STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-956	A. BUILDING: _____ B. WING _____	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MANOR AT RIVERBROOKE	2917 FAIRWAY DRIVE RALEIGH, NC 27603

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 11/22/21. The complaint was substantiated Intake #NC00181362. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness The survey sample consisted of audits of 1 current client & 1 former client The Home Manager identified in this report is the Administrator/Licensee's daughter	V 000		
V 107	27G .0202 (A-E) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (a) All facilities shall have a written job description for the director and each staff position which: (1) specifies the minimum level of education, competency, work experience and other qualifications for the position; (2) specifies the duties and responsibilities of the position; (3) is signed by the staff member and the supervisor; and (4) is retained in the staff member's file. (b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility: (1) is at least 18 years of age; (2) is able to read, write, understand and follow directions; (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and	V 107		

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	MHL092-956	A. BUILDING: _____ B. WING _____	11/22/2021

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V 107	Continued From page 1 (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry. (c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying. (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided. (e) A file shall be maintained for each individual employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification. This Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain a file that included training, experience and other qualifications for the position for 1 of 1 Former Staff #3 (FS#3). The findings are: During interview on 11/17/21 the Home Manager (HM) reported: - FS#3 worked at the facility in June 2021 - did not know FS#3's last name - worked a half a day at the facility - did not recall the exact date in June 2021	V 107		

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	MHL092-956	A. BUILDING: _____ B. WING _____	11/22/2021

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V 107	Continued From page 2 - was terminated due to the tone of voice she had with former client #3 - shredded her personnel record after FS#3 was terminated During interview on 11/19/21 the Administrator/Licensee reported: - was aware the HM shredded FS#3's personnel record - in the future personnel records will not be shredded	V 107		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their	V 108		

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V 108	Continued From page 3 equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain a file that included organizational orientation, trainings such as: first aid/cardiopulmonary resuscitation, training to meet mh/dd/sa needs of the clients & training in infectious diseases for 1 of 1 Former Staff #3 (FS#3). The findings are: During interview on 11/17/21 the Home Manager (HM) reported: - FS#3 worked at the facility in June 2021 - did not know FS#3's last name - worked a half a day at the facility - did not recall the exact date in June 2021 - was terminated due to the tone of voice she had with former client #3 - shredded her personnel record after FS#3 was terminated During interview on 11/19/21 the Administrator/Licensee reported: - was aware the HM shredded FS#3's personnel record - in the future personnel records will not be shredded	V 108		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MANOR AT RIVERBROOKE	2917 FAIRWAY DRIVE RALEIGH, NC 27603

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V 109	Continued From page 4	V 109		
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 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.	V 109		

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	MHL092-956	A. BUILDING: _____ B. WING _____	11/22/2021

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V 109	Continued From page 5	V 109		

This Rule is not met as evidenced by:
Based on record review and interview 1 of 1 Qualified Professional (QP) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are:

A. Cross Reference: 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (V112). Based on record review and interview, the facility failed to develop and implement goals & strategies to address the behaviors for 1 of 2 former clients (FC#3). The facility also failed to develop treatment plans in partnership with the legally responsible person for 1 of 3 current clients (#2) & 1 of 2 former clients (FC#3).

B. Cross Reference: 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (V367). Based on record review and interview the facility failed to ensure Level II incident reports were completed and submitted to the Local Management Entity/Managed Care Organization (LME/MCO).

C. Cross Reference: 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (V536). Based on record review and interview the facility failed to ensure 1 of 1 Qualified Professional (QP) was trained in the same alternatives restrictive intervention program utilized by the facility.

Review on 11/18/21 of the QP's personnel record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-956	A. BUILDING: _____ B. WING _____	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 109	Continued From page 6 revealed: - hire date: 2/26/18 - Master's degree dated 2016 - job description dated 2/26/18: "reports to the Administrator" (Administrator/Licensee) "supervise rehabilitation technicians I and II as appropriate to consumers' needs" "complete incident reporting via IRIS (Incident Reporting and Improvement System)" "review MARs (medication administration records) to accuracy on a monthly basis" "attend treatment team meetings for clients" "ensure all treatment plans reflect consumer's current state, interventions and goals" "audit client charts and files" "review consumer's progress at least monthly" "meet with client on a monthly basis to determine specific needs and ensure appropriate services are in place" "ensure staff are trained and privileged to provide designated consumer services" "provide opportunities for training to staff as needed" "completes progress notes as least monthly" During interview on 11/16/21 & 11/19/21 the QP reported: - had been the facility's QP for the last 3 years - visited the facility once a month - documented progress monthly but the facility received her progress notes twice a year (January & December) - there was not a lot of changes in the clients' behaviors - FC#3 was discharged from the facility but she was not aware of her current placement - she had 400 - 500 clients and could not recall	V 109		

