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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHY CHOICES	**1102 GROVE STREET KINGS MOUNTAIN, NC 28086**

(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 An annual and complaint survey was completed 9/3/21. The complaint was unsubstantiated (#NC177147). 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 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) 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. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures	V 109	DHSR - Mental Health OCT 25 2021 Lic. & Cert. Section	

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V 109	Continued From page 1 for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record reviews and interviews 2 of 2 Qualified Professionals (QP) (QP #1 and QP #2/Licensee) failed to demonstrate knowledge, skills and abilities required by the population served affecting 4 of 4 current clients (Client #1, #2, #3 and #4) and 1 of 2 audited former clients (FC #5). The findings are: CROSS REFERENCE: 10A NCAC 27G.0205 Assessment and Treatment/Habilitation or Service Plan (V112). Based on record review and interviews, the facility failed to develop and implement treatment plan strategies for 3 of 4 current clients (Clients #1, #2 and #3) and 1 of 2 audited former clients (FC #5). CROSS REFERENCE: 10A NCAC 27G.0209 (c) Medication Requirements (V118) Based on observation, record review and interviews, the facility failed to keep the MAR current, failed to follow the written order of a physician for 4 of 4 current clients (Client #1, #2, #3 and #4) and 1 of 2 audited former clients (FC #5). CROSS REFERENCE10A NCAC 27G.0209 (h)	V 109		

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V 109	Continued From page 2	V 109		

Medication Requirements (V123)
Based on record review and interview, the facility failed to ensure medication errors were reported immediately to a physician or pharmacist affecting 2 of 4 current clients (Client #1, #2) and 1 of 2 audited former clients (FC #5).

CROSS REFERENCE: 10A NCAC 27G.1704 Minimum Staffing Requirements (V296) Based on interviews, observations and record reviews the facility failed to provide the minimum number of staff required when children/adolescents are present in the home or community.

CROSS REFERENCE: 10A NCAC 27G.0604 Incident Reporting Requirements (V367) Based on interview and record review, the facility failed to report a Level II incident to the Local Management Entity (LME) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident.

CROSS REFERENCE: 10A NCAC 27E .0104 (e) (1-2) Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V518)
Based on interview and record review the facility failed to give consideration to the client's physical and psychological well-being before, during and after a restrictive intervention for 2 of 4 current clients (Clients #1 and Client #2) and 1 of 2 audited former clients (FC #5).

CROSS REFERENCE: 10A NCAC 27E .0104 (e) (9) Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V521)
Based on record review and interview the facility failed to ensure the minimum required

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V 109	Continued From page 3 documentation was completed whenever a restrictive intervention was used for 2 of 4 current clients (Clients #1 and Client #2) and 1 of 2 audited former clients (FC #5). CROSS REFERENCE: 10A NCAC 27E .0104 (e) (10) Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V522) Based on record review and interviews, the facility failed to ensure each client with a restrictive intervention (RI) of more than 15 minutes had verbal and written authorization, as well as, a physical and mental well-being assessment by a qualified professional that extended the RI for 2 of 4 current clients (Client #1 and Client #2) and 1 of 2 audited former clients (FC #5). CROSS REFERENCE: 10A NCAC 27E .0104 (e) (12-16) Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V524) Based on record reviews and interviews, the facility failed to notify the legally responsible person of minor clients immediately when a restrictive intervention was utilized for 2 of 4 current clients (Client #1 and Client #2) and 1 of 2 audited former clients (FC #5). CROSS REFERENCE: 10A NCAC 27E .0104 (e) (17) Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V525) Based on record reviews and interviews, the facility failed to maintain documentation of debriefing and planning conducted with the client, legally responsible person and staff following each restrictive intervention, to eliminate or reduce probability of future use of restrictive	V 109		

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interventions for 2 of 4 current clients (Client #1 and Client #2) and 1 of 2 audited former clients (FC #5).

CROSS REFERENCE: 10A NCAC 27E .0104 (e) (18-19) Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V526)
Based on record reviews and interviews, the facility failed to collect and analyze data on the use of physical restraint on at least a quarterly basis to monitor effectiveness, determine trends and take corrective action when necessary.

Review on 9/2/21 of 1st Plan of Protection completed by the QP #1 and dated 9/2/21 revealed:
"-10A NCAC 27G .0203. COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS
Licensed professional will train all QP's and AP's to ensure competence.
-10A NCAC 27G .0205(c) ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN
Provider will ensure that QP is responsible for Treatment Plan, and that it includes a strategy.
-10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS
Provider will ensure that there is a minimum of 2:1 staff/client ratio at all times.
-10A NCAC 27G .0209(c) MEDICATION REQUIREMENTS
Provider will ensure that upon receiving medication prescription that the doctor's order will be present in all charts.
-10A NCAC 27G .0209(h) MEDICATION REQUIREMENTS
Provider will ensure that all MAR's are completed in its entirety. Provider will ensure that if a

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medication is not given or refused that the physician or pharmacist will be notified. Provider will ensure that an incident report is completed within 72 hours. Provider will ensure a communication log is added to each client chart to log medication errors.
-10A NCAC 27G .0604. INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS
Provider will train all staff on incident reporting/ IRIS system.
-10A NCAC 27E .0104. (e)(1-2) SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL
Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be trained by date of implementation.
-10A NCAC 27E .0104. (e)(8) SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL
Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be trained by date of implementation.
-10A NCAC 27E .0104. (e)(10) SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL
Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be trained by date of implementation.
-10A NCAC 27E .0104. (e)(11) SECLUSION, PHYSICAL RESTRAINT AND ISOLATION

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V 109	Continued From page 6 TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be trained by date of implementation. -10A NCAC 27E .0104. (e)(12-16) SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be trained by date of implementation. -10A NCAC 27E .0104. (e)(17) SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be trained by date of implementation. -10A NCAC 27E .0104. (e)(18-19) SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be trained by date of implementation. -10A NCAC 27E .0104. (f) SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL Provider will only implement emergency restrictions. In the event that the restriction rises	V 109		

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V 109	Continued From page 7 to a level of restraint the police will be contacted immediately. All staff will be trained by date of implementation. -10A NCAC 27E .0104. (g) SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be trained by date of implementation. -10A NCAC 27E .0104. (g)(3) SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be trained by date of implementation." Review on 9/2/21 of 2nd Plan of Protection completed by QP #1 and dated 9/2/21 revealed: "-10A NCAC 27G .0203. COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS Healthy Choices will ensure that all staff receives training in all required areas while servicing consumers. Each staff will successfully complete all core trainings as required by the state before rendering services and training will be updated as necessary. All other required trainings will be successfully completed by staff within the specific time frame for each individual specific service. The Human Resource Manager will generate a compliance report in which reflects the names, hire dates, initial date of training, due date of training, and completion date of training for each staff member to ensure competency. The HR	V 109		

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V 109	Continued From page 8 manager will turn this report in to the QI/Training Director for review. QI/Training Director will then schedule training as needed. By 09/07/2021 ALL staff will have received ALL trainings required for each specific service that they are providing services for. -10A NCAC 27G .0205(c) ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN Provider will immediately ensure for the next twenty three days the Licensed Professional/ Qualified Professional will review all Treatment Plans/PCP's to ensure that the plans address the individual's needs and preferences. After this 23 day time frame has ended, all PCP's that need to be updated within thirty days will be reviewed by clinical staff members during the weekly clinical staff meeting. The Licensed Professional/ Qualified Professional will review all initial plans before submission to ensure the individual's needs and preferences are addressed in the plan. The QI Director will arrange for all staff to attend PCP development training with an outside source to assist in effective development of Treatment Plans/Person Centered Plans. -10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS Provider will ensure that there is a minimum of 2:1 staff/client ratio at all times. Provider will create monthly schedule that will be monitored by Executive Director and implemented by 09/06/2021. -10A NCAC 27G .0209(c) MEDICATION REQUIREMENTS Provider will ensure that upon receiving medication prescription that the doctor's order will be present in all charts. This will be monitored by QP. Effective immediately. -10A NCAC 27G .0209(h) MEDICATION REQUIREMENTS	V 109		

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V 109	Continued From page 9 Effective immediately provider will ensure that QP monitors the MAR's biweekly and ensure it is completed are completed in its entirety. QP will ensure that if a medication is not given or refused that the physician or pharmacist will be notified. Executive director will ensure that an incident report is completed within 72 hours. Provider will ensure a communication log is added to each client chart to log medication errors. -10A NCAC 27G .0604. INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS Executive Director will train all staff on incident reporting/ IRIS system on September 07,2021. -10A NCAC 27E .0104. (e)(1-2) SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be notified of policy changes/ updates and trained during Staff meeting on September 07,2021. This will be ensured by the Executive Director. -10A NCAC 27E .0104. (e)(8) SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be notified of policy changes/ updates and trained during Staff meeting on September 07,2021. This will be ensured by the Executive Director. -10A NCAC 27E .0104. (e)(10) SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL	V 109		

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V 109	Continued From page 10 Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be notified of policy changes/ updates and trained during Staff meeting on September 07,2021. This will be ensured by the Executive Director. -10A NCAC 27E .0104. (e)(11) SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be notified of policy changes/ updates and trained during Staff meeting on September 07,2021. This will be ensured by the Executive Director. -10A NCAC 27E .0104. (e)(12-16) SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be notified of policy changes/ updates and trained during Staff meeting on September 07,2021. This will be ensured by the Executive Director. -10A NCAC 27E .0104. (e)(17) SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be notified of policy changes/ updates and trained during Staff meeting on September 07,2021. This will be ensured by the Executive Director.	V 109		

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V 109	Continued From page 11 -10A NCAC 27E .0104. (e)(18-19) SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be notified of policy changes/ updates and trained during Staff meeting on September 07,2021. This will be ensured by the Executive Director. -10A NCAC 27E .0104. (f) SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be notified of policy changes/ updates and trained during Staff meeting on September 07,2021. This will be ensured by the Executive Director. -10A NCAC 27E .0104. (g) SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be notified of policy changes/ updates and trained during Staff meeting on September 07,2021. This will be ensured by the Executive Director. -10A NCAC 27E .0104. (g)(3) SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted	V 109		

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immediately. All staff will be notified of policy changes/ updates and trained during Staff meeting on September 07,2021. This will be ensured by the Executive Director."

