STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-159	A. BUILDING: _____ B. WING _____	08/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD FACILITY	2002-G SHACKLEFORD ROAD KINSTON, NC 28502

(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 A complaint survey was completed on 08/14/2020. A complaint was substantiated (Intake #NC00167869) and a complaint was unsubstantiated (Intake #NC00167432). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and	V 105		

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V 105	Continued From page 1 (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to implement written standards that assured operational and programmatic performance meeting applicable standards of practice to report serious occurrences to the State designated Protection and Advocacy system. The findings are: Review on 8/11/2020 of the LME-MCO (Local Management Entity-Managed Care Organization) communication Bulletin J287, "Clarifying the Reporting Standards for Psychiatric Residential Treatment Facilities [PRTF]" dated 5/11/18 revealed: -"... Serious Occurrences are any event that result in Restraint or Seclusion, Resident's Death, Any Serious Injury to a Resident, and a Resident's Suicide Attempt. NC [North Carolina] 483.374 specifies that facilities must report each Serious Occurrence to ... unless prohibited by State Law, the State-designated Protection and Advocacy system (Disability Rights North Carolina - DRNC)." -"DRNC reports are to be faxed to (919) 856-2244." Review on 8/12/2020 of the facility's policy, "Consumer Death or Serious Occurrence / Sentinel Event," dated 6/1/16 revealed: -The policy statement read, "It is the policy of NOVA to define a Serious Occurrence / Sentinel Even as the death of a Consumer or any significant impairment of the physical condition of a Consumer as determined by NOVA's Primary Care Medical Director or other qualified Medical Personnel ..." -"Each Consumer Death or Serious Occurrence /	V 105		

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V 105	Continued From page 3 Sentinel Event will be reported to Disability Rights of North Carolina (DRNC) within 24 hours of the event by fax, email and/or phone." Review on 08/11/2020 of a letter from DRNC to NOVA dated 02/18/2020 revealed: "-RE: All Psychiatric Residential Treatment Facilities are required to report each serious occurrence to DRNC under the CMS Conditions of Participation... -Since 2018, DRNC has only received three serious occurrence reports from NOVA, Inc., which currently operates three PRTF's; [Facility], [Facility] and [Facility]. Therefore, it is highly likely that NOVA, Inc. is not in compliance with the federal requirement to submit serious occurrence reports to DRNC for each serious occurrence that occurs. This matter needs immediate attention..." Interview on 8/11/2020 the Program Director stated: - There had been a lot of "back and forth" between her and DRNC regarding reporting serious occurrences. - She had sent serious occurrence reports to DRNC according to federal rule criteria. - The last serious occurrence report had been sent on 4/11/2020, even though it did not meet criteria for a serious occurrence. The last serious occurrence that met criteria was on 3/14/2020 and was reported to DRNC. - The facility did not report restrictive interventions as a serious occurrence unless it resulted in an injury.	V 105		