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	MHL084-085	A. BUILDING: _____ B. WING _____	12/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LORETTA'S PLACE	109 PENNY STREET ALBEMARLE, NC 28001

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 12-16-19. The complaint was unsubstantiated (#NC00158836). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 1900 Psychiatric Residential Treatment for Children or Adolescents	V 000		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review the facility failed to ensure that fire drills were completed at least quarterly on each shift. The findings are: Interview on 12-9-19 with the Quality Assurance Director revealed: -The facility ran on tow shifts, each being 12 hours.	V 114	DHSR - Mental Health JAN 7 2020 Lic. & Cert. Section Premier have since corrected the fact that there was no written and area wide disaster plan as well as a fire drill plan developed for both buildings 108 and 109 Penny Street Albemarle, NC 28001. We do have evacuation procedures posted for all staff in both buildings as well. We have also come up with a calendar so that we can keep track of all of our monthly fire drills on both shifts and have created fire/tornado drill sheet to record the results in terms of participants, dates, time for drill, where drill was done etc. We have ordered first aid kits for both facilities as well. Also on January 10, 2020 we will have a meeting with the fire Department of Albemarle who will talk to the staff about things to look for and various fire preventative measures as well as going over our currently planned fire drills. Responsible Party: Clarence Lawing, PD, Stacey Massey, QM	1/02/2020

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V 114	Continued From page 1 Review on 12-9-19 of fire drill documentation revealed: -No first shift fire drill for the second quarter (April-June) completed in 2019. -No second shift fire drill completed for the 3rd quarter (July-September) for 2019. Interview on 12-16-19 with the Program Director revealed: -They would ensure the facility ran and documented the appropriate amount of fire drills. This deficiency constitutes a recited deficiency and must be corrected within 30 days.	V 114		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments.	V 120		

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V 120	Continued From page 2 This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure that medications were stored separately for each client effecting 3 of 3 audited clients. The findings are: Observation on 12-11-19 of controlled medications for all clients revealed: -Client #1's Concerta 54 mg in a communal box with all controlled medications for the facility. -Client #2's Concerta 36 mg and Vyvanse 70 mg in a communal box with all controlled medication for the facility. -Client #3's Concerta 54 mg and Concerta 36 mg in a communal box with all controlled medication for the facility. Interview on 12-16-19 with the program Director revealed: -The nurses knew that medication should be stored separately. -They would fix the issue immediately. 13O .0102 HCPR - 24 Hour Reporting	V 120	Premier have purchased a much larger locked safe box to house the medications and have separated all medications per consumer with individual Ziploc bags. Responsible Party: Clarence Lawing, PD, Stacey Massey, QM	12/28/19
V 318	10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g).	V 318		

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V 318	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure that HCPR (Health Care Personnel Registry) was notified within 24 hours of becoming aware of allegations of abuse. The findings are: Review on 12-9-19 of internal investigation completed 12-5-19 revealed: -On 11-25-19 client #1 told two DSS (Department of Social Services) that staff #1 had hit him with a tee shirt leaving busies. -Incident was investigated and based on some inconsistencies in client #1's story and interviews with other staff, there was not enough information to substantiate client #1's claim. Review on 12-9-19 of Incident reports revealed: -No incident report was submitted and there was no notification to HCPR about the alleged abuse. Interview on 12-16-19 with the Program Director revealed: -He didn't know that he was supposed to report the incident since they did do an internal investigation and could not substantiate the allegation. -He would make sure in the future and allegation was correctly reported.	V 318	We have done training with information that has been provided through the NCDHHS website using the curricula that they provided which was the Incident Response and Reporting Manual and the Iris Technical Manual along with the coinciding `updates. We have also begun to use the Quality Manager to assist the Case Manager and the Program Director with the input of the reports as well and to go over the IRISs that are submitted are done correctly and in a timely fashion. The Program Director, Quality Manager and the Case Manager will also make sure that the incidents that require Iris input will be done as when needed.	12/27/2019
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT	V 367		

