter 20 of the General Statutes. (e) No right enumerated in subsections (b) or (d) of this section may be limited or restricted except by the qualified professional responsible for the formulation of the client's treatment or habilitation plan. A written statement shall be placed in the client's record that indicates the detailed reason for the restriction. The restriction shall be reasonable and related to the client's treatment or habilitation needs. A restriction is effective for a period not to exceed 30 days. An evaluation of each restriction shall be conducted by the qualified professional at least every seven days, at which time the restriction may be removed. Each evaluation of a restriction shall be documented in the client's record. Restrictions on rights may be renewed only by a written statement entered by the qualified professional in the client's record that states the reason for the renewal of the restriction. In the case of an adult client who has not been adjudicated incompetent, in each instance of an initial restriction or renewal of a restriction of rights, an individual designated by the client shall, upon the consent of the client, be notified of the restriction and of the reason for it. In the case of a minor client or an incompetent adult client, the legally responsible person shall be notified of each instance of an initial restriction or renewal of a restriction of rights and of the reason for it. Notification of the designated individual or legally responsible person shall be documented in writing in the client's record. This Rule is not met as evidenced by: Based on record reviews, and interviews, the	V 364		

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V 364	Continued From page 18 facility failed to ensure that restriction of clients' rights (make/receive phone calls, receive visitors) were implemented, documented, and reviewed as required effecting 1 of 2 current clients audited and 1 of 2 former clients (FC) audited (client #6, FC#9). The findings are: Review on 5/1/19 and 5/2/19 of client #6's record revealed: -19 year old female admitted 10/5/18. -Diagnoses included postpartum with infant, Opioid use disorder. -Note dated 12/28/18 documented, "[client #6] was caught shoplifting at [a local retail store] and was placed on probationary period due to her behavior." No documentation of the specific restrictions imposed by the "probationary period." -Documentation 4/23/19 client #6 failed urine drug screen and was given "consequences." -No written statement in the client's record documenting detailed reason for the restriction, how the restriction related to the client's treatment or habilitation needs, or the effective period of time the restrictions were to be in effect. No documentation of the Qualified Professional evaluation of restrictions that resulted from the December 2018 shoplifting behavior, or how long the restrictions were in place. -No documentation an individual designated by the client was notified of the restriction and of the reason for it. No documentation the client had chosen to to have an individual notified. Review on 5/2/19 of FC #9's record revealed: -Female admitted 9/6/18 and discharged 3/15/19. -Diagnoses included cocaine dependence, hepatitis C, depression, high risk pregnancy, probation, legal issues, homeless. -Documentation dated 12/28/18, FC #9 was counseled on her larceny behavior that she was	V 364		

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V 364	Continued From page 19 caught doing the prior day in a local retail store. FC #9 was upset over having to turn in her phone to the Program Director and showed negative behavior. FC #9 calmed down quickly and realized she was responsible for her actions and apologized and turned in her phone. -No written statement in the client's record documenting detailed reason for the restriction, how the restriction related to the client's treatment or habilitation needs, or the effective period of time the restrictions were to be in effect. No documentation of the Qualified Professional evaluation of each restriction and how long the restrictions were in place. -No documentation an individual designated by the client was notified of the restriction and of the reason for it. No documentation the client had chosen to to have an individual notified. Interview on 5/1/19 client #6 stated: -She had lost rights to visitors on Sundays, day passes, and had lost her phone when she failed a drug test. -The Qualified Professional, Program Director, and Facility Manager were the individuals that applied that punishment. -She did not feel like they applied these restrictions evenly to everyone. Some other girls failed their screenings and they did not have the same happen to them. -She was informed of how long she would lose her phone and passes, but not visitations. Interview on 5/1/19 Staff #8 stated: -If a client was on restriction her role as staff is to monitor and reinforce. -An example given, if the client could not have their cell phone, they could not use the house phone or borrow another client's phone.	V 364		

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V 364	Continued From page 20 Interview 5/2/19 the Facility Manager stated: -Restrictions were implemented by the Program Director and Qualified Professional. -Client #6 had her phone and home passes taken away as a consequence of her recent positive drug screen. -If a client's phone was taken, the phone was given to the Facility Manager. She had possession of client #6's phone. -It was her understanding that client #6's phone and passes had been taken "indefinitely" due to her recent positive drug screen. -She was not aware of a specific place restrictions were documented. -When a client's phone privileges were taken away the client could not use the house phone to make calls and could not borrow another client's phone to make calls.	V 364		
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 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	V 366		