This residential facility for adolescent males is currently serving 4 boys ages 10-15 with diagnoses of disruptive mood dysregulation disorder, oppositional defiant disorder, post-traumatic stress disorder, unspecified trauma, attention deficit hyperactivity disorder, conduct disorder, nocturnal enuresis and borderline intellectual functioning. These clients were prescribed the following medications: concerta, aripiprazole, Vitamin D3, dulera, olanzapine, melatonin, hydroxyzine, omeprazole, trazadone, quetiapine, mirtazapine and Miralax.

Three clients (Clients #1, #2, and FC #5) reviewed did not have strategies or interventions included in their treatment plans despite all having histories of aggression, property damage and AWOL. Additionally, the treatment plans were kept in the corporate office and only goals were entered into the electronic system used by staff on site. No strategies were in the electronic system. Clients continuted to display agression, property damage, and AWOL behaviors. Client #1 engaged with FC #5 in a fight at a local restaurant. At a separate time, Client #1 was placed in a therapeutic hold for impulsive behavior and refusing to sleep. FC #5 had 3 instances of fighting and engaged in property damage twice. Client #2 went AWOL 3 times and police were involved 2 of those times. In addition to the fight with FC #5, Client #2 had 2 additional instances of agression. One in involved picking up knives, stabbing the desk and wall with the knives and throwing objects. In another incident, Client #2 became angry, ran out the door, and

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V 109	Continued From page 13 began throwing rocks at the facility window, breaking 8 windows. Due to the absence of strategies in the treatment plans, staff did not have interventions to utilize to address the clients' behaviors. Three clients had a total of 5 medications administered without orders for as many as 86 days for one of the medications. Client #1 and FC #5 missed 7 doses of 6 different medications during the 3 months reviewed. Lack of accurate documentation on the MARS resulted in the inability to determine if medications were prescribed as ordered. Due to the Olanzapine for Client #2 not being refilled timely, Client #2 was without this medication for 6 days during which time he grabbed kitchen knives and stabbed walls, threw rocks at a staff member breaking a window and went AWOL (absence without leave) twice. Additionally, 4 other medication errors or refusals that were documented as such, were not reviewed immediately by a physician or pharmacist. One staff with 1 client was observed on 2 occasions at the facility. Additionally, a physical altercation between 2 clients while they were at a local restaurant revealed there was only 1 staff present. One client received an injury that required him to be seen at the local emergency room. Police were also called to the scene of the altercation. On that occasion 1 staff accompanied the client to the emergency department while only 1 staff transported 3 clients back to the facility. Police were involved in 5 different incidents for 3 different clients, but only 4 internal incident reports noted police involvement. Additionally, restrictive interventions were reportedly utilized	V 109		

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V 109	Continued From page 14 for another 5 incidents but no IRIS (incident response improvement system) reports were completed and reported for any restrictive interventions. QP #2/Licensee was responsible for entering reports into IRIS. There was no documentation in a log of all restrictive interventions nor the required elements including frequency, duration, precipitating circumstances, alternative strategies, authorization by QP for intervention lasting more than 15 minutes, immediate notification to guardians, debriefing with client, guardian and staff. There was no analysis to determine trends or effectiveness of the use ofrestrictive interventions. These deficiencies constitute a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 109		
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	V 112		

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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.

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to develop and implement treatment plan strategies for 2 of 4 current clients (Clients #1 and Client #2) and 1 of 2 audited former clients (FC #5). The findings are:

Record review on 8/25/21 for Client #1 revealed:
-Date of Admission-2/22/21
-Age-15 years
-Diagnoses- Disruptive Mood Dysregulation Disorder (DMDD), Post Traumatic Stress Disorder (PTSD), Attention Deficit Hyperactivity Disorder (ADHD) and Conduct Disorder (CD).
-History included-becomes easily angered, numerous foster and residential placements due to worsening aggression, defiance and repeated elopements; history of poor frustration tolerance,

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destruction of property and self- injurious behaviors.
-Treatment Plan last updated on 7/12/21 included goals as follows:
-Will actively engage in individual therapy.
-Will get healthy amount of sleep.
-Will demonstrate greater respect and compliance.
-Will identify triggers of feelings of uneasiness and distress.
-Will increase focus and attention.
-Strategies noted, "RE Health Group will monitor consumer in the home and community to ensure that all needs are met on a daily basis. RE Health Group (licensee) will monitor consumer's behavior and offer interventions to assist in achieving goals. RE Health Group will set clear expectations and rules while in respite care."
-No specific strategies or interventions were included in treatment plan to address aggression, property damage or AWOL (absence without leave) behaviors.

Record review on 8/25/21 for Client #2 revealed:
-Date of Admission-7/19/21
-Age-12 years
-Diagnoses- DMDD, ADHD, Oppositional Defiant Disorder (ODD) and unspecified trauma.
-History included "severe and recurrent temper outbursts manifested verbally and behaviorally that are grossly out of proportion in intensity or duration to the situation or provocation." Easily agitated when not getting his way; multiple hospitalizations and placements; witness of domestic violence and parental substance abuse.
-Treatment Plan dated 5/4/21 and updated 7/7/21 included goals as follows:
-Will comply with rules/policies.
-Will implement learned coping skills to help decrease/eliminate aggressive behaviors.

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-Will begin to process his trauma history.
-No specific strategies or interventions were included in treatment plan to address aggression, property damage or AWOL behaviors.

Record review on 8/26/21 for FC #5 revealed:
-Date of Admission-3/9/21
-Date of Discharge-8/2/21
-Age-12 years
-Diagnoses-PTSD, ADHD and ODD.
-History included:
-Continues to struggle with impulsivity
-Theft behaviors
-Needs adequate supervision
-Struggles with female authority-one instance of inappropriate sexual behavior at previous psychiatric residential treatment facility.
-Treatment Plan dated 3/3/21 updated 5/3/21, 6/3/21, 7/8/21 included goals as follows:
-Will learn to engage in healthy expressions of emotion related to past traumatic experiences
-Will learn to manage feelings in a more positive manner.
-Decrease episodes of disruptive behaviors by learning coping skills.
-Will have fewer disruptive incidents in both home and school.
-Strategies-"RE Health Group (licensee) will monitor consumer in the home and community to ensure that all needs are met on a daily basis. RE Health group will monitor consumer's behavior and offer interventions to assist in achieving goals. RE Health Group will set clear expectations and rules while in respite care."
-No specific strategies or interventions were included in treatment plan to address aggression, property damage or AWOL behaviors.

Record review on 8/26/21 or electronic record system revealed:

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-Calendar with drop down view of goals for each client. There were no interventions or strategies for staff to use; only goals listed.

Interview on 8/31/21 with Staff #2 revealed:
-Goals were online (in electronic record system). Staff chart online below drop-down goals; add notes regarding their interventions and the outcomes. Only the goals were online.

Interview on 9/2/21 with the Qualified Professional (QP) #1 revealed:
-Treatment plans were kept at their corporate office.
-The previous Associate Professional added goals from the plans to their electronic medical record. Goals were in a drop-down box for each client and under each shift. Staff could log in to add notes to the specific goal they worked on. There were no strategies or interventions in the electronic record only goals.
-He was responsible for completing and updating treatment plans with goals and strategies specific to the service the facility provided.
-"I'm trying to get strategies done through LP (licensed practitioner) discussions. This was an oversite on my part. I'm pretty new at this."
-"We are in process of creating a behavior plan for [Client #2]. Just trying to get him to buy into the program. We accelerated his access to a MP3 (moving picture experts group layer-3/ digital audio) player, we allow calls with his mom daily rather than just Mondays and Thursdays and take therapeutic walks."

This deficiency is cross referenced into 10A NCAC 27G.0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.

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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 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 hold fire and disaster drills on each shift at least quarterly. The findings are: Review on 8/26/21 of fire and disaster drills from December 2020- July 2021 revealed: -There was no documentation of fire drills having been conducted on 1st shift from December 2020-Feburary 2021 or March-May 2021. -There was no documentation of fire drills having been conducted on 2nd shift from December 2020-Feburary 2021. -There was no documentation of fire drills having been conducted on 3rd shift from December 2020-Feburary 2021 or March-May 2021. -There was no documentation of disaster drills having been conducted on 3rd shift from	V 114		

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V 114	Continued From page 20 March-May 2021. Interview on 8/26/21 with Client #1 revealed: -Yes, they had drills, but he could not be specific. Interview on 8/26/21 with Client #4 revealed: -They had fire and disaster drills but could not identify their frequency. Interview on 8/26/21 with the Qualified Professional #1 revealed: -Shifts ran 7am-3pm, 3pm-11pm, 11pm-7am and on weekends shifts ran 7am-7pm and 7pm-7am. -Began serving clients in December of 2020. -"We know we've got to do better with the drills."	V 114		
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;	V 118		

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(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 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 observation, record review and interviews, the facility failed to keep the MAR current, and failed to follow the written order of a physician for 4 of 4 current clients (Client #1, #2, #3 and #4) and 1 of 2 audited former clients (FC #5). The findings are:

Record review on 8/25/21 for Client #1 revealed:
-Date of Admission-2/22/21
-Age-15 years
-Diagnoses- Disruptive Mood Dysregulation Disorder (DMDD), Post Traumatic Stress Disorder (PTSD), Attention Deficit Hyperactivity Disorder (ADHD) and Conduct Disorder (CD).

Record review on 8/25/21 and 8/26/21 of MARs and physician orders for 6/1/21-8/26/21 for Client #1 revealed:
-Concerta ER (for attention deficit hyperactivity disorder) (ADHD) 36 milligrams (mg) 1 tablet each morning was ordered on 4/12/21 and not documented as administered on 6/30/21.
-Aripiprazole (mood stabilizer) 5mg, 1 tablet each

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morning was ordered on 4/12/21 and not documented as administered 6/30/21.
-Vitamin D3 (vitamin deficiency) 2000 international units (IU) 1 capsule each morning was documented as administered 6/1/21-6/29/21, 7/1/21-7/31/21, and 8/3/21-8/26/21. There was no physician order for Vitamin D3 2000 units provided by the facility.
-Dulera (asthma) 100mg/5mg 2 puffs twice daily was documented as administered 6/1/21-7/30/21 and 8/1/21 - 8/26/21. There was no physician order for Dulera 100mg/5mg 2 puffs twice daily provided by the facility.
- Aripiprazole (mood stabilizer) 10mg 1 tablet every evening. The MAR indicated the medication was not documented as administered on 7/31/21.