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V 367	Continued From page 4 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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V 367	Continued From page 5 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 6 This Rule is not met as evidenced by: Based on record review and interview the facility failed to report Level II incidents to the local LME (Local Management Entity) within 72 hours of becoming aware of the incident. The findings are: Review on 12-9-19 of internal investigation completed 12-5-19 revealed: -On 11-25-19 client #1 told two DSS (Department of Social Services) that staff #1 had hit him with a tee shirt leaving busies. -Incident was investigated and based on some inconsistencies in client #1's story and interviews with other staff, there was not enough information to substantiate client #1's claim. Review on 12-9-19 of Incident reports revealed: -No incident report was submitted and there was no notification to the LME about the alleged abuse. Interview on 12-10-19 with the Program Director revealed: -He was not aware that he should have filed an incident report since they investigated the allegation and unsubstantiated the compliant. -In the future he would make sure all allegations were properly documented and submitted to the IRIS (Incident Response Improvement System) in a timely manner so the LME would be notified. 27E .0101 Client Rights - Least Restictive Alternative	V 367	Premier will report all Level II incidents to the local LME via the IRIS (Incident Response Improvement System) within 72 hours of becoming aware of the incident. Responsible Party: Clarence Lawing, PD, Stacey Massey, QM and Case Manager	12/18/19
V 513		V 513		

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V 513	Continued From page 7 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use. This Rule is not met as evidenced by: Based on interview and observation the facility failed to provide services that promote a respectful environment one of eleven clients (client #5). The findings are: Observation on 12-16-19 at approximately 11:00 am revealed: -Client #5 sitting in classroom with only socks on. -All other clients had shoes/sandals on. Staff reported that client #5 broke his shoes	V 513	Since the situation, we have compiled a list of items that will be given to the guardian before intake that the consumer needs. This list includes room for extra items in the event that something is needed immediately, and we do not have time for the parent/ guardian to be able to supply an immediate replacement. After we find that there is a need, we will contact the parent/guardian and inform them that the consumer is in need of the item. In addition to this, we have had a training with staff members to notify administration immediately should a consumer be without a necessity, such as shoes. We will also	12/27/2019

periodically go through the consumers items to ensure that they are all intact and take action should they not be in an effort to prevent this instance from occurring again.

Responsible Party: Clarence Lawing, PD, Stacey Massey, QM, Henry Dillard, Staff Supervisor

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V 513	Continued From page 8 "sometime last week" and had not gotten replacements. When asked if the issue had been reported she replied that she hadn't thought that it had. Interview on 12-16-19 with the Program Director revealed: -He didn't know why the staff had not reported that client #5 needed new shoes. -Client #5 would receive new shoes that day so he wouldn't have to walk around in his socks.	V 513		
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 failed to be maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 12-16-19 at approximately 2:00 pm revealed: -Bedroom #1 had no light switch cover, window was 1/2 boarded up. -Bedroom #3 had a broken windowsill. -Tiles were missing in the second bathroom. -Bedroom #4 had large (approximately 3 feet wide) patch with no paint. -Bedroom #3 across the dayroom had a door that was peeling.	V 736	Repair to all bedrooms and bathrooms has begun. Work orders are in place to replace light switch covers, paint, windowsills and doors etc. A weekly checklist will be completed with all repairs noted and transferred to a work order. Facility Manager will review work orders for routine maintenance/repair. Responsible Party: Henry Dillard, Staff Supervisor, Reece Harris, Facility Safety Manager	12/16/2020

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V 736	Continued From page 9 Interview on 12-16-19 with the program Director revealed: -The building was being remodeled to remove the sheetrock and replace with wood. -They would make the needed repairs as soon as possible.	V 736		
V 750	27G .0304(b)(3) Maintenance of Elec., Mech., & Water Systems 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (3) Electrical, mechanical and water systems shall be maintained in operating condition. This Rule is not met as evidenced by: Based on observation and interviews the facility failed to ensure that all water systems were maintained in operating order. The findings are: Observation on 12-16-19 at approximately 2:00 pm revealed: -Out of order sign on the door in bedroom #3. Interview on 12-16-19 with staff #4 revealed: -They were unsure why the bathroom was out of order, they thought the sink might be broken. Interview on 12-16-19 with the Program Director revealed: -They were remodeling the bathrooms and he would make sure that one was the next one so it	V 750	Repair to all bedrooms and bathrooms has begun. Work orders are in place to repair bathroom sink. . A weekly checklist will be completed with all repairs noted and transferred to a work order. Facility Manager will review work orders for routine maintenance/repair. Responsible Party: Henry Dillard, Staff Supervisor, Reece Harris, Facility Safety Manager	1/16/2020

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V 750	Continued From page 10 would be repaired. This deficiency constitutes a recited deficiency and must be corrected within 30 days.	V 750		