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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on January 28, 2021. The complaint was substantiated (intake #NC00173453). Deficiencies were 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 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 (C) the disposition, including referrals and	V 105		

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V 105	Continued From page 1 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, observation and interview, the facility failed to develop and implement adoption of standards that assure operational and programmatic performance meeting applicable standards of practice amidst the COVID-19 (Coronavirus-Disease-2019) pandemic and in accordance with the facility's scope of licensed services. The findings are: Review on 1/21/21 of a North Carolina Department of Health and Human Services (DHHS) "RECOMMENDATIONS ON VISITATION IN LONG TERM CARE FACILITIES TO REDUCE RISK OF TRANSMISSION OF COVID-19" dated 03/13/20 revealed: - "...II. Screening Visitors There are situations where the welfare of the LTC (Long Term Care) resident/client will result in the need for a visit. In the event the facility determines the visit is necessary, the facility must carefully screen the visitor to determine whether it appears the visitor has respiratory illness or potential exposure to COVID-19, and if the visitor does, the facility should restrict the visitor from entering the facility. LTC facilities must screen every individual each and every time they are wishing to enter the facility. (A visitor is any person who is not an employee or resident/client of the facility and includes vendors and contractors.) Each potential visitor should be screened by asking the following questions: 1. Do you currently have signs or symptoms of a respiratory infection, such as fever, cough, shortness of breath, or sore throat? 2. In the last 14 days, have you had contact with	V 105		

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V 105	Continued From page 3 any of the following: a) someone with a confirmed or presumptive diagnosis of COVID-19, or b) someone under investigation for COVID-19, or c) someone with respiratory illness, or d) someone who has been asked to quarantine themselves? 3. Do you reside in a community where community-based spread of COVID-19 is occurring? If a visitor answers "yes" to any of the above questions, or appears to be suffering from respiratory illness (coughing, shortness of breath, fever), the visitor should be instructed to defer their visit and return when they will not pose a risk to the safety of the residents/clients in the facility. This means the facility should restrict (prohibit) this visitor from entering the facility. As the facility screens each visitor, the facility should record the full name and telephone of every visitor, the date and time of the visit, and the name or room number of the resident/client with whom they are visiting. At the conclusion of the visit, visitors should be required to sign out of the facility and exit through a designated exit. V. Use of Signage at Facilities and Other Preventive Measures Signage and visitor instructions: Facilities should increase visible signage at entrances/exits, increase availability of alcohol-based hand sanitizer, and may offer personal protective equipment (PPE) for individuals entering the facility (if supply allows). Before visitors enter the facility and residents'/clients' rooms, provide instruction to visitors on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy while in the resident's/client's room. Individuals with fevers,	V 105		

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V 105	Continued From page 4 other symptoms of COVID-19, or who are unable to demonstrate proper use of infection control techniques should be restricted from entry. Signage should also include language to discourage visits, such as recommending visitors defer their visit for another time or for a certain situation as mentioned above. 4 Limiting movement of visitors: In cases when visitation is allowable, facilities should instruct visitors to limit their movement within the facility to the resident's/client's room the visitor is there to see (e.g., reduce walking the halls, avoid going to dining room, etc.) Limiting movement of external individuals: Facilities should review and revise how they interact with volunteers, vendors and receiving supplies, agency staff, EMS personnel and equipment, transportation providers (e.g., when taking residents/clients to offsite appointments, etc.), other practitioners (e.g., hospice workers, specialists, physical therapy, etc.), and take necessary actions to prevent any potential transmission. For example, do not have supply vendors transport supplies inside the facility. Have supplies dropped off at a dedicated location (e.g., loading dock). Facilities can allow entry of these visitors as long as they are following the appropriate CDC guidelines for Transmission-Based Precautions. Visitor Reporting: Advise visitors to immediately report to the facility and local health department any signs and symptoms of COVID-19 or acute illness the visitor experiences within 14 days after visiting the facility. Activities Outside the Facility: Cancel activities that take residents/clients into the community to	V 105		