Record review on 8/25/21 for Client #2 revealed:
-Date of Admission-7/19/21
-Age-12 years
-Diagnoses- DMDD, ADHD, Oppositional Defiant Disorder (ODD) and unspecified trauma.

Observation of medication for Client #2 on 8/25/21 at approximately 3:00pm revealed:
-The current bottle of Olanzapine (antipsychotic) 5mg ½ tablet each evening was dispensed 8/5/21.
-The current bottle of Olanzapine 5mg ½ tablet each morning was dispensed 8/5/21.

Record review on 8/25/21 of MARs and physician orders for 6/1/21-8/26/21 for Client #2 revealed:
-Olanzapine 5mg ½ tablet each evening was ordered 7/23/21. Additionally, the medication was not given 8/1/21-8/4/21 due to waiting for Medicaid re-authorization.
-Olanzapine 5mg ½ tablet each morning was ordered on 7/9/21 and was not documented as

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administered on 8/5/21-8/6/21 (blank) although 8/1/21, 8/2/21, and 8/4/21 were marked with an 'x' and noted due to waiting for Medicaid re-authorization. 8/3/21 was initialed as given despite medication not being in the facility.
-Melatonin (sleep) 1mg 3 tablets at bedtime was ordered on 7/23/21. This was an increase from the 7/9/21 order for Melatonin 1mg 1 tablet at bedtime. The Melatonin 1mg 1 tablet was documented as administered on 8/1/21-8/16/21 and 8/19/21-8/24/21. There was no PRN (as needed) MAR presented for July.

Record review on 8/26/21 for Client #3 revealed:
-Date of Admission- 3/19/21
-Age-10 years
-Diagnoses-ADHD, ODD, Nocturnal Enuresis, Borderline Intellectual Functioning.

Record review on 8/25/21 and 8/26/21 of MARs and physician orders for 6/1/21 - 8/26/21 for Client #3 revealed:
-Physician order for Vitamin D3 (vitamin deficiency) 50 mg-2000IU 1 tablet every morning was dated 8/19/21 and was administered 6/1/21 - 8/26/21. No order for 6/1/21 - 8/18/21 was present.
-Hydroxyzine (anxiety) 50mg 1 tablet every evening was not documented as administered 7/1/21. The 8/26/21 MAR had the evening dose documented as administered before Client #3 arrived home from school.
-Clonidine (ADHD) 0.2mg 1 tablet every evening was not administered 7/31/21. Additionally, the MAR indicated the 8/26/21 dose was administered before Client #3 arrived home from school.

Record review on 8/26/21 for Client #4 revealed:
-Date of Admission-8/13/21

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-Age-10 years
-Diagnosis- ODD.

Record review on 8/27/21 of MARs and physician orders for 6/1/21-8/27/21 for Client #4 revealed:
-Omeprazole (acid reflux) 20mg 1 tablet every morning was administered 8/14/21-8/27/21. There was no order for Omeprazole 20mg 1 tablet every morning provided by the facility.

Record review on 8/26/21 for FC #5 revealed:
-Date of Admission-3/9/21
-Date of Discharge-8/2/21
-Age-12 years
-Diagnoses-PTSD, ADHD and ODD.

Record review on 8/26/21 of MARs and physician orders for 6/1/21-8/2/21 for FC #5 revealed:
-Trazadone (sedative) 100mg PRN at bedtime was ordered on 6/9/21 but was documented as administered 6/1/21-6/8/21. Trazadone 50mg was documented as administered 7/30/21. The MAR was blank for 7/31/21.
-Quetiapine (antipsychotic) 300mg 1 tablet every evening was ordered on 6/9/21 but was documented as administered 6/1/21-6/8/21. The medication was not documented as administered on 7/31/21.
-Mirtazapine (antidepressant) 30mg was ordered 6/9/21 but was documented as administered 6/1/21-6/8/21. The medication was not documented as administered on 7/31/21.
-PEG 3350 (constipation) 17 grams each evening was documented as administered 6/1/21-7/30/21. There was no order for this medication presented by the facility.

Interview on 9/2/21 with the Qualified Professional (QP #1) revealed:
-Each staff was responsible for oversight of

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V 118	Continued From page 25 medications although the QP #1 was ultimately responsible. -QP #1 reviewed count sheets and PRN medication log weekly. -Each client had monthly medication evaluations with local provider. Most of these had been virtual so obtaining change or ongoing orders was difficult. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. This deficiency is cross referenced into 10A NCAC 27G.0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 118		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by:	V 123		

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(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 123	Continued From page 26	V 123		

Based on record review and interview, the facility failed to ensure medication errors were reported immediately to a physician or pharmacist affecting 3 of 4 current clients (Client #1, #2, #4) and 1 of 2 audited former clients (FC #5). The findings are:

Refer to Tag V118 for client specific diagnostic information.

Review on 8/26/21 of internal incident reports from April-August 2021 in comparison with MARs of the specified times revealed:
-8/25/21 (incident report)-Client #4- 6:10am missed medication-unknown medication
- MAR marked on 8/25/21 as not administered (amphetamine 10 milligrams (mg).
-8/1/21 through 8/5/21 (incident report)- Client #2- medication out-required Medicaid prior approval
-Olanzapine 5mg ½ tablet twice a day was marked as given 8/3/21 am dose despite none being in the facility until 8/5/21. MAR was blank 8/6/21 am dose.
-7/24/21 (incident report)- Client #1- 6pm medication refusal
-MAR was marked R (aripiprazole 10mg)
-7/17/21 (incident report) -FC #5- 2:45 medication error
- There was no indication on MAR of what medication was missed-all 7 (am/pm) medications were initialed.
-6/10/21-Client #1-6am - Medication error
-There was no indication on MAR of what medication was missed-all 6 am medications were initialed.
-Incident reports did not document which medication was missed or why.
-There was no evidence a physician or pharmacist was contacted immediately when a medication was missed or refused.

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V 123	Continued From page 27 Interview on 8/31/21 with Staff #1 revealed: -If a client refused or missed a medication, he would notify the Qualified Professional (QP) #1 and fill out an incident report. Interview on 9/1/21 with the QP #1 revealed: -He was not aware medication errors required immediate contact to a physician or pharmacist. This deficiency is cross referenced into 10A NCAC 27G.0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 123		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure each staff member had no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire for 1 of 4 audited	V 131		

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V 131	Continued From page 28 staff (Staff #2). The findings are: Record review on 8/26/21 for Staff #2 revealed: -Date of hire: 2/13/21 -HCPR check: 6/7/21 Interview on 9/1/21 with the QP (Qualified Professional) #1 revealed: -Human Resources was responsible for completing the HCPR checks.	V 131		
V 133	G.S. 122C-80 Criminal History Record Check G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT. (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a	V 133		

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V 133	Continued From page 29 criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed,	V 133		

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except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency.
(c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant:
(1) The level and seriousness of the crime.
(2) The date of the crime.
(3) The age of the person at the time of the conviction.
(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed.
(7) The subsequent commission by the person of a relevant offense.
The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant.
(d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for:

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V 133	Continued From page 31 (1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual. (2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section. (e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders;	V 133		

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Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.

(f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section shall be guilty of a Class A1 misdemeanor.

(g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met:

(1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10.

(2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.)

This Rule is not met as evidenced by:

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V 133	Continued From page 33 Based on personnel record review and staff interviews, the facility failed to request a state or national criminal background check within 5 days of making the conditional offer of employment for 1 of 4 audited staff (Qualified Professional (QP) #1). The findings are: Record review on 8/26/21 for the QP #1 revealed: -Date of hire: 3/5/20 -Criminal background check 12/29/20. Interview on 8/17/21 with the QP #1 revealed: -"There must be another one because we were all approved before we opened in the summer." -Human Resources was responsible for completing the personnel background checks.	V 133		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as	V 296		

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V 296	Continued From page 34 follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on interviews, observations and record reviews the facility failed to provide the minimum number of staff required when children/adolescents are present in the home or community. The findings are: Finding #1 Observation on 8/25/21 at approximately 1:30pm upon arrival at facility revealed: -Client #2 and Qualified Professional (QP) #1 at	V 296		

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the facility.
-The QP #1 and Client #2 left the facility at approximately 2:30pm to pick up other clients from school and returned at approximately 3:15pm with all 4 current clients in the vehicle.
-Staff #3 was at the facility waiting for their return as second staff at facility.

Observation on 8/26/21 at approximately 3pm the school bus dropped off Client #4 while only the Associate Professional (AP) was at facility. At approximately 3:35pm the 3 other clients returned to the facility with 2 staff in the vehicle.

Interview on 8/25/21 with Client #2 revealed:
-Had been there about 1 ½ months.
-Did not participate in a summer program since being there.
-There were not 2 staff all the time.

Interview on 8/25/21 with Client #4 revealed:
-There were usually 2 staff in the facility. He doesn't remember if there had ever been just 1 staff.
-He was admitted approximately 2 weeks ago.

Interview on 8/31/21 with Staff #1 revealed:
-The first thing he did when he arrived to work was to clock in (log in) to electronic record system. Staff write their timesheets and send to human resources.

Interview on 8/31/21 with Staff #2 revealed:
-Worked Sat-Sun 7a-7p.
-There were 2 staff all the time-she's never by herself.

Finding #2
Record review on 8/25/21 of partial IRIS (incident reporting improvement system) reports entered

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by the QP #2/Licensee on 4/9/21 for Client #1 and Former Client (FC) #5 but not fully completed for reporting validation in IRIS system revealed:
-"On 4/4/21 staff took consumer out to eat and after eating [FC #5] dropped his hand sanitizer and [Client #1] picked it up and poured it out. [FC #5] jumped over the seat on [Client #1]. Consumer emptied out of the van and [FC #5] and [Client #1] started back up. [FC #5] and [Client #1] got back fight and staff stepped in between and [FC #5] tripped and hit his head. After altercation police and medic was called and consumer was treated."
-HCPR (Health care personnel registry) section was completed for Staff #2 with description "staff is being investigated for abuse on consumer while out in public." Injury of unknown source noted "[FC #5] had a cut on his head that required attention from hospital."
-Investigative results revealed date investigation was complete was 4/7/21 by QP #1 with note "staff on leave until investigation is over."

