Premier Behavioral Services, Inc.

2003 Godwin Avenue, Ste. B
Lumberton, NC 28358

(910) 671-1111 **Fax: (910) 671-4454**

August 23, 2019

DHSR - Mental Health

AUG 26 2019

Lic. & Cert. Section

NC Department of Health And Human Services
Division of Health Service Regulation
1800 Umstead Drive, Williams Building
Raleigh, NC 27699-2718

This letter is in reference to an annual, complaint and follow up survey that was completed on 8/7/19. I have attached the plan of correction along with this cover letter.

If you have any questions, please feel free to contact me at 910-374-8137 or via email at lynch@premierbehavioralservices.com.

Sincerely,

Rogelio Lynch, MA/QP
Administrative Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDEPJSUPPLIEFVCLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ e WING	(X3) DATE SURVEY COMPLETED R 08/07/2019

NAME OF PROVIDER OR SUPPLIER: PREMIER BEHAVIORAL SERVICES INC

STREET ADDRESS, CITY, STATE, ZIP CODE: 2003 GODWIN AVENUE STE B LUMBERTON, NC 28358

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on August 7, 2019. The complaint was substantiated (intake #NC00154298). Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G .1200 Psychosocial Rehabilitation Facilities for Individuals with Severe and Persistent Mental Illness; 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program and 10A NCAC 27G .4500 Substance Abuse Comprehensive Outpatient Treatment.	V 000	DHSR - Mental Health AUG 26 2019 Lic. & Cert. Section	
V 115	27G .0208 Client Services 10A NCAC 27G .0208 CLIENT SERVICES (a) Facilities that provide activities for clients shall assure that: (1) space and supervision is provided to ensure the safety and welfare of the clients; (2) activities are suitable for the ages, interests, and treatment/habilitation needs of the clients served; and (3) clients participate in planning or determining activities. (h) Facilities or programs designated or described in these Rules as "24-hour" shall make services available 24 hours a day, every day in the year. unless otherwise specified in the rule. (c)Facilities that serve or prepare meals for clients shall ensure that the meals are nutritious. (d) When clients who have a physical handicap are transported, the vehicle shall be equipped with secure adaptive equipment. (e) When two or more preschool children who require special assistance with boarding or riding in a vehicle are transported in the same vehicle, there shall be one adult, other than the driver, to assist in supervision of the children.	V 115	V115 Premier Behavioral Services will revise its procedures to require: • Eyes on supervision of any service recipient that appears agitated while in the care of the facility. • That a staff is stationed outside in the smoking area whenever a service recipient is present. • That staff who transport service recipients report who they transported to the staff on duty at the facility as part of a hand off procedure.	8/21/19

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	MHL078-251		R 08/07/2019

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V 115	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews staff failed to provide supervision to ensure safety of one of six audited clients (#24). The findings are: Review 08/06/19 of client #24's record revealed: - 61 year old male. - He is his own guardian. - Admission date of 03/19/19. - Diagnoses Schizophrenia-Unspecified Type, Hypokalemia, Dementia and Diabetes Mellitus (DM). - Treatment Plan dated 07/10/19. - No history of elopement and no approved unsupervised time at the facility. Review on 08/07/19 of a "DHHS (Department of Health and Human Services) Incident and Death Report" signed by the Administrative Director revealed: 08/01/19 - Date of Incident: 07/30/19. - Time of Incident: 10:00am. - "Describe the incident, including Who, What, When, Where, and How...[Client #24] sister had contacted me (Administrative Director) 7/29/19 to request that he needs to see the doctor discuss medication. [Client #24] was picked up from home and was being transported to the office. Driver contacted my cellphone and informed me that [Client #24] got out the car. Driver then contacted [local]County Sheriff to inform them that he got out of the car when van stopped and	V 115	• That staff on duty at the facility report to the staff that transports service recipients who they will be transporting as part of a hand off procedure. • That if a service recipient become severely agitated while being transported that the driver immediately call for help from the facility. If necessary, the driver will return to the facility or pull over in a safe area and wait for additional staff. • That facility staff will do documented head counts of participants every hour and immediately contact their supervisor if a service recipient is missing. The staff will immediately search for the missing service recipient. If the service recipient is not found on Premier's grounds or refuses to come back to the program staff will contact the police and report a missing person. The legally responsible person will be immediately contacted and kept abreast of the situation.	