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V 105	Continued From page 5 public places particularly with large gatherings, such as mall, movies, etc. (Note: this does NOT apply to residents/clients who need to leave the building for medical care such as dialysis, medical visits, etc). VI. Monitoring Facility Staff How should facilities monitor or restrict health care facility staff? o Staff should be screened at the beginning of their shift. o The same or a similar screening performed for visitors should be performed for facility staff. o Staff who have signs and symptoms of a respiratory infection should not report to work. o Any staff that develop signs and symptoms of a respiratory infection while on-the-job, should: Immediately stop work, put on a facemask, and self-isolate at home; o In a skilled nursing facility, inform the facility's infection preventionist, and include information on individuals, equipment, and locations the person came in contact with; and o Contact and follow the local health department recommendations for next steps (e.g., testing). o In an adult care home facility (or other long term care setting) where there is not an infection preventionist, inform the administrator and the designated infection control staff person and contact and follow the local health department for next steps (e.g., testing) o Refer to the CDC guidance for exposures that might warrant restricting asymptomatic healthcare personnel from reporting to work (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html)." Observation on 01/21/21 at approximately 10:45am revealed:	V 105		

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V 105	Continued From page 6 - No signage on the front entrance to identify Covid-19 protocols and educational information. - No screening questions were asked to protect the welfare of the clients. Interview on 01/21/21 and 01/28/21 the Licensee stated: - She had not created a specific policy for positive Covid-19 exposures. - She would check the facility for the necessary signage. - Staff should ask the relevant questions to screen visitors.	V 105		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid	V 108		

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V 108	Continued From page 7 techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record reviews and interview two of six audited staff (#1 and #2) failed to have current First Aid Certification. The findings are: Review on 01/21/21 of staff #1's personnel record revealed: - Date of hire: 07/01/14. - No current certification in 1st aid. Review on 01/21/21 of staff #2's personnel record revealed: - date of hire: 12/16/20. - No current certification in 1st aid. Observation on 01/21/21 at approximately 10:45am revealed: - Staff #1 and Staff #2 were at the facility with client #3 and staff #4. - No other staff were currently at the facility. Interview on 01/28/21 the Licensee stated: - She thought staff #1 had current 1st aide , however she was not able to locate it. - Staff #2 had just started and had not received 1st aid training.	V 108		

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V 108	Continued From page 8 - She understood at least one staff was required to have current 1st aid when working with the clients. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 108		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.	V 110		

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V 110	Continued From page 9	V 110		

This Rule is not met as evidenced by:
Based on record reviews and interviews, one of six audited paraprofessional staff (Assistant Manager) failed to demonstrate the knowledge skills and abilities required by the population served. The findings are:

Review on 01/21/21 and 01/27/21 of client #1's record revealed:
- 13 year old male.
- Admission date of 12/04/20.
- Diagnoses of Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder-Combined Type and Post Traumatic Stress Disorder.

Review on 01/21/21 and 01/27/21 of client #2's record revealed:
- 12 year old male.
- Admission date of 07/30/20.
- Diagnoses of Conduct Disorder-Adolescent Onset, Cannabis Use Disorder-Mild and Cocaine Use Disorder.

Review on 01/25/21 of a North Carolina Incident Response Improvement System report for client #1 and client #2 dated 01/21/21 revealed they had eloped from the facility on the morning of 01/21/21.

Interview on 01/27/21 client #1 stated:
- He was currently living with his mother.
- He and another client had recently eloped from the facility.

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V 110	Continued From page 10 - The Assistant manger had told him when he was admitted he would be discharged after being gone for five days. - None of the clients got along with staff Interview on 01/27/21 client #2 stated: - He was returned to the facility by his guardian on 01/26/21. He had eloped from the facility on 01/21/21. - The Assistant Manager said in the past, "I wished ya'll could stay gone five days so I could discharge you." - Staff would be nice at times but would bring their problems to work. Interview on 01/25/21 the Assistant manager stated: - She assisted the Residential Manager with operations. - She visited the facility daily. - Staff had client rights training. - She had not seen any staff mistreat the clients. Interview on 01/28/21 the Licensee stated: - There had not been any specific issue with clients eloping from the facility. - She would address staff interaction and therapeutic communication with clients. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 110		
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	V 114		

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V 114	Continued From page 11 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 and interviews, the facility failed to ensure disaster drills were held quarterly and repeated on each shift. The findings are: Review on 01/27/21 of the facility "Emergency Plan Drill Log" revealed: - Shifts at the facility: 1st, 2nd, 3rd, Weekend (8am to 8pm) and Weekend (8pm to 8am). - No disaster drills from April 2020 thru June 2020 (2nd quarter) for 1st shift, 3rd shift and Weekend (8pm-8am). - No disaster drills July 2020 thru September 2020 (3rd quarter) for 1st and 2nd shifts. Interview on 01/21/21 client #4 stated: - He had resided at the facility for approximately 4 months. - he had not participated in a fire or disaster drill at the facility. Interview on 01/28/21 the Licensee stated: - She had submitted all of the facility emergency drills. - She was aware disaster drills had to be	V 114		