Record review on 8/25/21 of summary of allegations from social services report dated 5/3/21 revealed:
-"Allegation indicated that 2 clients had gotten into an altercation during an outing a [local restaurant] in neighboring city. The lone staff member present attempted to intervene and break up the struggle between the boys in the process of breaking up the scuffle, the staff member fell and landed on top of the alleged victim child. The victim child had gotten up and was swinging and throwing rocks at his fellow housemate. Staff from the restaurant intervened to again stop the altercation and the police were called. The victim child also needed medical care to address the bleeding from his head but it was unclear if the

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bleeding occurred when the staff member fell on the child or when the child was in the altercation with the other child. The police responded and the child was brought to the hospital."

Interview on 8/25/21 with Client #1 revealed:
-There were usually 2 staff working when clients were in the facility.
-Regarding the incident at a local restaurant on 4/4/21, Client #1 revealed Staff #1 and Staff #2 had taken them to local restaurant for Easter. When the clients were leaving the restaurant and were outside, FC #5 started throwing rocks at him, then they got into a fight. He denied that anyone went to the hospital.

Interview on 8/31/21 with Staff #1 revealed:
-Staff wanted to teach the boys etiquette so they went to the local restaurant. "There were 2 guys in the van and 2 guys in my car."
-He couldn't remember exactly what happened, but FC #5 and Client #1 argued about hand sanitizers and "it blew up." Police were there then gone. He took FC #5 to the hospital but couldn't remember which hospital. FC #5 was bleeding from his head but he wasn't sure where he was injured. It took a long time at the hospital. He had to talk to Department of Social Services (DSS) and the police again at the hospital.
-"[FC #5] was already on the ground when he returned." He left the restaurant to go back home to get his check and then went by the bank to cash his check before returning. "I wasn't thinking it would get out of hand."
-"All the boys rode together in the van to the local restaurant and I followed them in my car."
-He was the only staff to transport FC #5 to the hospital and back to the facility.

Interview on 8/31/21 with Staff #2 regarding the

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incident on 4/4/21 revealed:
"The day started well [Client #1, Client #3, Former CLient (FC) #5 and FC #6] attended kids church. We rewarded them with going to [local restaurant] as reward. I didn't get permission [from the QP] but I've learned from that. [FC #5] climbed over seat to jump on [Client #1] when [Client #1] dumped out his hand sanitizer. They continued fighting in the parking lot. I got between them and we both [she and FC #5] fell to the ground. [FC #5] started throwing rocks at the car. I called [the QP #1] and he called the police and medic." FC #5 was treated on sight but said Client #1 hit his head. Staff #1 transported FC #5 to hospital. "I don't know where the accusation (of abuse) came from but everyone (police, social services) investigated". They had waited most of the day at the restaurant while local police, local social services asked questions. Then they sent another county (county home of facility) social services. They got home around 9pm and waited for [Staff #1] to return with [FC #5].

Attempts on 8/31/21 and 9/1/21 to reach the Social Services guardian for FC #5 were unsuccessful.

Interview on 8/26/21 and 9/2/21 with the QP #1 revealed:
-"[Client #2] came late in the summer and had to stay home so he stayed here with me."
-"We have 2 staff here on 2nd and 3rd shifts."
-"We don't have timesheets."
- He scheduled staff weekly using a scheduler online in electronic record program. The program didn't have reporting functions to pull more than 1 day and 1 shift.
-had a timesheet function on their electronic record program but it had never worked.
-"We're paying a lot of overtime."

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-Both QP #1 and QP #2/Licensee step in when needed.
-"Staff write their hours on timesheets and turn into payroll."
-was not aware 2 staff were required at all times with 1,2,3 or 4 clients.

This deficiency is cross referenced into 10A NCAC 27G.0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.

V 367 27G .0604 Incident Reporting Requirements V 367

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

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HEALTHY CHOICES	1102 GROVE STREET KINGS MOUNTAIN, NC 28086

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V 367	Continued From page 40 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 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	V 367		

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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 interview and record review, the facility failed to report a Level II incident to the LME (Local Management Entity)/ MCO (Managed Care Organization) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident. The findings are:

Record review on 8/25/21 of all IRIS (incident response improvement system) reports for the facility from August 2020 through August 2021 revealed only 1 incident on 3/29/21 involving a dryer fire and Former Client (FC) #5.

Review on 8/31/21 of local police reports for the

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facility from April through August 2021 revealed:
-8/23/21-7:06pm- damage to property (throwing rocks at the residence) and referred to juvenile justice and IVC (involuntary commitment) process.
-8/21/21-4:10pm-child has left the group home.
-8/1/21-7:38pm-subject has been referred to local county DJJ (department of juvenile justice) in reference to damage to property. 12- year old male is causing issues at the group home.
-4/9/21-06:45am-child had stolen staff members phone and called 911.
-4/4/21-3:40pm-location at parking deck retail shopping mall-simple assault-victim stated he was punched in the face and banged his head against the pavement. The victim was treated at local hospital.

Review on 8/26/21 of internal incident reports for April-August 2021 revealed:
-8/23/21-Client #2 -Level II-630pm-1 hour -AWOL (absence without leave) -incarceration-not noted that police were called.
-8/21/21-Client #2 -Level II- 1:50pm -3 hours 25 minutes -AWOL- police called 4:15pm-hospital
-8/21/21-Client #2 -Level I -1:50pm- 5-7 minutes-aggression-refusal to comply with directives- therapeutic hold
-8/1/21-FC #5- 8:10am- fighting-fire extinguisher set off- therapeutic hold- unknown amount of time of restrictive intervention
-8/1/21-Client #2- 7:41am- property damage-police called
-7/12/21-FC #5- 6.20am- 30 minutes- moderate aggression, stealing, AWOL- therapeutic hold
-7/11/21-FC #5-7am-45 minutes-aggression, fighting, stealing, property damage- therapeutic hold
-6/5/21-Client #1-Level I- 8:30pm- 15 minutes-impulsive behavior, refusing to

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sleep-therapeutic hold
-4/9/21-FC #5- 6:30am-30 minutes-property damage- police called
-4/4/21-Client #1 and FC #5 fight at local restaurant- police- hospital
-None of the incident reports included any narrative about the specific incident, who else might have been involved, what might have preceded the event or the resulting damage/consequences.
-Incident reports did not include all necessary information to determine level of incident.
-There were no IRIS reports submitted as required for any Level II internal incident reports involving use of restrictive interventions or police involvement.

Request on 8/25/21 and 8/27/21 for internal investigation of 4/4/21 incident at local restaurant revealed none had been documented.

Review on 8/31/21 of notes from Social Services guardian dated 8/31/21 for Client #2 revealed:
-On 8/2/21, the QP #1 reported Client #2 threw an object at a window in an attempt to hit staff which broke the window. This was the second major incident with the first being an AWOL the week of July 26 and a 2nd AWOL on 8/1/21, running around the house screaming, refusing to return and resulting in law enforcement being called.
-On 8/4/21 "[Client #2] has been picking up knives, throwing objects and went AWOL today ...stabbing desk and walls with knives ...[The QP #1] reported that they ran out of the Zyprexa; reported the pharmacy will not refill the med because Medicaid has not approved it."
-There was no incident report regarding Client #2's AWOL the week of 7/26/21 or the AWOL on 8/4/21.

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Interview on 8/25/21 with Client #2 revealed:
-He was responsible for breaking all the windows by throwing rocks at them because he was not being treated fairly. "[The Associate Professional (AP)] threw me to the ground because I wouldn't give the remote (for TV) back."
-"I went AWOL 3 days ago. I just walked to the police office because I was hungry and thirsty. They sent me to the hospital."

Interview on 8/26/21 with the AP revealed:
-"On 8/21/21 [Client #2] snatched remote control from [Client #3] and would not return it. He had the option for table restriction or to his room. I picked him up from the floor with arms crossed in front of [Client #2] but he kept dropping his weight to the floor. I escorted him to walk to his bedroom still with arms crossed in front of him and we both fell onto his bed."

Interview on 8/27/21 with the Qualified Professional (QP) #1 revealed:
-He reviewed incident reports and QP #2/Licensee put them in IRIS.
-He completed an internal investigation regarding Staff #2 and FC #5 at the local restaurant on 4/4/21 but he did not document interviews or make any notes. "I interviewed the kids and staff. [FC #5] just said [Staff #2] fell on top of him. I can't remember specifically but [FC #5] said he hit his head."
-Staff #2 was placed on leave until the investigation was complete. He accepted results from police and social services investigations. He did not substantiate Staff #2 did anything but try to prevent the fight between 2 clients.
-He thought the IRIS report for both Client #1 and FC #5 had been submitted.
-Client #2 told him that the AP did not actually throw him down; he dropped his weight and fell to

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V 367	Continued From page 45 the floor. -Client #2 grabbed a butter knife and stabbed the wall but he didn't remember any threats. -Client #2 told him he really wanted to stay at the group home and not move to another psychiatric residential treatment facility. This deficiency is cross referenced into 10A NCAC 27G.0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 367		
V 518	27E .0104(e1-2) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (1) the requirement that positive and less restrictive alternatives are considered and attempted whenever possible prior to the use of more restrictive interventions; (2) consideration is given to the client's physical and psychological well-being before, during and after utilization of a restrictive intervention, including: (A) review of the client's health history or the client's comprehensive health assessment conducted upon admission to a facility. The health history or comprehensive health assessment shall include the identification of pre-existing medical conditions or any disabilities and limitations that would place the client at greater risk during the use of restrictive interventions;	V 518		

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(B) continuous assessment and monitoring of the physical and psychological well- being of the client and the safe use of restraint throughout the duration of the restrictive intervention by staff who are physically present and trained in the use of emergency safety interventions;
(C) continuous monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being during the use of manual restraint; and
(D) continued monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a restrictive intervention;

This Rule is not met as evidenced by:
Based on interview and record review the facility failed to give consideration to the client's physical and psychological well-being before, during and after a restrictive intervention for 2 of 4 current clients (Clients #1 and Client #2) and 1 of 2 audited former clients (FC #5). The findings are:

Review on 8/26/21 of internal incident reports for April-August 2021 that included restrictive interventions revealed:
-8/21/21-Client #2 -Level I -1:50pm- 5-7 minutes-aggression, refusal to comply with directives- therapeutic hold
-8/1/21-FC #5- 8:10am- fighting, fire extinguisher set off- therapeutic hold-no indication of length of time in therapeutic hold or incident.
-7/12/21-FC #5- 6.20am- 30 minutes- moderate aggression, stealing, AWOL (absence without leave) - therapeutic hold

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V 518	Continued From page 47 -7/11/21-FC #5-7am-45 minutes-aggression, fighting, stealing, property damage- therapeutic hold -6/5/21-Client #1-Level I- 8:30pm- 15 minutes-impulsive behavior, refusing to sleep-therapeutic hold. -Duration of the holds were not noted only the duration of incidents. Interview on 9/2/21 with the Qualified Professional #1 revealed: -He was not aware of all the requirements for restrictive interventions. This deficiency is cross referenced into 10A NCAC 27G.0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 518		
V 521	27E .0104(e9) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (9) Whenever a restrictive intervention is utilized, documentation shall be made in the client record to include, at a minimum: (A) notation of the client's physical and psychological well-being; (B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior; (C) the rationale for the use of the intervention,	V 521		

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the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used;
(D) a description of the intervention and the date, time and duration of its use;
(E) a description of accompanying positive methods of intervention;
(F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions;
(G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and
(H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention.

