STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL028-013	A. BUILDING: _____ B. WING _____	R 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE TRAIL FACILITY	185 ROANOKE TRAIL MANTEO, NC 27954

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V 000	INITIAL COMMENTS An annual, follow up and complaint survey was completed on September 16, 2021. The complaints were unsubstantiated (intake #NC00180468 and #NC00180486). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
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 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	V 108		

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V 108	Continued From page 1 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 review and interview, the facility failed to ensure staff were trained in cardiopulmonary resuscitation (CPR) and First Aid affecting 1 of 3 staff audited (#3). Review on 9/16/21 of staff #3's personnel record revealed: -Hire date of 10/14/20. -American Red Cross Adult, Child and Baby CPR and First Aid Certification dated 4/27/20 "online only" -There was no evidence of a current CPR or First Aid Certification that had been conducted with an in-person instructor. Interview on 9/15/21 staff #3 stated: -She was hired in October 2020. -She had completed trainings that included CPR and First Aid, Mandt, Client Rights and Medication Administration. -Her CPR and First Aid Training had been completed at her other job. Interview on 9/16/21 the Program Director stated: -Staff #3's CPR and First Aid Certification had been completed through Staff #3's previous employer -The facility had accepted staff #3's CPR and First Aid Certification from the previous employer.	V 108		

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V 108	Continued From page 2 -Staff #3's CPR and First Aid had been completed online. -Staff #3 had not completed CPR and First Aid certification since being employed with the facility. -She was aware that CPR and First Aid Certification required the one on one instructor to be available.	V 108		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview the facility failed to develop goals & strategies to meet the needs for 1 of 3 audited clients (#5). The findings are: Review on 9/15/21 of Client #5's record revealed: -29 year old female admitted 2/15/21. -Diagnoses included Moderate Intellectual disability; Anxiety Disorder-Unspecified; Bipolar Disorder-unspecified and Schizoaffective Disorder-Unspecified. -Person-Centered Profile dated 1/28/21 and revision dated 8/3/21 revealed no implementation strategies for the use of Hydroxyzine PAM 25 milligram (mg) capsule (cap) for anxiety. Review on 9/15/21 of Client #5's signed physician orders dated 4/28/21 revealed: -Hydroxyzine 25 mg cap, give 1 capsule by mouth up to four times per day as needed for anxiety. Review on 9/15/21 of Client #5's September 2021 MAR's revealed: -Hydroxyzine PAM 25 mg cap, give 1 cap every 6 hours "AS NEEDED" for "ANXIETY". -No parameters for administration of the Hydroxyzine PAM 25mg after the first dose was administered. Interview on 9/16/21 Staff #3 stated: -Client #5 had received the Hydroxyzine PAM 25mg for pacing, aggression, if she was "worked up"verbal cues and inappropriate responses if she thought someone talked about her. -Client #5 had only received the the Hydroxyzine	V 112		

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V 112	Continued From page 4 PAM after permission from the nurse. Interview on 9/16/21 the Qualified Professional (QP) stated: -Client #5 could be administered the Hydroxyzine PAM 25mg for pacing, signs of agitation "nit picking." -The Registered Nurse (RN) had to approve Client #5 receiving he Hydroxyzine prior to staff administering. Interview on 9/16/21 the Program Director stated: -The Hydroxyzine PAM 25 mg cap should have been in Client #5's treatment plan. -She would ensure Client #5's treatment plan was revised to include the Hydroxyzine PAM 25mg cap.	V 112		
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;	V 366		

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V 366	Continued From page 5 (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 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;	V 366		