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V 114	Continued From page 12 completed on all the designated shifts and repeated quarterly. - Fire and disaster drills are something the facility constantly worked on. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner.	V 117		

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V 117	Continued From page 13	V 117		

This Rule is not met as evidenced by:
Based on record reviews, observation and interviews, the facility failed to assure all prescription medication had a packaging label containing the identifying information required by rule affecting 1 of 3 audited clients (#3) The findings are:

Review on 01/27/21 of client #3's record revealed:
- 12 year old male.
- Admission date of 07/15/20.
- Diagnoses of Disruptive Mood Dysregulation Disorder, Post Traumatic Stress Disorder and Borderline Intellectual Functioning.

Review on 01/27/21 of client #3's physician order dated 12/04/20 revealed Escitalopram (Lexapro-treats major depression) 10 milligrams(mg) take one tablet twice daily.

Review on 01/27/21 of client #3's November 2020 thru January 2021 MARs revealed the following transcribed entry:
- Escitalopram 10mg - take one tablet twice daily.

Observation on 01/21/21 at approximately 2:00pm of client #3's medications revealed:
- A bubble pack labeled as Escitalopram 10mg tablet - take 1 tablet by mouth twice daily.
- No label for the client name, no prescriber name or pharmacy information.

Client #3 refused multiple attempts for interview on 01/21/21.

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V 117	Continued From page 14 Interview on 01/28/21 the Licensee stated: - She did not know why client #3's medication was not labeled correctly. - The pharmacy would have dispensed the medication in the bubble pack. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 117		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or	V 118		

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V 118	Continued From page 15 checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to administer medications on the written order of a physician and failed to keep the MARs current affecting three of three audited clients (#1, #3 and #4). The findings are: Finding #1: Review on 01/21/21 and 01/27/21 of client #1's record revealed: - 13 year old male. - Admission date of 12/04/20. - Diagnoses of Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder (ADHD)-Combined Type and Post Traumatic Stress Disorder (PTSD). A. Review on 01/21/21 and 01/27/21 of client #1's record revealed no admission medication orders. Review on 01/21/21 and 01/27/21 of client #1's December 2020 MAR revealed the following transcribed entries with staff initials to indicate administration: - Melatonin (sleep aid) 3 milligrams (mg) - take 3 tablets at bedtime. - Senna (laxative) 8.6mg - take 2 tablets at bedtime. - Lithium Carbonate (treats Bipolar Disorder)	V 118		

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V 118	Continued From page 16 450mg - take twice daily. - Lithium Carbonate 300mg - take one tablet at 2pm. - Vitamin D3 (treats vitamin D deficiency) 2,000 units - take one capsule at bedtime. - Aripiprazole (anti-psychotic) 20mg - take one tablet daily at 7am. - Escitalopram (anti-depressant) 20mg - take one tablet every morning. B. Review on 01/21/21 and 01/27/21 of client #1's signed physician orders dated 01/08/21 revealed: - Lithium Carbonate 450mg - take twice daily. - Lithium Carbonate 300mg - take one tablet at 3pm. - Aripiprazole 20mg - take one tablet daily at 7am. - Escitalopram 20mg - take one tablet every morning. - Ativan (anti-anxiety) 0.5mg - take one tablet every morning. - No order to discontinue Vitamin D3. Review on 01/21/21 and 01/27/21 of client #1's January 2021 MAR revealed the following blanks or medications were documented as "out" and not available for administration: - No transcribed entry for Ativan. - Aripiprazole - 01/02/21 thru 01/11/21. - Escitalopram - 01/02/21-01/11/21. - Lithium Carbonate 450mg (7am) - 01/03/21 thru 01/11/21 and 01/13/21. - Lithium Carbonate 300mg (2pm/3pm) - 01/05/21 thru 01/10/21. - Vitamin D3 - 01/07/21 thru 01/21/21. Review on 01/27/21 of facility level I incident reports revealed: - 01/01/21 thru 01/08/21 - Client #1's had missed doses of medication.	V 118		