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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
(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

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V 366	Continued From page 22 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 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.	V 366		

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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 I and Level II incidents. The findings are:

Finding #1:
Review on 5/1/19 and 5/2/19 of client #6's record revealed:
-19 year old female admitted 10/5/18.
-Diagnoses included postpartum with infant, Opioid use disorder.
-Progress note dated 12/28/18 documented client #6 was caught shoplifting at local retail store.
-Client #6 was incarcerated 2/14/19 - 2/17/19 for shoplifting in December 2018.

Finding #2:
Review on 5/2/19 of FC #9's record revealed:
-Female admitted 9/6/18 and discharged 3/15/19.
-Diagnoses included cocaine dependence, hepatitis C, depression, high risk pregnancy, probation, legal issues, homeless.
-Documentation dated 12/28/18, FC #9 was caught shoplifting at a local retail store the prior day.

Finding #3:
Review on 5/1/19 and 5/2/19 of client #1's record revealed:
-27 year old female admitted 12/18/18.
-Diagnoses included Opioid dependence, depression, anxiety, high risk pregnancy, post-traumatic stress disorder (PTSD), and attention deficit hyperactivity disorder (ADHD).
-Order dated 1/09/19 for Iron 65mg one tablet,

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once daily. According to client #1's February, March, April, and May 2019 Medication Administration Records (MARs) Iron was not administered 2/15/19 - 2/17/19, 4/24/19, and 5/01/19.
-Order dated 4/24/19 for saline mist two sprays in each nostril 6 times daily for 10 days. According to client #1's April 2019 MARs saline mist was not administered for 20 doses between 4/26/19 and 4/30/19. May MAR was unavailable for review.
-Order dated 4/25/19 for Abilify 10 mg 1 tablet by mouth once daily (antipsychotic). Typed letter from Physician dated 5/01/19 stating patient was prescribed "Abilify 10mg." Patient requested a reduction in dosage and physician stated "It is my recommendation that patient remain on prescribed dosage of Abilify and Lamictal titration due to mood lability/anxiety." May 2019 MAR was unavailable for review and medication was not on hand.
-Order dated 3/28/19 for Olanzapine 2.5mg "1 tablet by oral route 1 time per day Take 1-2 tablets PO [taken by mouth] at night for mood stabilization." According to client #1's April 2019 MARs Olanzapine was not administered 4/02/19 - 4/04/19.

Finding #4:
Review on 5/1/19 and 5/2/19 of FC #10's record revealed:
-39 year old female admitted 9/6/18 and discharged 4/25/19.
-Diagnoses included Opioid dependence, chronic back pain, high risk pregnancy, pending legal issues, homeless.
-Order dated 2/5/19 for Labetalol 100 mg twice daily (treat high blood pressure). According to FC #10's February, March, and April 2019 Medication Administration Records (MARs) Labetalol 100 mg was not administered for 9 doses between 2/1/19

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V 366	Continued From page 25 and 2/6/19, and not administered in the morning on 3/7/19 or the evening on 4/3/19. -Order dated 2/8/19 for Gabapentin 300 mg every 8 hours for chronic pain. According to the documentation on FC #10's February 2019 MAR the client missed a dose of Gabapentin 300 mg on 2/19/19. Review on 5/1/19 and 5/2/19 of the facility incident reports revealed: -No incident reports were documented for client #6's shoplifting incident in December 2018 or incarceration in February 2019. -No incident report was documented for FC #9's shoplifting incident 12/27/19 -No level I incident reports were documented for client #1's medication omissions. -No level I incident reports were documented for FC #10's medication omissions. Interview on 5/2/19 the Clinical Counselor/Qualified Professional (QP) stated: -Client #6 and FC#9 were charged with shoplifting in December 2018 during a facility outing to shop at a local retail store. -The store called the police. -The facility was informed client #6 and FC #9 were being charged with trespassing and shoplifting. -When client #6 went before a judge in February 2019, she was sentenced to jail for 4 days. She was incarcerated from 2/14/19-2/17/19. -It would have been the former Program Director's responsibility to complete Level II incident reports.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT	V 367		

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V 367	Continued From page 26 REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (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	V 367		