This Rule is not met as evidenced by:
Based on record review and interview the facility failed to ensure the minimum required documentation was completed whenever a restrictive intervention was used for 2 of 4 current clients (Clients #1 and Client #2) and 1 of 2 audited former clients (FC #5). The findings are:

Refer to Tag 518 for specific restrictive interventions.

Review on 8/26/21 of internal incident reports revealed:
-There was no documentation in the internal incident reports for:
-Client's physical and psychological well-being;

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V 521	Continued From page 49 -Frequency, intensity and duration of the behavior which led to the intervention; -Any precipitating circumstance contributing to the onset of the behavior; -The rationale for the use of the intervention; -The inadequacy of less restrictive intervention techniques that were used; -A description of the intervention and duration of its use. Interview on 9/2/21 with the Qualified Professional #1 revealed: -He was not aware of all the requirements for restrictive interventions. This deficiency is cross referenced into 10A NCAC 27G.0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 521		
V 522	27E .0104(e10) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (10) The emergency use of restrictive interventions shall be limited, as follows: (A) a facility employee approved to administer emergency interventions may employ such procedures for up to 15 minutes without further authorization; (B) the continued use of such interventions shall be authorized only by the responsible professional or another qualified professional who	V 522		

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V 522	Continued From page 50 is approved to use and to authorize the use of the restrictive intervention based on experience and training; (C) the responsible professional shall meet with and conduct an assessment that includes the physical and psychological well-being of the client and write a continuation authorization as soon as possible after the time of initial employment of the intervention. If the responsible professional or a qualified professional is not immediately available to conduct an assessment of the client, but concurs that the intervention is justified after discussion with the facility employee, continuation of the intervention may be verbally authorized until an on-site assessment of the client can be made; (D) a verbal authorization shall not exceed three hours after the time of initial employment of the intervention; and (E) each written order for seclusion, physical restraint or isolation time-out is limited to four hours for adult clients; two hours for children and adolescent clients ages nine to 17; or one hour for clients under the age of nine. The original order shall only be renewed in accordance with these limits or up to a total of 24 hours. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure each client with a restrictive intervention (RI) of more than 15 minutes had verbal and written authorization, as well as, a physical and mental well-being assessment by a qualified professional that extended the RI for 1 of 2 audited former clients (FC #5). The findings are: Refer to Tag 518 for specific restrictive interventions.	V 522		

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V 522	Continued From page 51 Record review on 8/26/21 of internal incdient reports revealed: -There was no evidence of authorization for restrictive interventions lasting for more than 15 minutes. Interview on 9/2/21 with the Qualified Professional #1 revealed: -He was not aware of all the requirements for restrictive interventions. This deficiency is cross referenced into 10A NCAC 27G.0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 522		
V 524	27E .0104(e12-16) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (12) The use of a restrictive intervention shall be discontinued immediately at any indication of risk to the client's health or safety or immediately after the client gains behavioral control. If the client is unable to gain behavioral control within the time frame specified in the authorization of the intervention, a new authorization must be obtained. (13) The written approval of the designee of the governing body shall be required when the original order for a restrictive intervention is	V 524		

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renewed for up to a total of 24 hours in accordance with the limits specified in Item (E) of Subparagraph (e)(10) of this Rule.
(14) Standing orders or PRN orders shall not be used to authorize the use of seclusion, physical restraint or isolation timeout.
(15) The use of a restrictive intervention shall be considered a restriction of the client's rights as specified in G.S. 122C-62(b) or (d). The documentation requirements in this Rule shall satisfy the requirements specified in G.S. 122C-62(e) for rights restrictions.
(16) When any restrictive intervention is utilized for a client, notification of others shall occur as follows:
(A) those to be notified as soon as possible but within 24 hours of the next working day, to include:
(i) the treatment or habilitation team, or its designee, after each use of the intervention; and
(ii) a designee of the governing body; and
(B) the legally responsible person of a minor client or an incompetent adult client shall be notified immediately unless she/he has requested not to be notified.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to notify the legally responsible person of minor clients immediately when a restrictive intervention was utilized for 2 of 4 current clients (Client #1 and Client #2) and 1 of 2 audited former clients (FC #5). The findings are:

Refer to Tag 518 for specific restrictive interventions.

Review on 8/26/21 of internal incident reports revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-220	A. BUILDING: ___ B. WING ___	09/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHY CHOICES	1102 GROVE STREET KINGS MOUNTAIN, NC 28086

(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 524	Continued From page 53 -There was no evidence of immediate guardian notification when a restrictive intervention was used. Interview on 9/2/21 with the Qualified Professional #1 revealed: -He was not aware of all the requirements for restrictive interventions. This deficiency is cross referenced into 10A NCAC 27G.0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 524		
V 525	27E .0104(e17) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (17) The facility shall conduct reviews and reports on any and all use of restrictive interventions, including: (A) a regular review by a designee of the governing body, and review by the Client Rights Committee, in compliance with confidentiality rules as specified in 10A NCAC 28A; (B) an investigation of any unusual or possibly unwarranted patterns of utilization; and (C) documentation of the following shall be maintained on a log: (i) name of the client; (ii) name of the responsible professional; (iii) date of each intervention; (iv) time of each intervention;	V 525		

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V 525	Continued From page 54	V 525		

(v) type of intervention;
(vi) duration of each intervention;
(vii) reason for use of the intervention;
(viii) positive and less restrictive alternatives that were used or that were considered but not used and why those alternatives were not used;
(ix) debriefing and planning conducted with the client, legally responsible person, if applicable, and staff, as specified in Parts (e)(9)(F) and (G) of this Rule, to eliminate or reduce the probability of the future use of restrictive interventions; and
(x) negative effects of the restrictive intervention, if any, on the physical and psychological well-being of the client.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to maintain documentation of debriefing and planning conducted with the client, legally responsible person and staff following each restrictive intervention, to eliminate or reduce probability of future use of restrictive interventions for 2 of 4 current clients (Client #1 and Client #2) and 1 of 2 audited former clients (FC #5). The findings are:

Refer to Tag 518 for specific restrictive interventions.

Review on 8/26/21 of internal incident reports revealed:
-There was no documented evidence of debriefing with the client, legally responsible person or staff involved following each intervention to eliminate or reduce the probability of the future use of restrictive interventions.

Interview on 9/2/21 with the Qualified Professional #1 revealed:

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V 525	Continued From page 55 -He was not aware of all the requirements for restrictive interventions. This deficiency is cross referenced into 10A NCAC 27G.0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.	V 525		
V 526	27E .0104(e18-19) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (18) The facility shall collect and analyze data on the use of seclusion and physical restraint. The data collected and analyzed shall reflect for each incident: (A) the type of procedure used and the length of time employed; (B) alternatives considered or employed; and (C) the effectiveness of the procedure or alternative employed. The facility shall analyze the data on at least a quarterly basis to monitor effectiveness, determine trends and take corrective action where necessary. The facility shall make the data available to the Secretary upon request. (19) Nothing in this Rule shall be interpreted to prohibit the use of voluntary restrictive interventions at the client's request; however, the procedures in this Rule shall apply with the exception of Subparagraph (f)(3) of this Rule.	V 526		

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V 526	Continued From page 56	V 526		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to collect and analyze data on the use of physical restraint on at least a quarterly basis to monitor effectiveness, determine trends, and take corrective action when necessary. The findings are:

Refer to Tag 518 for specific restrictive interventions.

Review on 8/26/21 of internal incident reports revealed:
-There was no evidence of collection of data or review of physical restraints to monitor effectiveness, determine trends or take corrective action if necessary.

Interview on 9/2/21 with the Qualified Professional #1 revealed:
-He was not aware of all the requirements for restrictive interventions.

This deficiency is cross referenced into 10A NCAC 27G.0203 Competencies of Qualified Professionals and Associate Professionals (V109) for a Type A1 rule violation and must be corrected within 23 days.

V 736 — 27G .0303(c) Facility and Grounds Maintenance — V 736

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.