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V 118	Continued From page 17 - Client #1 had an appointment on 01/08/21 to refill medications. Observation on 01/21/21 at approximately 2pm of client #1's medications revealed: - A bubble pack with client #1's name from the pharmacy. - The bubble pack was label for Ativan 0.5mg - administer every morning. Interview on 01/27/21 client #1 stated: - He had run out of medications at the facility. - He had stayed in his room when he was off his medications. Interview on 01/21/21 staff #1 stated he was unable to locate a MAR for client #1's Ativan. Finding #2: Review on 01/27/21 of client #3's record revealed: - 12 year old male. - Admission date of 07/15/20. - Diagnoses of Disruptive Mood Dysregulation Disorder, PTSD and Borderline Intellectual Functioning. Review on 01/27/21 of client #3's medication orders revealed: 12/04/21 - Escitalopram 10mg - take one tablet twice daily. - Guanfacine (treats Hypertension) 2mg - take one tablet every morning. Review on 01/27/21 of client #3's January 2021 MAR revealed the following blanks: - Escitalopram - 01/09/21 thru 01/11/21 and 01/13/21. - Guanfacine - 01/09/21 thru 01/11/21 and 01/13/21.	V 118		

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V 118	Continued From page 18 Client #3 refused interview on 01/21/21. Finding #3: Review on 01/27/21 of client #4's record revealed: - 12 year old male. - Admission date of 09/01/20. - Diagnoses of Conduct Disorder, Oppositional Defiant Disorder and PTSD. Review on 01/27/21 of client #4's physician orders dated 01/19/21 revealed: - Methylphenidate (treats ADHD) 30mg - take one capsule daily. - Divalproex (treats seizures) 250mg - take one tablet every morning. Review on 01/21/21 of client #4's January 2021 MAR revealed the following blanks: - Methylphenidate - 01/05/21, 01/09/21 thru 01/11/21. - Divalproex - 01/09/21 thru 01/11/21. Interview on 01/21/21 client #4 stated he received his medications daily as prescribed. Interview on 01/28/21 the Licensee stated: - She had reviewed the medication orders for client #1 when he was admitted to the facility. - She was unable to locate client #1's admission orders. - There had been issues with getting client #1 seen at a doctor for medication refills. - She was actively seeking an alternate doctor to see the clients. - She would follow up on medication issues at the facility. Due to the failure to accurately document	V 118		

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V 118	Continued From page 19 medication administration it could not be determined if clients received their medications as ordered by the physician. This deficiency has been cited 5 times since the original cite on 10/15/18 and must be corrected within 30 days.	V 118		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors	V 293		

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V 293	Continued From page 20 related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to coordinate with other individuals within the child or adolescent's system of care for 1 of 3 clients audited (#1). The findings are: See Tag V118 for specifics. Review on 01/21/21 and 01/27/21 of client #1's record revealed: - 13 year old male. - Admission date of 12/04/20. - Diagnoses of Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder-Combined Type and Post Traumatic Stress Disorder.	V 293		

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V 293	Continued From page 21 Review on 01/27/21 of client #1's medication orders dated 01/08/21 revealed: - Ativan (anti-anxiety) 0.5 milligrams - take one tablet every morning. Interview on 01/26/21 and 01/27/21 client #1's mother/guardian stated: - She learned on 01/19/21 client #1 had been placed on a new medication. - She wanted to be involved in issues with medications. - Client #1 had been on several medications and she needed to be notified for possible side effects of new medications. - If clients are under 18, the guardian needed to be notified.. Interview on 01/26/21 client #1's Care Coordinator stated: - She was involved in a family team meeting with client #1 , facility staff and the legal guardian on 01/19/21. - She was informed of medication issues and a new medication had been added to client #1's drug regimen. - The facility stated the medication was administered for clients safety. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 293		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their	V 366		

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V 366	Continued From page 22	V 366		

response to level I, II or III incidents. The policies shall require the provider to respond by:
(1) attending to the health and safety needs of individuals involved in the incident;
(2) determining the cause of the incident;
(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;
(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;
(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;
(6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and
(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.
(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.
(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:
(1) immediately securing the client record by:
(A) obtaining the client record;
(B) making a photocopy;
(C) certifying the copy's completeness; and
(D) transferring the copy to an internal

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V 366	Continued From page 23 review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;	V 366		

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V 366	Continued From page 24 (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to document their response to level I and II incidents. The findings are: See Tag V118 for specifics. Review on 01/27/21 of facility incident reports for client #1 revealed: - No documented incident report client #1 was out of Lithium Carbonate 450 milligrams (mg) and Aripiprazole 20mg on 01/09/21 and 01/10/21 at 7am. - No documented incident report client #1 was out of Lithium Carbonate 300mg and Escitalopram on 01/09/21. Interview on 01/28/21 the Licensee stated: - Incident reports were generated when client #1 was out of medications. - She was not aware client #1 was out of medications on 01/09/21 and 01/10/21. - An incident report should have been generated	V 366		

