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| V 000 | INITIAL COMMENTS<br><br>A complaint survey was completed on May 30, 2019. The complaints were substantiated (Intake #NC00151976 and NC00152007). Deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment Facility for Children and Adolescents. | V 000 | | |
| V 314 | 27G .1901 Psych Res. Tx. Facility - Scope<br><br>10A NCAC 27G .1901 SCOPE<br>(a) The rules in this Section apply to psychiatric residential treatment facilities (PRTF)s.<br>(b) A PRTF is one that provides care for children or adolescents who have mental illness or substance abuse/dependency in a non-acute inpatient setting.<br>(c) The PRTF shall provide a structured living environment for children or adolescents who do not meet criteria for acute inpatient care, but do require supervision and specialized interventions on a 24-hour basis.<br>(d) Therapeutic interventions shall address functional deficits associated with the child or adolescent's diagnosis and include psychiatric treatment and specialized substance abuse and mental health therapeutic care. These therapeutic interventions and services shall be designed to address the treatment needs necessary to facilitate a move to a less intensive community setting.<br>(e) The PRTF shall serve children or adolescents for whom removal from home or a community-based residential setting is essential to facilitate treatment.<br>(f) The PRTF shall coordinate with other individuals and agencies within the child or | V 314 | | |

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| V 314 | Continued From page 1<br>adolescent's catchment area.<br>(g) The PRTF shall be accredited through one of the following; Joint Commission on Accreditation of Healthcare Organizations; the Commission on Accreditation of Rehabilitation Facilities; the Council on. Accreditation or other national accrediting bodies as set forth in the Division of Medical Assistance Clinical Policy Number 8D-1, Psychiatric Residential Treatment Facility, including subsequent amendments and editions. A copy of Clinical Policy Number 8D-1 is available at no cost from the Division of Medical Assistance website at http://www.dhhs.state.nc.us/dma/.<br><br>This Rule is not met as evidenced by:<br>Based on record review, observation, and interviews, the facility failed to assure coordination with agencies and individuals responsible for the treatment for 1 of 5 audited clients (client #3). The findings are:<br><br>Review on 5/30/19 of client #3's record revealed:<br>-13 year old male admitted 6/29/18.<br>-Diagnoses included Disruptive Mood Dysregulation Disorder; Attention Deficit Hyperactive Disorder (ADHD), Oppositional Defiant Disorder, Trauma and Stress related Disorders.<br>-5/16/19: Physician ordered right hand x-ray for pain and swelling.<br>-5/16/19: Physician ordered for client to go to an urgent care facility to have his right hand splinted for a boxer's fracture.<br>-5/16/19: Physician ordered the right hand brace | V 314 | | |

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| V 314 | Continued From page 2<br>(splint applied at urgent care center) to be worn at all times except when showering. The client was to be on close observation while wearing the brace.<br>-5/27/19: Physician ordered a follow up with an Orthopedic physician "as soon as possible." Ordered client #3 to wear the splint/brace with close observation "24/7" (24 hours every day) except when bathing.<br>-No documentation when client #3 lost his brace.<br>-No appointment for client #3 with an Orthopedic physician documented.<br>-No documentation the physician had been notified that client #3's brace had been lost and there was difficulty getting an appointment with an Orthopedic physician.<br><br>Observation on 5/30/19 at 9:15 am revealed client #3 was not wearing a splint or brace on his right hand.<br><br>Interview on 5/30/19 client #3 stated:<br>-He broke his right hand after punching a wall. He was evaluated at the facility and then taken for additional medical attention. Following an x-ray, he was provided with a removable splint for his hand and advised to remove the splint during showers. Hand splint was described as a supportive device with a metal insert which assisted in stabilizing the hand. On unspecified evening (he was unable to recall the date), he removed the splint and completed bathing. Splint was placed in the bathroom area prior to shower. Upon completion of bathing, he neglected to apply the hand splint and went to bed. When he awoke the next morning he applied the hand splint and noticed that the metal insert had been removed. He was not certain who had removed the insert. He was under "close obs" (close observation) during the period the splint insert | V 314 | | |

