STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411045	A. BUILDING: _____ B. WING _____	C 12/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LYDIA'S HOME, LLC PHASE 2	716 PRINCE ROAD GREENSBORO, NC 27455

(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 12/7/2020. The complaint was unsubstantiated (intake #NC171681). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment 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 missing or incomplete information. The provider	V 367		

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V 367	Continued From page 1	V 367		

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 the definition of a level II or level III incident;

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V 367	Continued From page 2 (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 ensure incidents were reported within 72 hours of becoming aware of the incident. The findings are: Reviews on 12/2/2020 and 12/3/2020 of former client (FC) #1's record revealed: - Admission date: 11/5/2020 - Discharge date: 11/8/2020 - Diagnoses: Anxiety D/O (disorder), unspecified; Post-traumatic stress disorder, unspecified; Major Depressive D/O, single episode, in full remission; and allergy to bee stings; Reviews on 12/1/2020 and 12/7/2020 of the Incident Response Improvement System (IRIS) revealed: - There were no incident reports for the facility since 11/1/2020.	V 367		

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V 367	Continued From page 3 Review on 12/1/2020 of an "Explanation of Emergency Discharge" for FC #1 revealed: - On 11/5/2020, FC #1 was taken to the facility by her Guardian for admission to the facility; - After the Guardian left, FC #1 eloped from the facility within 3 to 4 hours; - Law Enforcement Office (LEO) assistance was required with the incident. Voicemail messages were left on 12/2/2020 and 12/4/2020 requesting return calls from FC #1's Guardian. No interviews were completed with FC #1 or FC #1's Guardian due to no response from the Guardian by the time of exit. Interview on 12/3/2020 with staff #1 revealed: - On 11/5/2020, FC #1 was brought to the facility for admission by her Guardian; - FC #1 Ran away from the facility after asking to go to bed earlier than her peers; - LEO was called to assist with finding FC #1; - FC #1 was brought back to the facility on 11/6/2020 by her Guardian after the Guardian picked her up at a local hospital emergency department (ED); - FC #1 ran away again twice on 11/6/2020. Interview on 12/1/2020 with the Qualified Professional (QP) revealed: - On 11/5/2020, FC #1 was taken to the facility for admission by her Guardian; - FC #1 ran away from the facility the same evening; - The QP went to the facility to assist with searching for FC #1; - The QP saw FC #1 in the community and called 911; - The LEO and a local mental health crisis team (MHCT) met with FC #1 and took her to the local ED for evaluation;	V 367		

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V 367	Continued From page 4 - FC #1 was brought back to the facility by her Guardian on 11/6/2020, but ran away again while the Guardian was still there; - She had entered a report in IRIS for the incident; - She did not know why the incident report was not in IRIS; - She had been told in the past that incident reports could not be found in IRIS; - She usually took a picture of the IRIS screen that showed the incident number for the report, but the phone she used to do that was broken; - She had not printed a copy of the completed incident report. Interview on 12/7/2020 with the Assistant Director (AD) revealed: - The QP entered incident reports in IRIS; - There had not been any issues with the QP completing incident reports on time; - The QP used to take screen shots of the completed IRIS report screen, but she changed phones recently and did not have the screen shots for the incidents with FC #1. Interviews from 12/1/2020 to 12/7/2020 with the Director revealed: - FC #1 had been taken to the facility on 11/5/2020 by her Guardian for admission to the facility; - FC #1 ran away that evening; - LEO was called to assist, and FC #1 was transported to the local ED for evaluation; - The QP had entered the incident report into IRIS; - She believed that the incident report had been completed; - She did not know why the incident report for FC #1 was not present in IRIS.	V 367		