Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL001-159 | A. BUILDING: ______<br>B. WING ______ | R-C<br>11/30/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| V 000 | INITIAL COMMENTS<br><br>A complaint and follow up survey was completed on 11/30/21. The complaints were substantiated (intake #NC00175826, NC00175831, NC00175951 and NC00175980). Deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents.<br><br>The survey sample consisted of audits of 2 current clients, 1 former client, 1 deceased client. | V 000 | | |
| V 114 | 27G .0207 Emergency Plans and Supplies<br><br>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES<br>(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.<br>(b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.<br>(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.<br>(d) Each facility shall have basic first aid supplies accessible for use.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interviews, the facility failed to conduct disaster drills under conditions that simulate emergencies. The findings are: | V 114 | | |

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| V 114 | Continued From page 1<br><br>Review of the facility's disaster drill log on 4/7/21 revealed:<br>-3/6/21-1st shift<br>-2/6/21-1st shift<br>-1/1/21-no shift indicated<br>-There were no disaster drills conducted for 2nd and 3rd shift for the 1st quarter of 2021.<br>-There were no disaster drills conducted for 4th quarter of 2020.<br><br>Interview with client #1 on 4/1/21 revealed:<br>-He lived at the group home for about a month.<br>-He was not sure if staff did any fire or disaster drills with them.<br><br>Interview with client #2 on 4/1/21 revealed:<br>-He lived at the home for about three weeks.<br>-Staff had not done a fire and/or disaster drill with them.<br><br>Interview on 4/7/21 with the Program Director revealed:<br>-The group home had three separate staff shifts.<br>-She stopped taking referrals for a while. She did not have clients from March 2020 until November 2020. She got a client November 27, 2020.<br>-Staff #5 was a compliance officer within the agency and did the majority of the drills.<br>-She was a little surprised staff #5 did not complete disaster drills for all shifts.<br>-She confirmed staff failed to conduct disaster drills under conditions that simulate emergencies.<br><br>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. | V 114 | | |
| V 115 | 27G .0208 Client Services | V 115 | | |

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| V 115 | Continued From page 2<br>10A NCAC 27G .0208 CLIENT SERVICES<br>(a) Facilities that provide activities for clients shall assure that:<br>(1) space and supervision is provided to ensure the safety and welfare of the clients;<br>(2) activities are suitable for the ages, interests, and treatment/habilitation needs of the clients served; and<br>(3) clients participate in planning or determining activities.<br>(h) Facilities or programs designated or described in these Rules as "24-hour" shall make services available 24 hours a day, every day in the year. unless otherwise specified in the rule.<br>(c) Facilities that serve or prepare meals for clients shall ensure that the meals are nutritious.<br>(d) When clients who have a physical handicap are transported, the vehicle shall be equipped with secure adaptive equipment.<br>(e) When two or more preschool children who require special assistance with boarding or riding in a vehicle are transported in the same vehicle, there shall be one adult, other than the driver, to assist in supervision of the children.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews the facility failed to provide supervision to ensure the safety and welfare of one of one deceased client (DC #4) and one of one former client (FC #3).<br>The findings are:<br><br>a. Review on 4/7/21 of DC #4's record revealed: | V 115 | | |

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-Admission date of 3/17/21.
-Diagnoses of Intermittent Explosive Disorder, Depressive Disorder, Impulse Control Disorder, Conduct Disorder and Attention Deficit Hyperactivity Disorder.
-DC #4 died on 3/28/21.
-DC #4 was 15 years old.
-"Comprehensive Clinical Assessment" dated 3/11/21 had the following: "[DC #4] denied marijuana use, though his mother expressed concern that Facebook messages have been found between [DC #4] and peers related to marijuana." DC #4's biological parents had a history of substance abuse. DC #4 had a history of defiance, verbal and physical aggression, property destruction, depression and suicidal ideations.

Review of facility records on 3/30/21 revealed:
-An incident report dated 3/28/21 indicated DC #4 cause of death was unknown. There was no description of the incident included in this incident report.

Review of a police report on 4/7/21 revealed:
-The report was dated 4/2/21-The Program Director believed drugs were found in a vacant room at the group home. The Program Director advised when she touched the bag her mouth started tingling. An officer went to the home with a "K9" partner and searched the location. The dog came to a dresser in the vacant room and stared at it. There was a book bag containing white powder residue in one of the pockets of the bag.