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V 115	Continued From page 2 began An IVC (Involuntary Commitment) was done on client to notify police. Family was notified as well." - "Describe the cause of the incident...Client (#24) walked away from office while providing PSR (Psychosocial Rehabilitation) and/or medication management." - "Describe how this type of incident may be prevented in the future and any corrective measures that have been or will be put in place as a result of the incident...Ensure that staff monitor him closely when behavior is present to where he will be likely to walk away. - Checked boxes to indicate the Local Management Entity (LME)/Managed Care Organization (MCO), local law enforcement and family members were notified of the incident. 08/05/19 - "Current Consumer Status: [Client #24] has been discharged from hospital. [Client #24] had been admitted to the psychiatric unit 8/1/19, and was discharged 8/3/19...[Client #24] family will bring him back to office 8/6/19 for psychiatric evaluation. Family request that his medication be given by injection." Review on 08/07/19 of a local police department "Incident/Investigative Report" for client #24 revealed: - Missing person report. - Last seen 07/30/19 at 10am. - Found 08/01/19 at 2:22pm. Review on 08/06/19 of a local hospital Emergency Room provider documentation for client #24 and dated 08/01/19 revealed: - "Chief Complaint Patient (client #24) presents with Psychiatric Evaluation." - "History of Present Illness: [Client #24] is a 61 y.	V 115	• That the Program Director maintain contact with hospital staff and law enforcement if a service recipient in hospitalized or detained to ensure a clear chain of custody. • All facility staff will be trained in new procedures by the QM Director.	

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V 115	Continued From page 3 (year) o. (old) male who presents for psychiatric evaluation. Patient was resident of Premier Behavioral Service Center which he ran away from two days ago. Patient unable to say where he was for two days but states he did not sleep outside. He has also not been taking his psychiatric medications as prescribed per case manager. Patient's sister also reported patient has not been acting himself, crawling on the ground and throwing stuff out of the house. Patient's brother states patient has not stayed still and is constantly moving. Patient denies feeling depressed, anxious or angry. He does not say why he is not taking his medications. He denies suicidal ideation, homicidal ideation and hallucinations. He further denies h/a (Headache), dizziness, cough, dyspnea, chest pain, nausea, vomiting, diarrhea, abdominal pain." - "Physicial Exam Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished. No distress..." - "IVC paperwork initiated for schizophrenic patient who is non-compliant with medication and has had change in behavior and run away from group home (PSR). Patient does not have capacity to make informed decisions and is danger to self." - "Clinical Impressions:1. Schizophrenia, unspecified type 2. Noncompliance with medication regimen 3. Hypokalemia." Review on 08/06/19 of a "Psychiatry Consultation Note" from a local hospital and dated 08/02/19 revealed: - "[Client #24] is a 61 y. o. y/o (years old) young male with hx. (history) of auditory hallucination, DM, COPD (Chronic Obstructive Pulmonary Disease), Dementia, HTN (Hypertension), HLD (Hypersensitive Lung Disease), CHF (Congestive Heart Disease) per medical hospital records.	V 115		

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V 115	Continued From page 4	V 115		

Chief Complaint: Psych (psychiatric) evaluation. HPI (History of present illness) 61-year old male seen in emergency room for psychiatric evaluation. No family at bedside. According to ER (Emergency Room) notes, patient sister and brother reports he has not been acting himself, crawling on the ground and throwing stuff out of the house. According to ER notes, he was a resident of Premier Behavioral Service Center and ran away two days ago and has been non-compliant with prescribed medications. During psych interview, patient was disoriented." - "Plan: Consider consult case management for housing. Due to dementia, patient is not a candidate for inpatient psychiatric. Continue home psychiatric medications."

Review on 08/06/19 of "Progress Notes" from a local hospital Licensed Clinical Social Worker and dated 08/02/19 at 3:50pm revealed:
- She had spoken with client #24's brother.
- Client #24 lived in his own home and did not reside in a group home.
- Client #24's family lived next door to him.
- Client #24 had current services with Premier Behavioral Services.