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| V 314 | Continued From page 3<br>went missing, and detailed close observation as being within line of sight of staff at all times. He had not used the splint in approximately 2 weeks and identified use of pain medication, Tylenol and Ibuprofen, to address increased pain in his hand over the previous two weeks. His hand did not hurt as much when he wore the splint.<br><br>Interview on 5/30/19 staff #2 stated:<br>-Client #3 had informed her that he was permitted to remove his hand splint for bathing.<br>-Client #3 was under "close obs" during periods when his hand splint was in use.<br>-She was advised by nursing staff that client #3 should not do strenuous activities when wearing the hand splint. She was not advised on specific time frames for use of the splint and was not directed on how the splint should be used.<br>-She had last seen client #3 wearing the hand splint on 5/26/19 but could not recall an exact time.<br><br>Interview on 5/30/19 the Director of Nursing stated:<br>-She was not aware client #3 had not been wearing his hand brace.<br>-The nursing staff had tried to get an appointment with an Orthopedic physician, but it was difficult to get the appointment.<br>-There was no documentation the physician had been consulted about the loss of client #3's brace and the difficulty in getting an Orthopedic appointment.<br>-She had checked with the staff and no one knew when the client had lost his brace. | V 314 | | |
| V 366 | 27G .0603 Incident Response Requirments<br><br>10A NCAC 27G .0603 INCIDENT | V 366 | | |

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| V 366 | Continued From page 4<br>RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS<br>(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:<br>(1) attending to the health and safety needs of individuals involved in the incident;<br>(2) determining the cause of the incident;<br>(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;<br>(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;<br>(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;<br>(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<br>(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.<br>(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.<br>(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:<br>(1) immediately securing the client record by: | V 366 | | |

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| V 366 | Continued From page 5<br>(A) obtaining the client record;<br>(B) making a photocopy;<br>(C) certifying the copy's completeness; and<br>(D) transferring the copy to an internal review team;<br>(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:<br>(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;<br>(B) gather other information needed;<br>(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<br>(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 6<br>(3) immediately notifying the following:<br>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;<br>(B) the LME where the client resides, if different;<br>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;<br>(D) the Department;<br>(E) the client's legal guardian, as applicable; and<br>(F) any other authorities required by law.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews the facility failed to implement policies for response to incidents as required. The findings are:<br><br>Review on 5/28/19 and 5/29/19 of client # 1's record revealed:<br>-14 year old male admitted 1/6/19.<br>-Diagnoses included Major Depressive Disorder, recurrent, moderate; ADHD (Attention Deficit Hyperactive Disorder); Conduct Disorder; Generalized Anxiety Disorder.<br>-Staff Daily Monitoring Shift Note dated 4/25/19 at 10:15 pm read, "... stated roommate touch him last night..." and was signed by Staff #1.<br>-Case Management Progress note dated 4/30/19 by Former Staff Therapist documented client #1 disclosed in individual therapy an incident of sexual misconduct by his roommate the prior | V 366 | | |

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| V 366 | Continued From page 7 | V 366 | | |

week. The Director of Quality Assurance (QA) and Risk Management, Patient Representative, Director of Clinical Services were informed. The client's mother was notified.

Review on 5/28/19 of facility Incident Log and the North Carolina Incident Response Improvement System reports for April 2019 revealed no level I or II incident reports for client #1's allegations of sexual misconduct by a peer.

Review on 5/28/19 of facility electronic mail dated 4/30/19 revealed:
-Former Staff Therapist notified the Director of QA and Risk Management, Patient Representative, and Director of Clinical Services of client #1's allegations against his room mate.
-The Director of QA and Risk Management notified the Milieu manager and client #1 was moved to a different room on 4/30/19.