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	MHL092-956	A. BUILDING: _____ B. WING _____	11/22/2021

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V 109	Continued From page 7	V 109		

where all the clients were located
- the Home Manager completed staff supervisions
- "was not concerned with staff but the welfare of the clients"
- reviewed MARs once a year, the HM reviewed monthly
- audited charts once a year at the beginning of the year
- all clients' treatment plans were completed at the beginning of the year
- will let the Administrator/Licensee know he could find another QP
- "they needed a QP with more availability"

During interview on 11/19/21 the Administrator/Licensee reported:
- ensured the QP job duties were completed
- planned to update the QP's job description
- he was responsible for investigating any incidents at the facility
- he gives the information to the QP to complete the IRIS report

Review on 11/22/21 of the following Plan of Protections dated 11/22/21 submitted by the Home Manager revealed:

1. "What immediate action will the facility take to ensure the safety of the consumers in your care?
Accurate Incident reporting if any occurs.
Update PCP's (person center plans) as required.
Training for all staff.

Describe your plans to make sure the above happens.
We would ensure that all incidents that occur going forward will be documents and reported to the Iris system if they are level 2 or level 3 incidences. We would immediate start reviewing

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V 109	Continued From page 8 the clients PCP, ensure that we reach out to all guardian and schedule a treatment meeting with the QP and clients to update their PCP's. We would ensure that all staff practice the same restrictive intervention training." 2. "What immediate action will the facility take to ensure the safety of the consumers in your care? The Group home will immediately employ the services of another Qualified Professional to work with us to ensure all goals are met. We would immediate start reviewing the clients PCP, ensure that we reach out to all guardian and schedule a treatment meeting with the QP and clients to update their PCP's. We would ensure that all incidents that occur going forward will be documents and reported to the Iris system if they are level 2 or level 3 incidences. Group Home will ensure that all trainings including Alternatives to Restrictive Interventions are consistent across the board, documented and filed in staff charts Describe your plans to make sure the above happens. Employ another QP Accurate Incident reporting if any occurs. Update PCP's as required. Training for all staff. " This facility served clients with Schizoaffective Disorder, Hyperlipidemia & Type 2 Diabetes. FC#3 had elopement behaviors. She eloped from the facility approximately 8 times between August 2021 & October 2021. In October 2021, a missing persons report was filed due to FC#3's whereabouts being unknown. She took a cab to a town 103 miles from the facility. She was located at a restaurant by a police officer and had to be transported back to the facility. The QP said she didn't think to update FC#3's treatment plan to	V 109		

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V 109	Continued From page 9 address the elopement behaviors. She was aware of only 2 times FC#3 eloped from the facility. She didn't participate in any treatment team meetings because she worked a full time job at another place of employment. She completed all clients' treatment plans at the beginning of the year. She didn't include the guardians in the development of the treatment plans but had the Home Manager obtain their signatures. FC#3's guardian was not familiar with the QP & thought the Home Manager was the QP. She said in the future, instead of completing the treatment plans herself, she would use the Assertive Community Treatment Team or the day programs treatment plans. She didn't complete level II incident reports for FC#3's elopement behaviors even though it was her responsibility. The QP's job description had several job duties she failed to complete. Progress notes were to be completed monthly however she completed them twice a year. The medication administration records were to be reviewed monthly and she reviewed them once a year. She was responsible for ensuring staff trainings were completed, however the facility's staff were trained in Evidence Based Protective Interventions & she was trained in North Carolina Intervention. She was responsible for staff supervisions but said the Home Manager completed the supervisions. Due to the systemic failures of the QP, this deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000 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		