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V 736	Continued From page 57	V 736		

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility staff failed to ensure the facility and its grounds were maintained in a safe, clean, orderly and attractive manner. The findings are:

Observation on 8/25/21 upon arrival to facility at approximately 1:30pm revealed:
-In kitchen, dining, office area there was a rip in linoleum floor area approximately 6"x12" under dining table, 2-3 holes in a wall behind entrance door, unfinished drywall patch in the hallway to bedrooms, 2 panes in double windows broken beside the desk with jagged glass still in windows and no screens.
-In living area, 1 couch was ripped between cushions with foam sticking out, the wall adjacent to windows had a small dent in the drywall with the outside of drywall broken, double windows in living area had 3 broken panes with jagged glass still in the windows, louvered blinds were broken and there were no screens.
-Bedroom #1 (Client #4) had double windows with 4 broken panes with jagged glass still in windows, broken blinds, no screens, shards of glass in windowsill and on floor. The mattress was worn so that the inside coils/springs were sticking up in various places just inside the outer cover making the surface uneven and bumpy. There was no closet door and no rod or hangers to hang clothes. Clothes were piled on the floor in the closet.
-Bedroom #2 (Client #3) had 5-10 stains on the carpet, a single window on side of house had 1 pane broken with jagged glass still in window, no

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screen, an approximate 8x10 inch dent in drywall (outside of drywall broken but not completely broken through), 15-20 unfinished patched drywall areas, no closet door and no rod or hangers to hang clothes. Clothes were piled on the floor in the closet.
-Bedroom #3 (Client #1) had multiple stains on the carpet, no window screens and an approximate 8x12 inch unfinished drywall patch, no closet door and no rod or hangers to hang clothes. Clothes were piled on the floor in the closet.
-Bedroom #4 (Client #2) had 2 broken window panes with jagged glass still in windows, shards of glass on floor and windowsill, broken curtain rod with curtains hanging, an approximate 18x8 inch unfinished patch on wall, hollow core door with 4 holes on inside of door, no sheets on bed (only blanket) no closet door and no rod or hangers to hang clothes. Clothes were piled on the floor in the closet.
-Outside of the facility, pieces of glass remained on the concrete landing at the front door and on the ground around the perimeter of the facility.
-Weeds, 6-8 inches tall were growing in the gutters in the front corner of the house as well as in the back of the house.

Record review on 8/26/21 of internal incident reports revealed:
-No incident reports specifically noted when, how or by whom the windows might have been broken.

Interview on 8/25/21 with Client #2 revealed:
-He was responsible for breaking all the windows by throwing rocks at them from outside the facility because he "was not being treated fairly."

Interview on 8/25/21 with Client #4 revealed:

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-When asked how he slept he said he was sore in several places on his body and pointed to his right shoulder, arm, left side of torso, and side of his left calf.

Interview on 8/31/21 with Staff #2 revealed:
-Client #2 got mad and broke windows. He threw a rock at the office window because she was sitting at the desk beside the window. This occurred the 1st of August and the police were called. Client #2 also broke the other windows more recently but she was not there when that occurred.

Interview on 8/27/21 with Staff #3 revealed:
-On 8/23/21 "afternoon after dinner [Client #2] wanted to make a phone call but was on restriction. [The Associate Professional (AP)] took the phone from him and [Client #2] began being disrespectful. I stepped outside to get my backpack and saw [Client #2] was outside. I asked, 'How'd you get out here?' He said he climbed out his window. [The AP] caught [Client #2] climbing back in the window. Then we heard rocks hitting the door so [the AP] went outside. [Client #1 and Client #3] were sitting on couch when [Client #2] started throwing rocks into windows. I told the boys to come into the kitchen. [Client #4] was already in kitchen talking to me. [Client #2] started throwing rocks at windows in back. I told everyone to get under the table. Police arrived. [Client #2] was outside still banging on door trying to get in. [The AP] was still outside when police came."
-Staff #3 swept up glass in den and behind desk, from Client #4's bed and Client #2's bed.

Interview on 8/26/21 with the Associate Professional (AP) revealed:
-"On 8/23/21 [Client #2] got upset because he

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couldn't call his social worker. He began being disrespectful, slammed his door, climbed out the window but came back in window. He threatened to kill staff. He grabbed knives in the house and stabbed the wall. He went to his room and back out his window. He was running around outside, kept ringing the doorbell then I went outside to deal with [Client #2]. He threw rocks at the door; he didn't want to throw rocks at me. He threw them at the door then started on the windows. Kids got under the table inside so glass wouldn't hit them. Police came. [Client #2] went to the hospital emergency room for evaluation."

Interview on 8/27/21 with the Qualified Professional (QP) #1 revealed:
-"We talked about cleaning up this mess and then things just happened. It got pushed back and I didn't think about it again. It's on me."
-"We just rent this house. Am I supposed to replace the carpet?"
-"Closet doors get ripped off and rods are used as weapons."

Review on 8/27/21 of Plan of Protection completed by the QP #1 and dated 8/27/21 revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care?
-QP will remove all broken glass inside and outside of the facility and replace open window seals with cardboard on 8-27-2021 for a temporary fix. QP will have all windows permanently fixed by close of business 9-3-2021.
Describe your plans to make sure the above happens.
-QP will complete/supervise each project until its completion. Upon completion of the permanent fix, QP will inspect the project to ensure that there is no further health/safety risk for all persons

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served at Healthy Choices 1102 Groves St. Kings Mt. NC 28086."

This residential facility for adolescent males is currently serving 4 boys ages 10-15 with diagnoses of disruptive mood dysregulation disorder, oppositional defiant disorder, post-traumatic stress disorder, unspecified trauma, attention deficit hyperactivity disorder, conduct disorder, nocturnal enuresis and borderline intellectual functioning. Of the15 windows in the home, 8 windows had at least 1 broken pane with jagged glass pieces still in window. Small shards of glass were still present in windowsills and on floors below windows in bedrooms and living areas, as well as outside all around the facility. Jagged pieces of glass were still present in the window frames in client's bedrooms and living areas inside and outside the facility. These broken windows and glass pieces remained accessible to clients with aggressive behavior,including fighting, for 6 days while 1 broken window was accessible for 27 days. There were no screens on any facility windows, no closet doors in any bedroom, no rod or hangers to hang clothes so clothes were piled up on the floor of the closets. The mattress in Client #4's bedroom had coils/springs prominent in various places throughout the top side. Client #4 reported he was sore in the morning from sleeping on the mattress. The carpet in 2 bedrooms was worn and heavily stained. Numerous drywall patches on the walls throughout the facility that had not been sanded or painted as well as holes that had not been patched.

This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative

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V 736	Continued From page 62 penalty of $1000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 736		

DHSR - Mental Health
OCT 25 2021
Lic. & Cert. Section

RE Health Group, LLC Plan of Correction Form

Plan of Correction Response to Statement of Deficiencies	
Please complete all requested information and mail completed Plan of Correction form to: Jeanne Bronisewski NC Division of Health Service Regulation 1800 Umstead Drive, Williams Building 2718 Mail Center Raleigh, NC 27699-2718	**In lieu of mailing the form, you may e-mail the completed electronic form to: Jeanne Bronisewski-Jeanne.broniszewski@dhhs.nc.gov**

Provider Name:	**RE HEALTH GROUP, LLC**	**Phone:**	**252-484-8260**
Provider Contact Person for follow-up:	**Rashaad Woods Yvette Lewis**	**Fax:**	
		Email:	**Rehealthgroup100@gmail.com**
Address:	1102 Grove Street, Kings Mountain, NC 28086	**Provider #** MHL# 023-220	

Finding	Corrective Action Steps	Responsible Party	Time Line
V109: 27G .0203 Competencies of Qualified Professionals and Associate Professionals:	Healthy Choices recently entered a contract with an outside provider to assure compliance. An outsider provider is being used to assure that process changes are objective. Yvette Lewis BA, QMHP [Compliance Officer] has reviewed facility's policies and procedures regarding its New Hire Orientation Process and internal ongoing training and supervision program. • Training was held with both Qualified Professionals (QP). Training included a review of the population served and member Person Centered Plans (PCP). Supervision plans for each QP was reviewed by the Compliance Officer. Completion Date: 09/08/2021 ***Ongoing Plan***: • Compliance Officer will ensure that upon hire of all staff, annually and/or as needed, that an individualized supervision plan be	Compliance Officer	Implementation Date: 09/08/2021 Projected Completion Date: 09/23/2021: Ongoing

	developed and implemented as written within 30 days. Supervision and training shall focus on ensuring that all staff is able to demonstrate knowledge, skills and abilities required by the population served. • Compliance Officer will conduct an audit of all HR records monthly to ensure that monthly supervision is being provided to all associate professionals by a qualified professional with the child/adolescent population for the period as specified in Rule .0104. • Compliance Officer will also review monthly supervision plans for QPs to ensure that they continue to demonstrate knowledge, skills and abilities required by the population served. • Compliance Officer to conduct quarterly reviews of all staff charts to ensure that all staff has actively participated and completed necessary core trainings at time of hire, annually thereafter and as needed. Staff training and supervision log will be maintained in all staff charts as evidence of competencies of all staff. • Compliance Officer will assess for understanding and schedule trainings as needed.		
Cross Reference: 10A NCAC 27G.0205 Assessment and Treatment/Habilitation or Service Plan (V112):	Healthy Choices recently entered a contract with outside providers Compliance Officer, Yvette Lewis BA, QMHP [negotiations began 9/01/2021; contract began 09/07/2021] to assure compliance, and Sunflower Therapeutic Solutions PLLC [negotiations began 9/23/2021; contract began 10/1/2021] to assure clinical oversight and Candice Willey BSNRN [negotiations began 9/10/2021; contract began 09/20/2021] to assure medication administration compliance. An outsider provider is being used to assure that process changes are objective. Compliance Officer,	Clinical Provider Compliance Officer BSNRN	Implementation Date: 09/04/2021 Projected Completion Date: **09/23/2021: Ongoing**

	Yvette Lewis BA, QMHP and Tiffany Sanders LCSW, LISW-CP/Kwanza Winn LCSWA with Sunflower Therapeutic Solutions PLLC [Clinical Provider] have conducted chart reviews for compliance and clinical oversight. • A PCP training was held with QP staff Yvette Lewis on 09/09/2021 and consisted of the reviewing of clinical assessments, evaluations, and reports and meeting with member and legally responsible person, and any other identified supports and collaborating providers and agencies, to develop and implement plan. • A clinical review of charts was completed on October 13, 2021, by Tiffany Sanders, LCSW, LISW-CP. Recommendations sent to the Compliance Officer after the audit was conducted. ***<u>Ongoing Plan</u>*** Role of the QP: • QPs will make necessary changes to the charts audited by Tiffany Sanders LCSW, LISW-CP by October 27, 2021. [refer to email sent to rehealthgroup100@gmail.com] • QP staff are expected to ensure that each member's plan has goals, strategies, interventions, outcomes, and supports that address each individual member's diagnosis and treatment needs. • QP staff are expected to ensure that plans developed and implemented reflect strategies, interventions, outcomes and supports that address the appropriate treatment needs and services of the member served.		

