STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL-059-072	A. BUILDING: _____ B. WING _____	C 06/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEAR SKY GROUP HOME	55 RAILROAD STREET MARION, NC 28752

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V 000	INITIAL COMMENTS A complaint survey was completed on June 10, 2019. The complaint was substantiated (intake #NC00151771). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.	V 000		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following 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	V 367	DHSR - Mental Health JUL 11 2019 Lic. & Cert. Section	

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V 367	Continued From page 1 missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death 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	V 367	Reference page 3	

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V 367	Continued From page 2 the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to notify the Local Management Entity (LME) of all Level II incident reports within 72 hours. The findings are: Review on 6/7/19 of facility incident reports for April 2019 and May 2019 revealed: -4/18/19, a Level 1 written incident report contained the following information: -Former Client (FC #1) vomited at school and appeared to have been under the influence of illicit substances; -He returned to the facility where staff gave him two drug tests that were positive for an illicit substance; -FC #1 was taken to a local hospital by the Qualified Professional (QP #3) due to concern he may have swallowed an object; -There was no finding he had swallowed an object but FC #1 was given a 5-day out of school suspension for illicit substance activity; -QP #3 completed an IRIS (NC Incident Response Improvement System) report about	V 367	Resident was taken to the hospital where he was determined to be using THC at the High School. SAfety and Judicial procedures were followed but it has been noted that this would be considered a Level II type incident vice Level I. All staff have been trained in the reporting requirements and the criteria for each level.	

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V 367	Continued From page 3 this incident; -5/9/19, a Level 1 written incident report described the following: -At approximately 7:03 pm, FC #1 was in the facility's living room talking with other clients when Client #7 came into the living room and attempted to assault FC #1; -FC #1 and Client #7 were separated by Staffs #3 and #4 in the living room and these clients were walked by these two staff to their individual bedrooms; -Client #7 exited his bedroom, entered FC #1's bedroom, and attempted to assault FC#1; -The House Manager (HM) was notified by staff of the incidents between Client #7 and FC #1; -FC #1 sustained superficial injuries or "rub burns" to his neck and no First Aid was required; -FC #1 was transported to the local magistrate by the Administrator/QP #2 where FC #1 and the Administrator/QP #2 each gave their "testimony" about what had happened between Client #7 and FC #1 at the facility and which resulted in a legal charge against Client #7; -The Administrator/QP #2 viewed camera footage at the facility of the aggressive incident; -There was no documentation that indicated the legal guardians of Client #7 and FC #1 were notified of this incident. -5/28/19, a Level 1 written incident report had Client #1 had walked out of the facility and walked around the building but never left the property; -Client #1 was reminded by staff that if he left the property, it would become a law enforcement matter; -No additional incident reports were found during this time period that related to attempted or actual elopement incidents by facility clients. Review on 6/7/19 of the NC Incident Response Improvement System (IRIS) for reports for FC #1	V 367	Reference page 5	

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V 367	Continued From page 4 and Client #7 revealed: -No Level II reports that pertained to FC #1 were found; -The last IRIS report found for Client #7 was dated 3/25/19. Review on 6/7/19 of a written local law enforcement incident/investigation report dated 5/9/19 at 7:43pm revealed Client #7 was charged and arrested on 5/9/19 with simple assault of FC #1 by having punched FC #1 and no injuries to either client was identified. Review on 6/7/19 of the facility's written policy on incident reporting dated 8/2016 revealed: -A Level II response was any incident that involved a threat to a resident's health or safety or a threat to the health and safety of others due to a resident's behavior; -Staff were required to notify a QP immediately of a Level II or Level III incident; -The QP was required to report a Level II or Level III incident to IRIS; -A QP was responsible for forwarding all incident reports to the facility's administrative staff for submission to the Local Management Entity. Interview on 6/7/19 with the Administrator/QP #2 revealed: -FC #1 was discharged from the facility on 5/19/19 due to his incarceration; -His incarceration was due to possession of scheduled IV controlled substances at school; -Client #7 returned to the facility after he spent 5-6 days in jail from his assault on FC #1; -FC #1 was not at the facility when Client #7 returned from jail as FC #1 spent most of his out-of-school suspension time from 5/10/19 to 5/19/19 in a local juvenile detention center; -The assault incident between Client #7 and FC	V 367	After review of Incident Matrix, Clear Sky Behavioral Staff understand the guidelines for reporting a Level I, II, or III Incident. The MATRIX has been incorporated into company policy and all staff with reporting requirements have been familiarized with the policy. Clear Sky Behavioral followed safety and judicial Guidelines but failed in the reporting aspect of this. IRIS reports were filed and Incident report stated Level I. This has been noted and inaccurate. Copy of revised policy and MATRIX have been included.	