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V 112	Continued From page 10	V 112		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement goals & strategies to address the behaviors for 1 of 2 former clients (FC#3). The facility also failed to	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-956	A. BUILDING: _____ B. WING _____	11/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 112	Continued From page 11	V 112		

develop treatment plans in partnership with the legally responsible person for 1 of 3 current clients (#2) & 1 of 2 former clients (FC#3). The findings are:

A. Review on 11/15/21 of FC#3's record revealed:
- admitted 11/20/17 & discharged 10/8/21
- diagnoses of Schizoaffective Disorder; Constipation; Hypothyroidism, Urinary Incontinence & Vitamin D Deficiency
- treatment plan dated 1/2/21 with no goals or strategies to address the elopement behaviors for FC#3
- no signatures on the treatment plan's signature page

B. Review on 11/19/21 of client #2's record revealed:
- admitted 4/3/18
- diagnoses of Schizoaffective Disorder, Type 2 diabetes & Hyperlipidemia
- treatment plan dated 1/2/21
- no signatures on the treatment plan's signature page

Review on 11/18/21 of the facility's internal incident reports for FC#3 revealed:
- documentation on a piece of paper of times & a brief synopsis she eloped from the facility
- no staff signatures were noted on the paper
- between 8/14/21 - 10/7/21 FC#3 eloped 8 times

Review on 11/18/21 of the police call for service reports regarding FC#3 revealed:
- refer to tag V367 in regards to FC#3's elopements from the facility
- between 9/15/21 - 10/7/21 there were 4 police calls in regards to FC#3's elopement behaviors

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V 112	Continued From page 12 - "10/7/21 - I responded to the incident address for a report of a missing person. This is the fourth time [FC#3] has walked away from the facility...made statements that when she leaves she will go to [town 103 miles from facility] to be with her family...entered as missing at 1337 (1:37pm)...as I was working on the Silver Alert paperwork, I received a call from [PD (police department) another town] officer...stated that [FC#3] had been located in [town 103 miles from facility] at [restaurant in town 103 miles from facility]]. Apparently she had taken a taxi from Raleigh to [town 103 miles from facility] be with her family..." During interview on 11/15/21 & 11/19/21 the Home Manager reported: - FC#3 would elope to locate her family in a town 103 miles from facility - the pandemic made her more agitated because the family couldn't see her - they did not start to contact her until this year - attended several treatment team meetings to address the elopements - she didn't document the dates or discussion of the treatment team meetings - recalled a treatment meeting held 8/31/21 to discuss placement in a town 103 miles from facility for FC#3 - FC#3's guardian, ACTT (Assertive Community Treatment Team), Administrator/Licensee and she attended the meeting - the ACTT worker had the updated treatment plan - the team had discussed several strategies - chimes were already on the facility's door prior to FC#3's admission - if she attempted to elope, redirect her and and ask if she wanted to contact her family which	V 112		

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V 112	Continued From page 13 sometimes worked - if she made the comment she planned to leave and go to a town 103 miles from facility , redirect her and request she speak with the guardian to complete the discharge paper work - the ACTT visited during the week to engage her in activities - FC#3 refused to go to a day program - client #2's guardian was an attorney and was difficult to contact - she did not know the guardians had to sign the treatment plans During interview on 11/16/21 & 11/18/21 FC#3's guardian reported: - FC#3 had been at the facility over 3 years - FC#3 wanted to be close to her family in a town 103 miles from the facility - family started to call her more this year after the Administrator/Licensee reached out to the family - elopement at the facility began this year - FC#3 eloped from the facility maybe 5 - 10 times this year - staff followed protocol that was discussed - call law enforcement, call the crisis center and call her (guardian) if FC#3 eloped from the facility - there had been several treatment team meetings this year about FC#'s elopements - she does not recall the dates of the treatment team meetings - the Home Manager (HM) and the Administrator attended all the meetings - the HM was the Qualified Professional (QP) - she (guardian) assumed the HM was the QP because that was whom she always spoke with - staff were to redirect FC#3 if she attempted to elope from the facility - the facility had chimes on the doors	V 112		

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	MHL092-956	A. BUILDING: _____ B. WING _____	11/22/2021