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V 366	Continued From page 25 for medication errors.	V 366		
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 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	V 367		

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V 367	Continued From page 26 (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; (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	V 367		

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V 367	Continued From page 27 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 interview, the facility failed to report a critical incident to the home and host Local Management Entity (LME) as required. The findings are: Review on 01/21/21 and 01/27/21 of client #1's record revealed: - 13 year old male. - Admission date of 12/04/20. - Diagnoses of Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder-Combined Type and Post Traumatic Stress Disorder. Review on 01/27/21 of facility records revealed no Level II incident for client #1 on 01/08/21. Review on 01/27/21 of the North Carolina Incident Response Improvement System website revealed: - Incident Date: 01/06/21. - Time of incident: 7:15pm. - Provider Comments: "ON 01-06-21, Staff ([#1])was in the office preparing the evening medications. At that time [Client #1] asked to see his signature sheet. staff gave him his sheet and	V 367		

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V 367	Continued From page 28 [Client #1] immediately had a tantrum because of signatures he had received for behaviors. [Client #1] was screaming, cussing out staff and calling them stupid motherf****** and he wasn't scared of Mr. [Staff #1]. Staff attempted to calm [Client #1] down before the issue escalated. [Client #1] stated to Mr. [Staff #1] f*** you, you white ignorant Indian n*****. Staff redirected [Client #1] several times' to calm down. [Client #1] then stated I'm going to f*** you up right now, fight me. [Client #1] picked up a container and threw it at Mr. [Staff #1]'s' head. Staff had the other members to go to their room so staff could deal with [Client #1] behaviors and still monitor the other members. While Mr. [Staff #1] was ensuring the hallway was secure, [Client #1] ran up behind Mr. [Staff #1] and tried to tackle him. [Client #1] was placed in a restraint for 15 minutes. [Client #1] was not able to calm down but the restraint was released. The manager and the QP (Qualified Professional) were called and both went to the facility to assist with the situation. MS. [Assistant Manager] ask [Client #1] to sit at the table, which he did for a few minutes then he stood up and ran out the facility. When [Client #1] realized on one was chasing him, he returned to the facility and to his room with no further incidents during the night." - "Describe the cause of this incident, (the details of what led to this incident). Client became upset because he was given signatures in the level system for behaviors he had displayed. Client then displayed aggressive and destructive behavi0r as wells going AWOL (Absent Without Leave)." - ".Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. In the future staff should process with client to explain the reason for signatures when	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-159	A. BUILDING: _____ B. WING _____	R 01/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A BETTER WAY RESIDENTIAL SERVICES	220 CALVINS ROAD SHANNON, NC 28386

(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 367	Continued From page 29 they give them to the client. Also when client is upset he should be required to calm down in his room to prevent the client form going AWOL." - No documentation of a doctor visit for potential head injury and treatment by Urgent Health Care Provider attached to Level II report. Review on 01/21/21 of an "Appointment" for client #1 dated 01/08/21 revealed: - "Reason for Appointment: Headach as a result of head injury." - "Follow up with PCP (Primary Care Provider) on Monday or ED (Emergency Department) if symptoms worsen. - Care Provider Treatment/Finding: No signs of consussion PE (Physical Exam) consistent with abrasion and contusion." Interview on 01/28/21 the Licensee stated: - A Level II incident report had been created for client #1's behavior on 01/06/21. - He subsequently went to the doctor on 01/08/21 to get checked out after a request by his mother. - I should have added the information to the previous Level II incident report. - Client #1 hit his head during a behavior. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 367		
V 774	27G .0304(d)(7) Minimum Furnishings 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1,	V 774		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 774	Continued From page 30 1988 shall meet the following indoor space requirements: (7) Minimum furnishings for client bedrooms shall include a separate bed, bedding, pillow, bedside table, and storage for personal belongings for each client. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to ensure adequate storage for personal belongings affecting 1 of 4 clients (#3). The findings are: Observation on 01/21/21 at approximately 10:57am of client #3's bedroom revealed: - No bedside table for use. - The head board was broken. Interview on 01/21/21 and 01/28/21 the Licensee stated: - Client #3 had broken his furniture. - She replaced items at the facility often. - She had replaced the bedside table in client #3's bedroom. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 774		