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	MHL078-045	A. BUILDING: _____ B. WING _____	05/02/2019

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V 367	Continued From page 27 obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided 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.	V 367		

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V 367	Continued From page 28 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all level II incidents within 72 hours of becoming aware of the incident for 1 of 2 current clients, and 1 of 2 former clients (FC) audited (client #6, FC#9).The findings are: Review on 5/1/19 and 5/2/19 of client #6's record revealed: -19 year old female admitted 10/5/18. -Diagnoses included postpartum with infant, Opioid use disorder. -Progress note dated 12/28/18 documented, client #6 was caught shoplifting at local retail store. -Client #6 had been incarcerated 2/14/19 - 2/17/19 for shoplifting in December 2018. Review on 5/2/19 of FC #9's record revealed: -Female admitted 9/6/18 and discharged 3/15/19. -Diagnoses included cocaine dependence, hepatitis C, depression, high risk pregnancy, probation, legal issues, homeless. -Documentation dated 12/28/18, FC #9 was caught shoplifting at a local retail store the prior day. Review on 5/1/19 of the North Carolina Incident Response Improvement System (IRIS) reports from December 2018 through April 30, 2019 revealed no Level II incident reports for the facility. Interview on 5/2/19 the Clinical Counselor/Qualified Professional (QP) stated: -The police were called to the scene of the	V 367		

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V 367	Continued From page 29 shoplifting incident in December 2018 by client #6 and FC#9. -It would have been the former Program Director's responsibility to complete Level II incident reports. -She was not "privy" to the IRIS system. Refer to V366 for additional information.	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 5/01/19 at approximately 10:15am of the facility revealed: - There were 2 light bulbs in kitchen area in non-working order. - Debris particles scattered on the bottoms of kitchen and dining room cabinets and drawers. - Upholstery surfaces worn away on seats of 3 dining room chairs. - Top of dining room table "sticky" to touch. - Paint worn from around the dining room exit door hardware. - Dust visible on kitchen ceiling heat/air vent and on the wall above the door leading to the pantry.	V 736		

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V 736	Continued From page 30 - The dining room revealed dust build up accumulated on ceiling vent. Air filter for ventilation system was missing from the vent. Cobwebs were observed in top left and right corners, and 1 light bulb was noted in non-working order. - Room A revealed 2 light bulbs in non-working order. Splatter stains appeared on 2 of the 3 walls (left and right) over the sink, approximately 3-4 feet from the floor. - Room B revealed splatter stains on 2 of the 3 walls (left and right) over the sink. Stains were identified approximately 3-4 feet from the floor. - Room C revealed splatter stains on 2 of the 3 walls (left and right) over the sink. Stains were identified approximately 3-4 feet from the floor. - Room D revealed splatter stains on 2 of the 3 walls (left and right) over the sink. Stains were identified approximately 3-4 feet from the floor. Water stain was observed running the length of the wall from under the wall mounted air-conditioning unit. - Room E revealed splatter stains on 2 of the 3 walls (left and right) over the sink. Stains were identified approximately 3-4 feet from the floor. Water stain was observed running the length of the wall (approximately 6 feet) from the wall mounted air-conditioning unit. There were 2 light bulbs in bathroom area in non-working order. - Room F revealed splatter stains on 2 of the 3 walls (left and right) over the sink. Stains were identified approximately 3-4 feet from the floor. There was a towel bar that was not completely attached to the bathroom wall. - Room G revealed scuff marks along a 24" x 24" space in the right corner of the back wall. There was a crack in the ceiling over the sink, extending approximately 16". There were splatter stains on 2 of the 3 walls (left and right) over the sink. Stains were identified approximately 3-4 feet from	V 736		

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V 736	Continued From page 31 the floor. - Room I revealed splatter stains on 2 of the 3 walls (left and right) over the sink. Stains were identified approximately 3-4 feet from the floor. The baseboard running along the far wall with window was separating, extending approximately 48" from the right hand corner. Interview on 5/1/19 the Maintenance Staff stated: - He was on site making repairs on a faucet in the kitchen. - He checked the air return vent in the dining room and stated there was no filter in the vent and there should have been one in place. He would make sure it was replaced. - He fixed the towel bar in room- F. Interview on 5/1/19 the Facility Manager stated: - She would follow up to address the cleanliness of the cabinets and dust accumulation. - She would follow up on identified issues.	V 736		