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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 112	Continued From page 14 - one staff worked at the facility with 5 clients, therefore, it would be impossible to monitor FC#3 at all times - there was no funding for extra staff During interview on 11/17/21 the ACTT worker reported: - had worked with her for the last 4 - 5 years - he worked with FC#3 on employment - visited once a week & alternated with other ACTT workers - FC#3 had eloped from the facility several times - treatment team meetings were held - discussed ways to decrease the elopement behaviors - staff were to redirect her if she attempted to elope - allow her to voice her opinions and what she needed from the facility - facility's staff did the best they could to keep FC#3 at the facility - eloped from the facility at least 5 - 6 times since June 2021 - could not recall if FC#3's elopement behaviors were addressed in the treatment plan - he was not responsible for the facility's goals in the treatment plans - the facility's staff were invited to their team meetings because they were part of FC#3's natural supports - treatment team meetings were held on two different occasions prior to discharge - the ultimate goal for the meetings were to find placement in a town closer to FC#3's family During interview on 11/16/21 & 11/19/21 the QP reported: - FC#3 had eloped from the facility a couple of times	V 112		

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	MHL092-956	A. BUILDING: _____ B. WING _____	11/22/2021

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V 112	Continued From page 15 - did not have the FC#3's chart in front of her & could not recall how often - recalled at least 2 elopements - she did not think to update FC#3's treatment plan to address the elopements - responsible for the completion of treatment plans and revision of the treatment plans - requested staff to engage with FC#3 & encourage her to remain at the facility - staff were to call 911, guardians & administrator if FC#3 eloped from the facility - chimes were on the facility doors to notify staff when a client left out of the facility - staff should be aware of clients whereabouts at all times - the ACTT also completed treatment plans for FC#3 - will plan in the future to use the ACTT or day program treatment plans - she did not contact guardians to participate in the development of the treatment plans - she completed all treatment plans at the beginning of the year - the Home Manager was to obtain the guardian signatures - if the guardians had any concerns, they could reach out to her (QP) - have not attended any treatment team meetings for the clients - worked a full time job at another place of employment - had limited time to be at the facility - will run by on the weekends & some weekdays to visit the clients - was not available to sit down at clients' treatment team meetings - the facility had other staff that was available to participate in the treatment team meetings During interview on 11/15/21 & 11/19/21 the	V 112		

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V 112	Continued From page 16 Administrator/Licensee reported: - FC#3 eloped from the facility often - had several treatment team meetings with the guardian and the ACTT - the treatment team meetings were documented by the ACTT worker - requested the ACTT worker be contacted for the updated treatment plan - could not recall dates & discussion of meetings - staff were to contact the police, guardian and him if FC#3 eloped - the QP did not attend any treatment team meetings - no reason why the QP was not present - the QP came to the facility once a month sometimes more if needed - in the future the QP will be part of the treatment team meetings This deficiency is crossed 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 112		
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.	V 131		

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V 131	Continued From page 17 This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 of 2 staff (#1) Health Care Personnel Registry (HCPR) was completed prior to hire. The findings are: Review on 11/18/21 of staff #1's personnel record revealed: - Hire date 3/27/20 - HCPR was completed 11/15/21 During interview on 11/18/21 the Home Manager reported: - was responsible for ensuring HCPR checks were completed - was cited in June 2021 because staff #1 did not have a HCPR - forgot to complete the HCPR after the June 2021 survey This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 131		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident;	V 366		

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V 366	Continued From page 18	V 366		

(2) determining the cause of the incident;
(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;
(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;
(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;
(6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and
(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.
(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.
(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:
(1) immediately securing the client record by:
(A) obtaining the client record;
(B) making a photocopy;
(C) certifying the copy's completeness; and
(D) transferring the copy to an internal review team;
(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals

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V 366	Continued From page 19 who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's	V 366		

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V 366	Continued From page 20 treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interview the facility failed to implement their incident reporting policy. The findings are: Review on 11/18/21 of the facility's incident reporting policy revealed: - "...the purpose of incident reporting is to ensure that serious adverse events involving persons living in Manor at Riverbrook are addressed quickly and analyze trends to prevent future occurrences and improve the service...direct care staff is to call the Administrator or Qualified Professional (QP) immediately. The QP or Administrator will then report the incident using (Incident Reporting and Improvement System) IRIS if classified as a Level II..." Review on 11/18/21 of the facility's incident reports for Former Client (FC#3) revealed: - documentation on a piece of paper - no staff signatures - between 8/14/21 - 10/7/21 FC#3 eloped from the facility Review on 11/18/21 of the police call for service	V 366		