Review on 08/06/19 of a "Behavioral Health Progress Note" for client #24 dated 08/04/19 revealed:
- Client #24 appeared psychiatrically stable.
- Client #24's family feels he is stable and agreeable to return home 08/04/19.

Interview and observation on 08/06/19 at approximately 11:15am client #24 stated:
- He had seen the doctor this morning.
- He was unable to state how long he had been receiving services at the facility.
- He did not recall leaving the facility or why he

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V 115	Continued From page 5 was in the hospital. He was not able to state where he went when he left the facility. - He lived next to his sister. - He is picked up and brought to the facility. - Staff treat him well at the facility. - He was neat clean and well-groomed. The facility van driver was unavailable for interview due to hospitalization. Interview on 08/06/19 the Associate Professional stated: - She began work at the facility in May 2019 and client #24 was on her caseload. Client #24 did not have a history of elopement. - She was not working when client #24 eloped from the facility on 07/30/19. - She was told client #24 arrived at the facility on 07/30/19 and walked off. - She was aware an IVC was completed for client #24 and he was hospitalized from 08/01/19 thru 08/04/19. - Client #24's sister had brought him to the agency today for a medication evaluation. - Client #24's family preferred to have medications injected due to his refusal to take oral medications at times. - Client #24 lived alone next to his sister. - Client #24 had social anxiety and answering yes or no was his baseline. Interview on 08/07/19 the Administrative Director stated: - Client #24's sister called him on 07/29/19 and stated she needed assistance due to his refusal to take medications. Client #24's family did not mention he had been walking away. - The van driver called him after client #24 was picked up on 07/30/19. When they stopped to pick up another client, client #24 walked away. He	V 115		

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V 115	Continued From page 6 left the facility to assist the van driver. The van driver called to say client #24 was walking down the road. The local sheriff was contacted. The local sheriff refused any type of IVC because client #24 was not in the road and they assisted him on the van. - Client #24 was brought to the facility for PSR and to have a medication evaluation on 07/30/19. Client #24 had never eloped from the facility before. - Client #24 apparently walked away from the facility and was not observed to be missing for approximately one and one-half hours on 07/30/19. He went looking for the client and visited the local sheriff office to have client #24 IVC'd. The family was notified on 07/30/19. The local police stated they could not take a missing person report until after 24 hours. The local sheriff office went to find client #24 with an IVC. The IVC was good for 24 hours. - He contacted the family on 08/01/19 to check on client #24's status. The family had not spoken with the client or law enforcement. He checked at the hospital to see if client #24 was IVC'd and there was no current admission. - He met client #24's sisters on 08/01/19 and they went to the local police station to fill out a missing person report. The police found him one or two hours later approximately one mile from the facility on 08/01/19. Client #24 was taken to the hospital on 08/01/19. - Client #24 remained in the hospital until 08/04/19. Client #24 was brought to the facility on 08/06/19 for a medication evaluation. - He apologized because staff should have supervised client #24 when he got to the facility on 07/30/19. He should have gotten client #24's family to bring the client in for a medication evaluation if the behaviors were that severe. - He had never had an incident like that to	V 115		

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V **115**	Continued From page 7 happen before at the facility. "I dropped the ball." He would ensure processes were put in place to ensure supervision at the facility. Review on 08/07/19 of a Plan of Protection written by the Administrative Director dated 08/07/19 revealed: - "What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm?: If clients behavior becomes irrate or there is a change in any behavior pattern, PBS (Premier Behavioral Services) staff that has witnessed the behavior will monitor client on site and/or off site. PBS staff member will request other PBS staff member to contact police. PBS staff member will monitor client until police have arrived." - "Describe your plans to make sure the above happens. PBS staff members will be trained within the next 2 weeks on how to handle level II crisis reporting as well as handling and monitoring client behavior while participating with PSR, SAIOP (Substance Abuse Intensive Outpatient Program), and SACOT (Substance Abuse Comprehensive Outpatient Treatment)." Client #24 is a 61 year old male with diagnoses of Schizophrenia-Unspecified Type, Hypokalemia, Dementia, CHF, COPD and Diabetes Mellitus. On 07/29/19 client #24's sister had contacted the facility Administrative Director regarding his non-compliance with medications. After being picked up by the facility van driver, client #24 walked away during another stop to pick up a client. The local sheriff's office had to assist with getting him back into the van and proceed to the PSR. Once arriving at the PSR, client #24 was left unsupervised even after walking away earlier and showing erratic behavior and discussion of being IVC'd. Client #24 left the facility for	V **115**		