Review of the Report of Autopsy Examination on 11/30/21 for DC #4 revealed:
-The report was completed by the medical examiner on 11/18/21.

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-The medical examiner determined DC #4's cause of death was cocaine and fentanyl toxicity.
-There was no natural disease or physical injury detected during the exam.

b. Review on 4/1/21 of FC #3's record revealed:
-Admission date 3/16/21.
-Diagnoses of Attention Deficit Hyperactivity Disorder, Disruptive Mood Dysregulation Disorder and Cannabis Abuse.
-FC #3 was discharged on 3/29/21.
-FC #3 was 14 years old.
-"Clinical Assessment" dated 3/16/21 had the following: The previous placement was concerned FC #3 would harm someone or be seriously harmed due to his lack of regard for others. He had a history of substance abuse, storytelling, possible gang involvement, homicidal ideations, elopement and assaultive behaviors.
-"Comprehensive Clinical Assessment" dated 1/22/21 had the following: "On 1/5/21 [FC #3's] grandmother reported to the therapist that [FC #3's] biological mother, from whose custody he was removed due to substantiated reports of neglect and substance use, had aided [FC #3] in eloping from the home. It was reported that biological mother had assisted [FC #3] in gaining access to substances including marijuana. [FC #3] reported during this period of elopement on or around 1/5/21 he had access to Methamphetamines and marijuana; [FC #3] declined to provide details around the frequency and severity of his substance use during this time."

Interview on 4/1/21 with client #2 revealed:
-DC #4 did talk to him about wanting to get high a few days before he passed away.
-On 3/27/21 "[DC #4 and FC #3] told him they had some "Molly"

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(Methylenedioxymethamphetamine). They tried to peer pressure him into doing drugs with them." He never saw the Molly they kept saying they had. He was not even sure what Molly looked like.
-He never saw DC #4 and/or FC #3 doing drugs in the group home. He suspected they were doing drugs because they kept talking about doing drugs in the home on other occasions.

Interview on 4/8/21 with FC #3 revealed:
-On 3/28/21 around 10:00 am he noticed something was wrong with DC #4.
-DC #4 was still laying in bed and his lips and arms looked blue. He checked DC #4's pulse and there was no pulse. When he touched DC #4 he felt cold.
-He told staff #1 he thought something was wrong with DC #4.
-Staff #1 made a phone call and police officers and Emergency Medical Services (EMS) staff came out to the group home.
-He was informed later the police officers found a vape pen that belonged to him. He was told "the vape pen may be laced with Molly." He brought the vape pen with him when he was admitted to the home. "He used the vape pen to smoke tobacco, not Molly." "I don't understand how that vape pen could contain Molly."
-He used drugs in the past, however he was clean for about 80 days.
-In the past he used Molly, heroin, cocaine, marijuana and other drugs.
-He never did any drugs at Alamance Academy. He never did drugs with DC #4 and never saw DC #4 doing any drugs.

Interview on 4/5/21 with staff #1 revealed:
-On 3/28/21 around 10:00 am FC #3 informed him that something did not look right with DC #4.

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-He let DC #4 and FC #3 sleep in later that morning. Third shift staff informed him the clients were up a little late the night before.
-He went into their bedroom and saw DC #4 lying in bed. He called DC #4's name, tapped his leg and noticed DC #4's body was stiff.
-DC #4 was unresponsive. DC #4's face, arms and legs looked blue.
-He saw a yellowish, bloody, foamy like substance coming from DC #4's mouth and nose.
-He called 911 and pulled DC #4 onto the floor and started doing Cardiopulmonary Resuscitation (CPR) with the dispatcher on the phone.
-EMS arrived, they took over and he left the bedroom.
-Staff #3 was running a little late and arrived to the home shortly after EMS arrived.
-He talked to FC #3 after he found DC #4 unresponsive. FC #3 said "he and [DC #4] were taking Molly by using a vape pen." FC #3 did not specify which day and time this occurred.
-FC #3 had a history of substance abuse. FC #3 would sometimes say he took substances in the past.

Interview on 4/9/21 with staff #2 revealed:
-On 3/27/21 she worked 3rd shift with staff #4. She arrived for her shift around 9:00 pm.
-The clients were in their rooms initially, they came out to greet staff and went back into their bedrooms.
-The clients were in their bedrooms playing music and playing video games.
-DC #4 came to her a little later and told her that client #1 was bothering him. He asked if it was ok if he slept in the room with FC #3 for the night. FC #3 did not have a roommate and there was an empty bed in his room. She told DC #4 he could sleep in the room with FC #3, but just for that one night.