	Role of the Compliance Coordinator: • Compliance Officer to conduct a monthly review of member service records to ensure that an appropriate plan has been developed and is being implemented for each member served related to compliance timeframes. Role of the Clinical Provider: • Clinical Provider will review client PCPs to assure that diagnosis, treatment needs, and treatment goals are met and appropriate for individual clients monthly and/or as needed.		
Cross Reference: 10A NCAC 27G. 0209 (c) Medication Requirements (V118)	Candice Willey, BSNRN and QP staff met and reviewed the agency's policy and procedure regarding Medication Requirements. • Training was held with all staff, training consisted of a review of agency's policy and procedure regarding Medication Requirements and the completion of MARs. ***Completion Date: 09/21/2021.*** ***Ongoing Plan:*** • Candice Willey, BSNRN to conduct a monthly review of member service records to include the review of MAR to ensure that member's MAR has been completed correctly, are current and the written order of a physician is being followed and is present in member's record.	Candice Willey, BSNRN Compliance Officer	Implementation Date: 09/08/2021 Projected Completion Date: **09/21/2021: Ongoing**
Cross Reference: 10A NCAC 27G. 0209 (h) Medication Requirements (V123)	Candice Willey, BSNRN, Compliance Officer and QP staff met and reviewed the agency's policy and procedure regarding Medication Requirements. • Training was held with all staff, training	Compliance Officer/ Candice Willey, BSNRN	Implementation Date: 09/08/2021 Projected Completion Date: 09/23/2021: Ongoing

	consisted of a review of agency's policy and procedure regarding Medication Requirements and the completion of MARs. ***Completion Date: 09/21/2021.*** ***Ongoing Plan:*** • Candice Willey, BSNRN to conduct a monthly review of member service records to include the review of MAR to ensure that member's MAR has been completed correctly, are current and the written order of a physician is being followed, including the reporting of medication errors to a physician or pharmacist. • Compliance Officer/ Candice Willey, BSNRN to also ensure that member's service record contains a communication log that reflects communication of medication errors to physician and others as needed. Agency's Client Rights Committee (CRC) to review all medication errors and ensure that reporting of medication errors is communicated immediately to a physician or pharmacist. • Compliance Officer to ensure that an incident report has been completed and reviewed for medication errors.		
Cross Reference: 10A NCAC 27G .1704 Minimum Staffing Requirements (V296):	Executive Director/Compliance Officer held staff meeting with all staff to address staffing issues. Compliance Officer will ensure that facility meets minimum staffing requirements of at least two staff for every one through four children present in the home or community. ***Completion Date: 09/04/2021.*** ***Ongoing Plan:*** • Compliance Officer will perform unannounced checks on every shift to	Executive Director Compliance Officer	Implementation Date: 09/04/2021 Projected Completion Date: 09/23/2021: Ongoing Implementation Date: N/A Projected Completion Date: N/A

	ensure that there are two staff always present on every shift. • Compliance Officer and Qualified Professional will ensure that staff schedule reflects the appropriate staffing ratio of at least two staff for every one through four children, and that they are present in the home or community.		
Cross Reference: 10A NCAC 27G .0604 Incident Reporting Requirements (V367)	Executive Director conducted an internal Incident Reporting training with all staff. Training consisted of a review of agency's policy and procedures for incident reporting and process for entering Level II incidents in IRIS. Training also consisted of how to complete agency's internal incident reporting form, process and timelines to be followed when reporting a Level II incident. ***Completion Date: 09/07/2021*** ***Ongoing Plan:*** • Agency's CRC to review all incidents reported on a quarterly basis, and as needed to ensure that process is followed regarding reporting a Level II incident to the Local Management Entity (LME) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident. • Compliance Officer to review all Level II incidents to ensure incident has been reported and entered into IRIS within 72 hours of becoming aware of the incident. • Compliance Officer to ensure during review that copy of IRIS report and all correspondences/follow ups regarding incident is filed in agency's Incident Reporting binder.	Executive Director Clinical Provider Compliance Officer	Implementation Date: 09/07/2021 Projected Completion Date: Ongoing

Cross Reference	Action	Responsible	Dates
Cross Reference: 10A NCAC 27E .0104 (e) (1-2) Seclusion, Physical Restraint and Isolation Time-out and Protective Devices Used for Behavioral Control (V518)	Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be notified of policy changes/ updates and trained during Staff meeting on September 07,2021. Executive Director conducted a staff meeting with all staff. Meeting consisted of a review of agency's policy and procedure regarding Seclusion, Physical Restraint and Isolation Time-out and Protective Devices Used for Behavioral Control. Meeting included the implementation of emergency restrictions only. Review of each member's plan was conducted to ensure that staff gives consideration to the member's physical and psychological well being before, during and after a restrictive intervention (RI). During quarterly CRC, if a RI is used, committee to ensure that consideration to the member's physical and psychological well being before, during and after RI was given. Compliance Officer to conduct monthly reviews of incident reports to ensure that documentation in agency's Incident Reporting binder reflects consideration provided to member.	Executive Director Clinical Provider Compliance Officer All Staff	Implementation Date: 09/07/2021 Projected Completion Date: Ongoing
Cross Reference: 10A NCAC 27E .0104 (e) (9) Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V521):	Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be notified of policy changes/ updates and trained during Staff meeting on September 07,2021. Executive Director meeting consisted of a review of agency's policy and procedure regarding Seclusion, Physical Restraint and Isolation Time-out and Protective Devices Used for Behavioral Control. Agency's process for completing the required documentation whenever a RI is used was reviewed and discussed with staff. Compliance Officer to conduct monthly reviews of incident reports to ensure that documentation has been completed whenever a RI is used. Compliance Officer to ensure during monthly review that documentation is present in agency's incident reporting binder. **Implementation Date: 09/08/2021 Completion Date: Ongoing.**	Executive Director Clinical Provider Compliance Officer All Staff	Implementation Date: 09/07/2021 Projected Completion Date: Ongoing

Cross Reference: 10A NCAC 27E .0104 (e) (9) Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V522):	Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be notified of policy changes/ updates and trained during Staff meeting on September 07,2021. Executive Director meeting consisted of a review of agency's policy and procedure regarding Seclusion, Physical Restraint and Isolation Time-out and Protective Devices Used for Behavioral Control. Compliance Officer to conduct monthly review of member service records to ensure that verbal and written authorization has been obtained and is filed in member service record. Executive Director, along with CRC to ensure that authorization and physical and mental well being assessment has been filed and is present in agency's incident reporting binder and attached to corresponding incident report for member.	Executive Director Clinical Provider Compliance Officer All Staff	Implementation Date: 09/07/2021 Projected Completion Date: Ongoing

Cross Reference: 10A NCAC 27E .0104 (e) (12-16) Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V524):	Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be notified of policy changes/ updates and trained during Staff meeting on September 07,2021. Executive Director meeting consisted of a review of agency's policy and procedure regarding Seclusion, Physical Restraint and Isolation Time-out and Protective Devices Used for Behavioral Control. Notification process for informing legally responsible parties immediately when a RI has been utilized, was discussed and reviewed with all staff in great detail. Compliance Officer to perform a review of member service records on a monthly basis, as well as when an incident has occurred and reported, to ensure that the report and service record reflects documentation of the legally responsible person being notified immediately when a RI was utilized. Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be notified of policy changes/ updates and trained during Staff meeting on September 07,2021.	Executive Director Clinical Provider Compliance Officer All Staff	Implementation Date: 09/07/2021 Projected Completion Date: Ongoing

Cross Reference: 10A NCAC 27E .0104 (e) (12-16) Seclusion, Physical Restraint	Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the	Executive Director Clinical Provider	Implementation Date: 09/07/2021

and Isolation Time-Out and Protective Devices Used for Behavioral Control (V525):	police will be contacted immediately. All staff will be notified of policy changes/ updates and trained during Staff meeting on September 07,2021. Executive Director meeting consisted of a review of agency's policy and procedure regarding Seclusion, Physical Restraint and Isolation Time-out and Protective Devices Used for Behavioral Control. Documentation of debriefing and planning with the member, legally responsible person and staff following each RI, to eliminate or reduce probability of future use of RI, was reviewed and discussed in great detail with all staff. Compliance Officer to perform a monthly review of member service records and agency's incident reporting binder to ensure documentation of debriefing and planning, including immediate notification to legally responsible person, is present and filed. Compliance Officer to ensure that member service record reflects documentation in a log of all RI required elements including the frequency, duration, precipitating circumstances, alternative strategies, and authorization by QP for intervention lasting more than 15 minutes.	Compliance Officer All Staff	Projected Completion Date: Ongoing
Cross Reference: 10A NCAC 27E .0104 (e) (12-16) Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control (V526):	Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be notified of policy changes/ updates and trained during Staff meeting on September 07,2021. Executive Director meeting consisted of a review of agency's policy and procedure regarding Seclusion, Physical Restraint and Isolation Time-out and Protective Devices Used for Behavioral Control. Compliance Officer to review all incidents requiring the use of physical restraint, on a monthly basis. Documentation of review to be filed in agency's incident reporting binder and reviewed with agency's CRC at least quarterly and as needed. Agency's Quality Management Committee (QMC) to collect and analyze data on the use of physical restraint on at least a quarterly basis to monitor effectiveness, determine trends and take corrective action when necessary.	Executive Director Clinical Provider Compliance Officer Quality Management Committee CRC All Staff	Implementation Date: 09/07/2021 Projected Completion Date: Ongoing
V112: 27G .0205 (C-D) Assessment/Treatment/Habilitation	Compliance Officer met with QP staff and conducted a meeting regarding the development and implementation of	Clinical Provider Compliance Officer	Implementation Date: 09/07/2021

Plan:	treatment plan strategies. PCP training was held with QP staff and consisted of the reviewing of clinical assessments, evaluations, and reports and meeting with member and legally responsible person, and any other identified supports and collaborating providers and agencies, to develop and implement plan. QP staff to ensure that each member's plan has goals, strategies, interventions, outcomes, and supports that address each individual member's diagnosis and treatment needs. Compliance Officer to review member service records on a monthly basis to ensure that plans have been developed and is being reviewed and updated as needed according to guidelines and treatment	Qualified Professional	Projected Completion Date: Ongoing
V114: 27G .0207: Emergency Plans and Supplies:	Compliance Officer met with staff and reviewed agency's policies and procedures regarding written fire plan, fire and disaster drills. Each staff was provided with written fire plan, as well as was informed of written file being housed within agency and available for review as needed. Mock fire and disaster drills were held with both staff and members for every shift. Compliance Officer and Safety Committee will monitor and ensure fire and disaster drills are being held on a quarterly basis and repeated for each shift. Safety Committee will be responsible for ensuring that drill log is completed at the end of each drill for each shift. Agency's Safety Committee will review fire and disaster drill logs at least quarterly to ensure compliance with fire and disaster drill policy. Compliance Officer shall also ensure that members are educated on fire and disaster drills and actively engage and participate in all fire and disaster drills.	Compliance Officer Safety Committee	Implementation Date: 09/07/2021 Projected Completion Date: Ongoing
V118: 27G .0209 (c) Medication Requirements:	Compliance Officer met with staff and conducted a meeting in which the agency's policy and procedure for Medication Requirements were reviewed. Staff discussed and reviewed in great detail, process for completing MAR, including the importance of ensuring that MAR is completed and accurately reflects medication administration, MAR is current and adheres to the written order of a physician. Compliance Officer to review each member's service record on a monthly basis to ensure that MAR is present in member service record, MAR is completed and accurately reflects medication	Compliance Officer BSNRN	Implementation Date: 09/07/2021 Projected Completion Date: Ongoing

	administration, MAR is current and written order of a physician is being followed.		