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V 115	Continued From page 8 approximately 1 and 1/2 hours before any staff identified he was missing. Client #24 had serious health conditions and was in the community for approximately 48 hours before he was located on 08/01/19. This systemic failure of client #24's supervision, after clear evidence of his acute status and inability to make rational decisions, constitutes serious neglect. This is a Type AI rule violation and must be corrected within 23 days. An administrative penalty in the amount of $3,000.00 is imposed.	V 115		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY AAND 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	V 367	V367 All facility staff will be retrained in critical incident reporting by the QM Director. All Level II deaths involving any clients to whom Premier rendered any service within 90 days prior to the death will be reported to the LME and DHSR through the IRIS system immediately The QM Director will be responsible to reporting the death within 72 hours of becoming aware of the death. All Level II and III incidents including elopement will be reported to the LME and DHSR through the IRIS system by the QM Director within 72 hours of the incident unless required to do so sooner by statute.	8/21/19

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V 367	Continued From page 9 (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) CategoryA 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) CategoryA 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:	V 367		

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V 367	Continued From page 10 (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 report critical incidents to the home Local Management Entity (LME) as required. The findings are: Review on 08/06/19 of the "North Carolina Incident Response Improvement System (IRIS)" website for July 2019 thru present revealed no Level II incident reports for the facility had been generated. See Tag V115 for specifics. Review on 08/07/19 of Deceased Client (DC) #1's record revealed: - Date of admission: 04/11/18. - 34 year old female. - Diagnoses of Schizoaffective Disorder-Depressive Type and Diabetes. - 07/19/19 last documented service note.	V 367		

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V 367	Continued From page 11 - Deceased 07/26/19. Interview on 08/07/19 the Administrative Director stated: - He had completed an incident report for client #24's elopement and had contacted the LME/MCO. - He did not complete an IRIS report for client #24's elopement and police involvement nor when DC #1 passed away. - He was now aware to complete a Level II IRIS report whenever a death of a client occurs within 90 days of the last service provided.	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 observations and interviews, the facility was not maintained in a clean, attractive and orderly manner. The findings are: Observations on 08/06/19 at the facility revealed: 11:30am - The carpet near the Psychosocial Rehabilitation (PSR) office threshold was ripped and frayed. - The carpet in the large PSR room was wrinkled and bunched together in several areas. The carpet was soiled with numerous large dark stains.	V 736	V 736 Premier will: • Replace the carpet in the office area. • Clean and if necessary, replace the carpet in the large PSR room. • The offensive sign in the bathroom will be removed. • The toys will be removed from the SAOCT classroom. • The SACOT classroom will be painted.	9/6/19

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	MHL078-251	A. BUILDING: ___ B. WING ___	R 08/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER BEHAVIORAL SERVICES INC	2003 GODWIN AVENUE STE B LUMBERTON, NC 28358

(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 736	Continued From page 12 - The client restrooms had a sign on the outside of the door which read to check behind themselves and "Don't Be Nastylum" 1:30pm - The classroom used by the Substance Abuse Comprehensive Outpatient Treatment (SACOT) class revealed children's toys throughout the room. The walls of the room had numerous dark scuff marks and black writing throughout. Interview on 08/06/19 The Human Resources Director stated: - SACOT met in the classroom Monday, Wednesday and Friday. - The SACOT classroom was used for other purposes throughout the week. - The toys were taken out and additional chairs were brought in for the SACOT classes. Interview on 08/07/19 the Administrative Director stated: - The carpet in the PSR was cleaned after a previous survey at the facility. He would have the carpets cleaned again. - The carpet in the PSR was loose and caused it to wrinkle up. - He would follow up on the signs on the bathrooms and other items identified at exit. [This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.]	V 736		