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MAPLEWOOD FACILITY	2002-G SHACKLEFORD ROAD KINSTON, NC 28502

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on May 18, 2021. One complaint was substantiated (intake # NC00176539); one complaint was unsubstantiated (intake # NC00176516). Deficiencies were 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	V 105		

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to adopt standards that assured operational and programmatic performance meeting applicable standards of practice for reporting serious occurrences to the State designated Protection and Advocacy system.
The findings are:

Review on 5/05/21 of LME-MCO (Local Management Entity-Managed Care Organization) Communication Bulleting J287 "Clarifying the Reporting Standards for Psychiatric Residential Treatment Facilities (PRTF)" dated May 11, 2018 revealed:
- ". . . As a reminder, 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 §483.374 specifies that facilities must report each Serious Occurrence to both the State Medicaid agency (Division of Medical Assistance - DMA) and, 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 5/06/21 of the facility's "Restrictive Intervention Log" for January - March 2021 revealed:
- 33 therapeutic holds.
- 62 seclusions.

During interview on 5/06/21 the Director of PRTF Services stated:
- No serious occurrences involving restraint or

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V 105	Continued From page 3 seclusion were reported to DRNC. - A representative from DRNC sat in on the facility's Consumers' Rights Committee meetings and received a copy of the facility's quarterly Restrictive Intervention Log, which included clients' names, dates, and types of restrictive intervention used. - The facility did not consider restrictive interventions to be serious occurrences. - Restrictive interventions were not included in the definition of serious occurrences in the Code of Federal Regulations (CFR). This deficiency has been cited 6 times since the original cite on August 14, 2018 and must be corrected within 30 days.	V 105		
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 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	V 366		

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V 366	Continued From page 4 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 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;	V 366		

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V 366	Continued From page 5 (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; (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.	V 366		

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V 366	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interview the facility failed to document their response to a level II incident. The findings are: Refer to tag 367 for specifics. During interviews on 5/14/21 and 5/18/21 the Director of PRTF Services stated: - The treatment team viewed fc #18's behavior of tying an electric cord around her neck as self-injurious behavior and not a suicide attempt. - The incident did not meet the requirements of a level II incident report.	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;	V 367		

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V 367	Continued From page 7 (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 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	V 367		

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V 367	Continued From page 8 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. This Rule is not met as evidenced by: Based on record review and interview the facility failed to submit a Level II incident report as required. The findings are: Review on 5/06/21 and 5/18/21 of former client #18's (fc #18) record revealed: - 16 year old admitted 3/12/21, discharged 4/19/21. - Diagnoses included Intellectual/Developmental Disability, mild; Major Depressive Disorder; Disruptive Mood Dysregulation Disorder;	V 367		

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V 367	Continued From page 9 Attention Deficit Hyperactivity Disorder, combined type; Autism Spectrum Disorder. - "Medical Progress Notes" dated 4/13/21 and signed by a Registered Nurse included "@(at) 12:10. Seen in psych (psychiatric) clinic by [the Psychiatrist] & (and) tx (treatment) team. Meds (medications) & behaviors discussed with consumer. Consumer currently in behavior. . . " - "Medical Progress Notes" dated 4/13/21 and signed by a Registered Nurse included "@1240 consumer's guardian called in ref (reference) to consumer being placed on 1:1 dt (due to) her tying the cord to her CPAP (Continuous Positive Airway Pressure) machine around her neck. All items removed from her room . . . " - "Medical Progress Notes" dated 4/13/21 and signed by a Registered Nurse included "@2115 (9:15 pm) . . . Pt. (Patient) is now continuing to process remaining 1:1 and is argumentative and non-compliant toward staff. . . " - "Medical Progress Notes" dated 4/14/21 and signed by a Registered Nurse included "@1640 (4:40 pm) consumer remains 1:1 today has had physical aggression towards staff and peers x 3 today . . . " - "Psychiatric Consultation/Psychotropic Medication Review Subsequent Visit" dated 4/13/21 and signed by the Psychiatrist included ". . . Mood is stable. Some irritability & disruptive behaviors, some self injurious behavior, pushing door on staff. Denies suicidality . . . " - "Tool for Assessment of Suicide Risk: Adolescent Version (TASR-A) dated 4/13/21 and signed by the Psychiatrist included positive responses for both "Suicidal Ideation" and "Past Suicidal Behavior." Review on 5/05/21 of the North Carolina Incident Response Improvement System (IRIS) March 2021 - April 2021 revealed no level II incident	V 367		

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V 367	Continued From page 10 report for former client #18 placing an electric cord around her neck on 4/13/21. During interviews on 5/14/21 and 5/18/21 the Director of PRTF Services stated: - The treatment team viewed fc #18's behavior of tying an electric cord around her neck as self-injurious behavior and not a suicide attempt. - The incident did not meet the requirements of a level II incident report.	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 safe, clean, attractive and orderly manner. The findings are: Observations on 5/06/21 between approximately 3:45pm and 4:40pm revealed: - Walls with scuffed paint and unpainted repairs of various sizes throughout the facility. - Profanity written on the seclusion room walls in Unit 1. - The drawer and cabinet door under the television in the Unit 1 Pod B TV room were missing. - A cabinet door under the sink in the Unit 1 Pod	V 736		

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V 736	Continued From page 11 B bathroom was missing. - 2 cabinet doors and the drawer were missing under the television in the Unit 1 Pod A TV room. - The closet doors in the Unit 1 Pod A day area were dented. - An area of exposed plywood approximately 4 inches by ¼ inch near the window in bedroom A-1 in Unit 1 Pod A. - The Unit 1 Pod A bathroom had paint peeling near the floor by the toilet and near the ceiling in the shower. - An approximately 3 foot long cable was hanging out of the wall across from the Unit 2 medicatin room. - The Unit 2 Pod A bathroom had paint peeling on the wall behind the toilet. - 2 cabinet doors and 2 drawers were missing under the television in the Unit 2 Pod B TV room. - A light fixture cover was missing in the Unit 2 Pod B TV room. - 2 cabinet doors and 1 drawer were missing under the television in the Unit 3 Pod A TV room. - 2 light fixture covers were missing in the Unit 3 Pod A TV room. - The under-sink cabinet door was missing in the Unit 3 Pod A bathroom. - Red ink stains on the walls in bedroom A-2 in Unit 3 Pod A. - The cabinet doors and drawers were missing under the television in the Unit 3 Pod A TV room. - The Unit 3 Pod B bathroom door scrapped the floor when opened and was difficult to move. During interview on 5/06/21 the Maintenance Manager stated: - The clients sometimes took markers and crayons into the seclusion rooms. - Repairs were constantly being made.	V 736		

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V 752	Continued From page 12	V 752		
V 752	27G .0304(b)(4) Hot Water Temperatures 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. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit. This Rule is not met as evidenced by: Based on observations and interview the facility failed to maintain water temperatures between 100 and 116 degrees Fahrenheit in areas where clients are exposed to hot water. The findings are: Observations on 5/06/21 between approximately 3:45 pm and 4:40 pm revealed: - Hot water temperature in the Unit 3 Pod A bathroom sink was 120 degrees. - Hot water temperature in the Unit 3 Pod B bathroom sink was 120 degrees. During interview on 5/06/21 the Maintenance Manager stated the water in the Unit 3 bathrooms was hotter than in other bathrooms because it was closest to the water heater. He would see that the temperature was adjusted on the water heater. This deficiency has been cited 3 times since the original cite on 2/28/20 and must be corrected within 30 days.	V 752		