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-She thought the clients actually went to bed around 11:00 pm on 3/27/21.
-Staff normally sit in the hallway once the clients go to bed for the night. They sit outside of the clients bedrooms so they can listen for anything unusual with the clients.
-"Staff normally don't go into the bedrooms once the clients go to bed for the night. Staff don't want to disturb the clients while they are sleeping." Staff are not required to do bed checks once the clients go into their bedrooms.
-DC #4 came out of his room at least two times after 12 am on 3/28/21 to use the bathroom. Staff #4 asked DC #4 if he was he ok each time and he replied he was ok. She didn't notice anything out of the ordinary with DC #4.
-She left the group home around 8:00 am on 3/28/21 and the clients were all in bed.

Interview on 4/5/21 with staff #4 revealed:
-He and staff #2 were working the night prior to DC #4 passing away. They worked 3rd shift and their shift started at 9:00 pm on 3/27/21.
-He thought all of the clients were in their bedrooms by 10:00 pm that night.
-When the clients are in their bedrooms they check on them occasionally. They are not actually required to do bed checks during 3rd shift.
-Staff normally just sit in the hallway in a chair outside of the bedrooms.
-DC #4 did get up a couple of times during 3rd shift. He asked DC #4 if he was ok and he replied he was ok. He thought DC #4 got up for the last time around 2:00 am.
-He left the home on 3/28/21 around 7:30 am and all the clients were still in bed sleeping.

Interview with FC #3's Social Worker on 4/5/21 revealed:
-FC #3 had a history of substance abuse. FC #3

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was always talking about taking different drugs and having gang affiliations.
-She was not sure if FC #3 was always being truthful about some of the things he was saying.
-She thought FC #3 was clean for about two months prior to his admission to Alamance Academy.
-When FC #3 lived at another group home he had an incident with another client. FC #3 eloped with a 12 year old client. They went to a store and got some over the counter medication. The 12 year old took the medication and overdosed, but did not die. It could not be determined if FC #3 coerced the 12 year old client into taking the over the counter medication.
-She thought that overdose incident with the 12 year old happened about a year ago.

Interview with the Clinical Quality Clinician for Managed Care Organization (MCO) on 3/30/21 revealed:
-She was looking into the death incident with DC #4.
-She was informed there is a search warrant for the group home. The police officers on the scene suspected DC #4 passed away from a drug overdose.
-She was informed the police officer found blood and vomit on his bedding.
-It was suspected that FC #3 supplied DC #4 with the drug Molly.
-FC #3 told the Qualified Professional he and DC #4 were using a vape pen that may have been laced with Molly the night before DC #4 passed away.
-She was informed by a Department of Social Services staff that FC #3 had a history of coercing others to do things.
-FC #3 had a similar incident at another placement. FC #3 persuaded a younger client to

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take drugs, that client overdosed but did not die.
-"She had her concerns about this facility because [DC #4] was not found deceased on 3/28/21 until 10:00 am by [FC #3]. She was trying to figure out why it took so long for anyone to realize [DC #4] had passed away."

Interview with a Local Police Officer on 3/30/21 revealed:
-He responded to the incident with DC #4.
-His main priority was to secure the crime scene once he arrived.
-When he arrived EMS staff were still on the scene and had DC #4 on the floor. EMS staff pronounced DC #4 had passed away within a minute of his arrival. He heard one of EMS workers say "rigor mortis had already started, so [DC #4] was possibly dead for several hours."

Interviews with the Local Detective on 4/5/21 and 4/12/21 revealed:
-She was investigating the death of DC #4. They did suspect DC #4 overdosed on drugs.
-She suspected DC #4 possibly used Molly, Fentanyl and other drugs. They must wait on the toxicology report to confirm which drugs were in DC #4's system.
-This was an open investigation and she was not allowed to give a lot of information related to that incident.
-FC #3 was interviewed about the incident with DC #4.
-FC #3 never admitted to them that he and/or DC #4 were doing drugs at the group home.

Interview with the Qualified Professional on 4/9/21 revealed:
-He talked with FC #3 after he was informed about the passing of DC #4.
-FC #3 said he and DC #4 smoked some tobacco

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on 3/27/21. FC #3 said "they used a vape pen and he thought the vape pen was laced with Molly. FC #3 said this was his personal vape pen.
-FC #3 also said he had a bag in the home that belonged to a friend. He said the bag possibly had Molly in it. The police officers took that bag and some other items out the home on the day of the incident.
-FC #3 kept changing his story. He felt like FC #3 was trying to cover up something.
-Client #2 said FC #3 offered him Molly the day before the incident.