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V 366	Continued From page 21 reports for FC#3 revealed: - between 9/15/21 - 10/7/21 the police was called to the facility for the elopement of FC#3 During interview on 11/19/21 the Administrator/Licensee reported: - he was responsible for investigating any incidents at the facility. - staff were to write down what happened - what time the incident happened - why it happened, any behavior change - he would give the information to the QP to complete the IRIS report - it was "a lapse" on his part for not completing the investigation	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information;	V 367		

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V 367	Continued From page 22 (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the	V 367		

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V 367	Continued From page 23 catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure Level II incident reports were completed and submitted to the Local Management Entity/Managed Care Organization (LME/MCO). The findings are: Review on 11/18/21 of the facility's internal incident reports for Former Client (FC#3) revealed: - documentation on a piece of paper - no staff signatures - "[FC#3] has been walk out of group home	V 367		

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V 367	Continued From page 24	V 367		

since about 2 weeks ago."

"8/14/21 - she went out of the home. I called [Licensee/Administrator] to talk to her [FC#3]."

"8/16/21 - she woke up and went out by 5am"

"8/25/21- has ben tresting (threatening) since morning that she is going to her family house. Around 2:30pm she walked away and I asked her to let me to called her son. she said no."

"9/13/21- ...went to a neighbor's house"

"9/15/21 - left group home with a trash bag on her hand."

"9/23/21 - [FC#3] came to me that she is going home on 9/24/21 morning...left home on 9/24/21 at about 8:40am...today 9/27/21 [FC#3] walk out from group home by 10:04am

- "9/30/21 - ...bring all her belonging downstairs. She treating (threatening) to go out. She went out of the group home around 1pm and come back 1:50pm of the same day
- [FC#3] walk out of the home by 8:15am this morning 10/7/21. She said she was hearing voice somewhere."

Review on 11/18/21 of the police call for service reports regarding FC#3 revealed:

- "9/15/21 - 10:18am - female reported missing was alleged to have left the facility between 8:30am and 10am"
- "9/24/21 - 9:09am - incident started at 8:40am and ended at 9:30am ...the manager of the home called and stated and elderly female [FC#3] walked away from the group home again.
- "9/28/21 reported at 11:06am - incident started 10:45am & ended 12pm - the manager of the home called and stated an elderly female who suffers from mental illness walked away from the home again."
- "10/7/21 reported 10:32am: incident started 8:30am - 10:30am - manager called and stated an elderly female ...walked away from the home

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V 367	Continued From page 25 again." During interview on 11/16/21 & 11/22/21 the Qualified Professional reported: - aware of elopements from the facility - did not complete incident reports - it was her responsibility to complete incident reports and submit through the Incident Reporting and Improvement System This deficiency is crossed 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 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered.	V 536		

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V 536	Continued From page 26 (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe).	V 536		

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V 536	Continued From page 27 (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule. (5) Acceptable instructor training programs shall include but are not limited to presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) methods for evaluating trainee performance; and (D) documentation procedures. (6) Trainers shall have coached experience teaching a training program aimed at preventing,	V 536		

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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 536	Continued From page 28 reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach. (7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually. (8) Trainers shall complete a refresher instructor training at least every two years. (j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 of 1 Qualified Professional (QP)	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-956	A. BUILDING: _____ B. WING _____	11/22/2021

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V 536	Continued From page 29 was trained in the same alternatives restrictive intervention program utilized by the facility. The findings are: Review on 11/18/21 & 11/22/21 of the QP's personnel record revealed: - Hired 2/26/18 - restrictive intervention: NCI+ (North Carolina Intervention) training dates: 11/30/20 - 11/29/21 During interview on 11/19/21 the QP reported: - she did not ensure staff were trained - the facility contracted out for trainings - when she was initially hired as the QP, she ensured staff were trained - now the facility contracted out for staff trainings - the Home Manager (HM) ensured staff had current trainings in personnel records During interview on 11/19/21 the HM reported: - she ensured staff trainings were completed During interview on 11/22/21 the Administrator/Licensee reported: - the facility practiced EBPI (Evidence Based Protective Interventions) - he would ensure all staff received the EBPI restrictive to alternative training This deficiency is crossed 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 536		