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V 366	Continued From page 6 (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; (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 7 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: Review on 9/15/21 of Client #5's record revealed: -29 year old female admitted 2/15/21. -Diagnoses included Moderate Intellectual disability; Anxiety Disorder-Unspecified; Bipolar Disorder-unspecified and Schizoaffective Disorder-Unspecified. Review on 9/15/21 of Facility Formal Inquiry Form dated 8/20/21 revealed: -On 8/4/21 Client # 3 told the facility nurse that Client #5 had touched her inappropriately on 7/30/21 and several days after. -Facility implemented the used of a door lock with a key that Client #5 had maintained. -Client #3 and Client #5 counseled about not going into each others bedrooms. -Staff had been told to monitor Client #3 and Client #5's interactions. -Client #3's guardian and the local department of social services had been notified of Client #3's allegation on 8/5/21. -Facility had not completed a level I report until 8/20/21. -A level II report had not been submitted to the Incident Response Improvement System (IRIS) because "it was felt the situation was handled and had initially been a consensual relationship." -IRIS report submitted on 8/20/21 after the local managed care organization told the facility to submit an IRIS report. Interview on 9/16/21 the Registered Nurse (RN)	V 366		

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V 366	Continued From page 8 stated: -Client #3 had told her on 8/4/21 that Client #5 had touched her inappropriately. -She (RN)and Client #3 had informed the Qualified Professional (QP) on 8/4/21 of Client #3's allegation. Interview on 9/16/21 the Program Director stated: -She had informed Client #3's guardian and the local department of social services of the allegation. -A safety plan had been implemented for Client #3 to include a locked door and notification of right to make a formal report with law enforcement. -She had interviewed both Client #3 and Client #4 regarding the allegation. -There had been no further incidents of inappropriate touching between Client #3 and Client #5.	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	V 367		

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V 367	Continued From page 9	V 367		

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 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

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V 367	Continued From page 10 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. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to complete a Level II incident report within 72 hours as required. The findings are: Review on 9/15/21 of Client #5's record revealed: -29 year old female admitted 2/15/21. -Diagnoses included Moderate Intellectual	V 367		

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V 367	Continued From page 11 disability; Anxiety Disorder-Unspecified; Bipolar Disorder-unspecified and Schizoaffective Disorder-Unspecified. Review on 9/15/21 of Facility Formal Inquiry Form dated 8/20/21 revealed: -On 8/4/21 Client # 3 told the facility nurse that Client #5 had touched her inappropriately on 7/30/21 and several days after. -Facility implemented the used of a door lock with a key that Client #5 had maintained. -Client #3 and Client #5 had been counseled about not going into each others bedrooms. -Staff had been told to monitor Client #3 and Client #5's interactions. -Client #3's guardian and the local department of social services had been notified of Client #3's allegation on 8/5/21. -Facility had not submitted an Incident Response Improvement System (IRIS) report as required because "it was felt the situation was handled and had initially been a consensual relationship." -IRIS report submitted on 8/20/21 after the local managed care organization told the facility to submit an IRIS report. Interview on 9/16/21 the Registered Nurse (RN) stated: -Client #3 had told her that Client #5 had touched her inappropriately. -She (RN) had informed the Qualified Professional (QP) of Client #3's allegation. Interview on 9/16/21 the Program Director stated: -There had been no further incidents of inappropriate touching between Client #3 and Client #5. -She had informed Client #3's guardian and the local department of social services of the allegation on 8/5/21.	V 367		

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V 367	Continued From page 12 -Client #3 had maintained a key to the lock on her bedroom door -An IRIS report had been submitted on 8/20/21 after the local managed care organization told the facility to submit an IRIS 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 observation and interview, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 09/15/21 at approximately 11:30am revealed: -Debris, dead bugs and leaves inside the the back door frame. -Inside the microwave had a burnt spot and black hole in the back on the left side. -Handicap bathroom had a stained and lifted area on the baseboard under the paper towels; bathroom ceiling light fixture was rusty. -Client #4 ceiling vent was dusty. -Client #2 had an approximately 2 inch hole in the wall behind the recliner. -Client #3's 5 drawer chest had the last 3 drawers off track and Client #3's 8 drawer chest had 2 drawers on the right side at the bottom off track.	V 736		

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V 736	Continued From page 13 -Client #5's 10 drawer dresser had two drawer off track on the left side at the top. wall inside closet heavily covered in dark marks and te ceiling vent had dust. -Hall bathroom had rust at the bottom of the door frame. -Left side of the driveway had a wooden swing that was discolored and hung by one chain. Interview on 09/16/21 the Program Director stated she would follow up on identified items at the facility	V 736		