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V 367	Continued From page 5 #1 occurred on 5/9/19; -He was not present at the time of this incident but was notified by staff the same evening the incident occurred, and he came onsite to the facility to assess the situation and safety of all the clients; -The video footage had expired and he was no longer able to make the video footage of the incident available for review on 6/7/19; -He gave the following account of the 5/9/19 incident between Client #7 and FC #1 based on the information he gathered from his review of the video and his interviews with Staffs #3, #4 and #9: -FC #1 and 2 peers were watching a movie in the living room while Client #7 was in his bedroom; -FC #1 made loud statements about Client #7's grandmother not having lived long enough to see Client #7's graduate and Client #7 overheard these statements which made him angry; -Client #7 came out of his room and entered the living room where he "took a swing" at FC #1 and missed which resulted in no physical hit of FC #1; -Client #7 was tackled to the couch by a peer until Staff #3 took over and held Client #7 while Staff #4 held FC #1 to prevent further fighting; -Client #7 and FC #1 were escorted to their individual bedrooms by Staffs #3 and #4; -Staffs #3 and #4 stood at each doorway of each of these clients and talked with them individually to de-escalate their behaviors; -Once Client #7 appeared to have calmed down, Staffs #3 and #4 remained in the hallway and Client #3 found a way out of his room and ran into FC #1's room to attempt to assault him again; -Staffs #3 and #4 took control of both these clients and returned Client #7 to his bedroom -Client #7 nor FC #1 had injuries that	V 367	Reference page 5	

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V 367	Continued From page 6 required First Aid or a local emergency room visit; -He (Administrator/QP #2) took FC #1 to the local magistrate the night of 5/9/19 and the magistrate decided on Client #7's simple assault charge with no charge of property destruction; -He thought the legal guardians of Client #7 and FC #1 had been contacted by QP #3; -He did not consider the incident between Client #7 and FC as an unusual occurrence but he agreed Client #7's aggression on 5/9/19 caused him concern about the safety of all the clients; -The holds and escorts by Staffs #3 and #4 with Client #7 and FC #1 were appropriate and approved techniques for which staff had been formally trained; -Client #1 walked around the facility outside on 5/28/19 but never left the property; -The clients served by the facility had behaviors that included school suspensions and acts of aggression and defiance which were not, in his opinion, unusual occurrences; -The QPs were responsible for completing and submitting Level II and Level III incident reports into IRIS. Interview on 6/7/19 with Client #7 revealed: -He fought with FC #1 in the living room one evening in 5/2019; -He started the fight with FC #1 when he overheard FC #1 talking "crap" about his grandmother not loving him to live long enough to see him graduate high school; -He was in his bedroom when FC #1 talked about his grandmother and it made him mad; -When he came into the living room, he threw a punch at FC #1 but missed him and Client #6 held him (Client #7) down on the couch until Staff #3 held him and Staff #4 held FC #1 back from fighting; -He and FC #1 were walked by Staffs #3 and #4	V 367	Reference page 5	

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V 367	Continued From page 7 and placed into their rooms; -His other house peers were sent to their rooms; -Staff #3 stood in his bedroom doorway and Staff #4 stood in FC #1's bedroom doorway to keep them separated; -He stated, "As soon as Staffs #3 and #4 thought we were okay, I made my move into [FC #1]'s room" because he was thinking he was not done with FC #1; -He threw a punch at FC#1's face and missed him again because FC #1 turned away from him; -He elbowed FC #1 in the groin area and confirmed there was physical contact with FC #1 with intent to harm him; -Staffs #3 and #4 were in the hallway and between their rooms when he ran into FC #1's room; -Either Staff #3 or #4 walked FC #1 out of his room while the other staff (Staff #3 or #4) walked him back to his room; -FC #1 had red marks around his neck where he (Client #7) grabbed FC #1's neck with his hands when Staff #4 held FC #1 in the living room; -Clients #5 and #6 witnessed the incident in the living room between him and FC #1; -He felt like a different person since came back to the facility from jail because he was no longer on his behavior medications; -He stated he believed the behavior medications caused him to have less control over his anger; -He was seen by his doctor after he returned to the facility and his medications were discontinued. Interviews on 6/7/19 with Clients #5 and #6 revealed: -They were consistent in their verbal accounts of FC #1 having talked disrespectful about Client #7's family which triggered Client #7's aggression toward FC #1 in the living room;	V 367	Reference page 5	

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V 367	Continued From page 8 -Client #7 missed physically hitting FC #1 when he swung to hit him; -Staffs #3 and #4 intervened to hold Client #7 and FC #1 from fighting and they were walked back to their individual bedrooms by these two staff while the they (Clients #5 and #6) and their peers were sent to their bedrooms to stay; -Staff #3 stood inside Client #7's bedroom doorway while Staff #4 stood inside FC #1's doorway and were talking with both these clients about calming down; -They heard but did not see the commotion in FC #1's bedroom when Client #7 ran into FC #1's bedroom to attack him; -FC #1 received the red marks around his neck from Client #7 having placed his hands between Staff #4's hold on FC #1 and around his neck to choke him; -They had not seen Client #7 try to fight since he came back from jail. Interviews on 6/7/19 with Staffs #3 and #4 revealed their accounts of the aggression between Client #7 and FC #1 on 5/9/19 were consistent with the accounts provided by Clients #5 and #6. Interviews on 6/7/19 with FC #1's Legal Guardian and Care Coordinator revealed: -The facility had not informed either of them about the 5/9/19 incident between Client #7 and FC #1; -The Care Coordinator learned of the incident from FC #1's juvenile justice counselor who had received a warrant listing of FC #1 as a victim of an assault.	V 367	Reference Page 5	