Interview on 5/28/19 client #1 stated:
-He had been hurt by a roommate, client #2, but he did not want to say what had happened.
-It happened during the night and he told 3 staff the very next day.
-Nothing happened in response to his report for 2-3 weeks.
-He told his mother and she had "pressed charges."
-He told his therapist. She seemed "very worried" about him and "changed everything." He was moved to another room and his therapist "processed" with him. This therapist no longer worked for the facility.
-When his room mate hurt him, he (client #1) made a "squeaking sound." Staff heard this and looked inside the room, but client #2 had gotten back to his side of the room.
-The Director of QA and Risk Management or

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| V 366 | Continued From page 8<br>Patient Representative had not spoken with him about the incident.<br>-He did not feel safe.<br><br>Interview on 5/28/19 Staff #1 stated:<br>-Client #1 told her client #2 had touched him inappropriately. She reported this to staff #4 because he had been an employee longer.<br>-She did not think she needed to do anything else, but now knows she should have done an incident report.<br>-She thought Staff #4 told the nurse, but she could not recall the nurse on duty.<br><br>Interview on 5/28/19 Staff #4 stated:<br>-Client #1 told him client #2 put his hands down into his pajama pants while he was sleeping.<br>-He passed this on to the nurse but was not sure who was on duty.<br>-He wrote a statement and gave it to the Milieu Manager.<br><br>Interview on 5/30/19 the Milieu Manager stated she moved client #1 into another room the same day she was informed of his allegations about his roommate.<br><br>Telephone interview on 5/29/19 the Former Staff Therapist stated:<br>-She was not sure if anything other than moving client #1 from the room with client #2 had been done.<br>-Typically the Director of QA and Risk Management or the Patient Representative will look into a situation and give the therapist feedback. She had not been informed either had talked with client #1.<br>-When she asked client #1 why he had not told her sooner, his response was that he had told other staff. | V 366 | | |

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| V 366 | Continued From page 9<br>-She did not do an incident report.<br>-She was concerned client #1 stayed in the same room with client #2 a week after making his report to staff. Generally the facility does follow up on incidents and this was out of the ordinary. | V 366 | | |
| V 367 | 27G .0604 Incident Reporting Requirements<br><br>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS<br>(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:<br>(1) reporting provider contact and identification information;<br>(2) client identification information;<br>(3) type of incident;<br>(4) description of incident;<br>(5) status of the effort to determine the cause of the incident; and<br>(6) other individuals or authorities notified or responding.<br>(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 | V 367 | | |

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| V 367 | Continued From page 10 | V 367 | | |

day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided 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

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| V 367 | Continued From page 11<br>the possession of a client;<br>(5) the total number of level II and level III incidents that occurred; and<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to report all level II incidents within 72 hours. The findings are:<br><br>Review on 5/28/19 and 5/29/19 of client # 1's record revealed:<br>-14 year old male admitted 1/6/19.<br>-Diagnoses included Major Depressive Disorder, recurrent, moderate; ADHD (Attention Deficit Hyperactive Disorder); Conduct Disorder; Generalized Anxiety Disorder.<br>-Staff Daily Monitoring Shift Note dated 4/25/19 at 10:15 pm read, "... stated roommate touch him last night..." and was signed by Staff #1.<br>-Case Management Progress note dated 4/30/19 by Former Staff Therapist documented client #1 disclosed in individual therapy an incident of sexual misconduct by his roommate the prior week. The Director of Quality Assurance (QA) and Risk Management, Patient Representative, Director of Clinical Services were informed. The client's mother was notified.<br><br>Review on 5/28/19 of the North Carolina Incident Response Improvement System (IRIS) reports from 5/16/19 to 5/28/19 revealed no Level II | V 367 | | |

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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 |
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| V 367 | Continued From page 12<br>incident reports pertaining to client #1's allegation and involvement with other oversight agencies or law enforcement.<br><br>Telephone interview on 5/28/19 with local Department of Social Services staff revealed:<br>-A report had been received about an allegation of sexual assault by client #2 against client #1. It had been reported the two clients shared a room and continued to be in the same room for a week following the alleged incident.<br>-She and a detective had made a visit to the facility to investigate the incident on 5/21/19.<br><br>Interview on 5/28/19 the Quality Specialist stated:<br>-He could not locate an incident report for client #1's allegation.<br>-There was no level II incident report filed following the social services and law enforcement representatives on site visit to investigate client #1's allegation.<br><br>Refer to tag V366 for additional information. | V 367 | | |