V 123: 27G .0209 (H) Medication Requirements:	Compliance Officer met with staff and conducted a meeting in which the agency's policy and procedure for Medication Requirements were reviewed. Staff discussed and reviewed in great detail, process for completing MAR, including the importance of ensuring that MAR is completed and accurately reflects medication administration, MAR is current and adheres to the written order of a physician. Staff discussed and reviewed, agency's communication log developed, which shall reflect medication errors reported immediately to a physician or pharmacist. Agency's CRC to monitor and ensure that medication errors are documented as an incident, process for reporting incident is followed and medication errors were reported immediately to a physician or pharmacist.	Compliance BSNRN CRC	Implementation Date: 09/07/2021 Projected Completion Date: Ongoing
G.S. 131E-256 (D2) HCPR- Prior Employment Registry:	Compliance Officer met with HR staff person to review the agency's New Hire processes, including the required time frames for completing HCPR for new hires. Compliance Officer to conduct a review of all new hire staff records upon hire to ensure that HCPR has been conducted and documentation of findings are filed and maintained in staff's record.	Compliance Officer Human Resources	Implementation Date: 09/07/2021 Projected Completion Date: Ongoing
G.S. 122 C-80 Criminal History Record Check:	Compliance Officer met with HR staff person to review the agency's New Hire processes, including the required time frame of within five days of making the conditional offer of employment, for completing criminal history record check, state and national, for all new hires. Compliance Officer to conduct a review of all new hire staff records upon hire to ensure that criminal history record check has been performed within five days of making the conditional offer of employment, and documentation of findings are filed and maintained in staff's record.	Compliance Officer Human Resources	Implementation Date: 09/07/2021 Projected Completion Date: Ongoing
V 296: 10A NCAC 27G .1704: Residential Tx. Child/Adol- Minimum Staffing Requirements:	Compliance Officer held a staff meeting with all staff to address staffing issue within the home and community when children/adolescents are present. Compliance Officer will ensure that upon developing staff schedules, that each shift is properly staffed with two staff persons present on	Clinical Provider Compliance Officer	Implementation Date: 09/07/2021 Projected Completion Date: 09/23/2021: Ongoing

	each shift. Compliance Officer will perform unannounced checks on each shift and to ensure that conformance to staffing policy is adhered to.		
V367: 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers:	Compliance Officer held a meeting with staff to review and discuss the agency's policy and procedure for reporting incidents. Incident Reporting training was held with all staff and included how to document incidents on agency's internal incident reporting form, as well as entering Level II and Level III incidents into IRIS. Agency's CRC will monitor the compliance of reporting a Level II incident to the LME/MCO responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident. Compliance Officer will monitor all Level II incidents to ensure conformance to Level II incident reporting.	Clinical Provider Compliance Officer All Staff	Implementation Date: 09/07/2021 Projected Completion Date: 09/23/2021:Ongoing
V 518: 27E .0104 (e1-2) Client Rights- Sec Rest. & ITO 10A NCAC 27E .0104 Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control:	Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be notified of policy changes/ updates and trained during Staff meeting on September 07,2021. Executive Director meeting consisted of a review of agency's policy and procedure regarding Seclusion, Physical Restraint and Isolation Time-out and Protective Devices Used for Behavioral Control. Meeting included the implementation of emergency restrictions only. Review of each member's plan was conducted to ensure that staff gives consideration to the member's physical and psychological well being before, during and after a restrictive intervention (RI). During quarterly CRC, if a RI is used, committee to ensure that consideration to the member's physical and psychological well being before, during and after RI was given. Compliance Officer to conduct monthly reviews of incident reports to ensure that documentation in agency's Incident Reporting binder reflects consideration provided to member.	Executive Director Compliance Officer CRC All Staff	Implementation Date: 09/07/2021 Projected Completion Date: Ongoing
V521 27E .0104 (e9) Client Rights- Sec. Rest. & ITO 10A NCAC 27E .0104 Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control:	Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be notified of policy changes/ updates and trained during Staff meeting on September 07,2021. Executive Director	Executive Director Compliance Officer All Staff	Implementation Date: 09/07/2021 Projected Completion Date: Ongoing

	meeting consisted of a review of agency's policy and procedure regarding Seclusion, Physical Restraint and Isolation Time-out and Protective Devices Used for Behavioral Control. Agency's process for completing the required documentation whenever a RI is used was reviewed and discussed with staff. Compliance Officer to conduct monthly reviews of incident reports to ensure that documentation has been completed whenever a RI is used. Compliance Officer to ensure during monthly review that documentation is present in agency's incident reporting binder.		

V522 27E .0104 (e10) Client Rights- Sec. Rest. & ITO 10A NCAC 27E .0104 Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control:	Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be notified of policy changes/ updates and trained during Staff meeting on September 07,2021. Executive Director meeting consisted of a review of agency's policy and procedure regarding Seclusion, Physical Restraint and Isolation Time-out and Protective Devices Used for Behavioral Control. Compliance Officer along with agency's CRC to ensure that each member with a RI of more than 15 minutes had verbal and written authorization, as well as, a physical and mental well being assessment by QP staff that extended the RI for the member. Compliance Officer to conduct monthly review of member service records to ensure that verbal and written authorization has been obtained and is filed in member service record. Executive Director, along with CRC to ensure that authorization and physical and mental well being assessment has been filed and is present in agency's incident reporting binder and attached to corresponding incident report for member.	Executive Director Compliance Officer All Staff	Implementation Date: 09/07/2021 Projected Completion Date: Ongoing

V524 27E .0104 (e12-16) Client Rights- Sec. Rest. & ITO 10A NCAC 27E .0104 Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control:	Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be notified of policy changes/ updates and trained during Staff meeting on September 07,2021. Executive Director meeting consisted of a review of agency's policy and procedure regarding Seclusion, Physical Restraint and Isolation Time-out and Protective Devices Used for Behavioral Control. Notification process for informing	Executive Director Compliance Officer All Staff	Implementation Date: 09/07/2021 Projected Completion Date: Ongoing

	legally responsible parties immediately when a RI has been utilized, was discussed and reviewed with all staff in great detail. Compliance Officer to perform a review of member service records on a monthly basis, as well as when an incident has occurred and reported, to ensure that the report and service record reflects documentation of the legally responsible person being notified immediately when a RI was utilized.		

V525 27E .0104 (e17) Client Rights-Sec. Rest. & ITO 10A NCAC 27E .0104 Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control:	Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be notified of policy changes/ updates and trained during Staff meeting on September 07,2021. Executive Director meeting consisted of a review of agency's policy and procedure regarding Seclusion, Physical Restraint and Isolation Time-out and Protective Devices Used for Behavioral Control. Documentation of debriefing and planning with the member, legally responsible person and staff following each RI, to eliminate or reduce probability of future use of RI, was reviewed and discussed in great detail with all staff. Compliance Officer to perform a monthly review of member service records and agency's incident reporting binder to ensure documentation of debriefing and planning, including immediate notification to legally responsible person, is present and filed. Compliance Officer to ensure that member service record reflects documentation in a log of all RI required elements including the frequency, duration, precipitating circumstances, alternative strategies, and authorization by QP for intervention lasting more than 15 minutes.	Executive Director Compliance Officer All Staff	Implementation Date: 09/07/2021 Projected Completion Date: Ongoing

V526 27E .0104 (e18-19) Client Rights-Sec. Rest. & ITO 10A NCAC 27E .0104 Seclusion, Physical Restraint and Isolation Time-Out and Protective Devices Used for Behavioral Control:	Provider will only implement emergency restrictions. In the event that the restriction rises to a level of restraint the police will be contacted immediately. All staff will be notified of policy changes/ updates and trained during Staff meeting on September 07,2021. Executive Director meeting consisted of a review of agency's policy and procedure regarding Seclusion, Physical Restraint and Isolation Time-out and Protective Devices Used for Behavioral Control. Compliance Officer to review all incidents requiring the use of physical restraint, on a monthly basis. Documentation of review to be filed in	Executive Director Compliance Officer CRC QMC All Staff	Implementation Date: 09/07/2021 Projected Completion Date: Ongoing

	agency's incident reporting binder and reviewed with agency's CRC at least quarterly and as needed. Agency's Quality Management Committee (QMC) to collect and analyze data on the use of physical restraint on at least a quarterly basis to monitor effectiveness, determine trends and take corrective action when necessary.		
V 736 27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303(c) Location and Exterior Requirements:	Compliance Officer has made contact with several contractors to assist with ensuring that the agency is in compliance with identified areas of concerns regarding safety. Compliance Officer held meeting with staff to discuss how to maintain and ensure the cleanness, orderly and attractive manner of the agency. Safety Committee to perform monthly internal inspections to ensure that agency is in compliance with facility, grounds, location and exterior requirements.	Executive Director Compliance Officer Safety Committee Contractors	Implementation Date: 09/07/2021 Projected Completion Date: 09/23/2021: Ongoing