Interviews with the Program Director on 4/5/21, 4/7/21, 4/12/21 and 11/30/21 revealed:
-Staff #1 called her on 3/28/21 and said DC #4 was unresponsive in his bedroom.
-She went to the group home and was informed DC #4 had passed away.
-Staff #2 and staff #4 worked during 3rd shift and left the home the morning of 3/28/21.
-Third shift staff said they didn't notice anything out of the ordinary with any of the clients during their shift.
-Staff are not required to check on the clients during 3rd shift once they go to bed.
-She had staff take the clients to the main office following the incident with DC #4.
-She talked with the clients about the incident with DC #4. Client #2 said someone came to group home and dropped drugs off to a bedroom window for DC #4, however he was not specific as to when that occurred. Client #2 also thought FC #3 had the drugs on him about two days prior to the incident with DC #4. Client #2 did not specify how or where FC #3 got the drugs.
-Client #1 really did not give her any information related to the incident with DC #4.
-FC #3 said he had a vape pen at the group home. FC #3 said "the vape pen could have been

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laced with Molly. "She thought FC #3 and DC #4 possibly used the vape pen prior to DC #4's death."
-She asked FC #3 why DC #4 died and not him after using the vape pen. FC #3 told her "because [DC #4] was not used to doing drugs like he was."
-She was aware FC #3 had a history of substance abuse, however he had been clean. She did not think FC #3 was still using drugs.
-She heard FC #3 possibly had the drugs on him when he was admitted. She was informed about that after the incident with DC #4.
-She decided FC #3 needed to be discharged after that incident with DC #4. She contacted FC #3's Social Worker to start the discharge process.
-When she told FC #3's Social Worker about the incident, she said it seemed to be a pattern with FC #3. She said at another facility FC #3 possibly bullied a 12 year old client into doing drugs and that client overdosed. The 12 year old did not die.
-"The week leading up to [DC #4's] death [client #2] told her [DC #4] said he wanted to get high." Client #2 said "he knew [DC #4] had access to drugs."
-DC #4 did not have a history of substance abuse. DC #4's mother said he would occasionally smoke marijuana, but he did not seem to have a substance abuse issue.
-It was suspected that DC #4 overdosed on drugs. When she saw DC #4 he had a lot of fluid coming from his mouth, it was a bloody substance.
-The police officer said it looked a little suspicious. The fact that FC #3 was in the same bedroom and did not hear or see anything with DC #4.
-DC #4 was not supposed to be in the room with FC #3 the night prior to that incident. Staff #2 allowed DC #4 to sleep in the room with FC #3. DC #4 told staff #2 he wanted to sleep in the

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room with FC #3 because client #1 was bothering him. Staff #2 told DC #4 he could sleep in the room with FC #3 just for that one night.
-"Now when she think about it, she feels like [DC #4] was trying to get in that room with [FC #3] so he could do drugs."
-She thought FC #3 admitted to the police he had Molly in the group home and gave some to DC #4 on 3/27/21.
-The police said "they possibly found residue from Molly in [FC #3's] book bag, however it had to be tested."
-She had a cleaning service come into the home after the incident. The cleaning crew found something in a bag that looked like drugs. She informed the police and they sent someone out in order to take a look at the substance. The police told her it was something you use to cut drugs.
-She was informed about a month ago that the white liquid substance she found in the empty bedroom was actually drugs. A police officer informed her the substance in the bag found in the empty room was Fentanyl.
-The officer also informed her DC #4's toxicology report indicated he had drugs in his system at the time of death.

Review on 11/30/21 of a Plan of Protection written by the Program Director dated 11/30/21 revealed:
What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm?: "Room checks hours and will ensure compliance through the video monitoring and checklist. Search policy document searches of new consumers. If consumer leave group home consumer will be searched when they return. After bedtime, door will be partially closed to ensure privacy and staff will check hourly. Group home staff will be trained on monitoring and PCP (Person Centered Plan)

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service definition of Level II and monitoring and grief/loss. Substance Abuse and triggers training will be done by Licensed Counselor in Substance Abuse. All consumer with a substance abuse diagnosis will have a SA (Substance Abuse) assessment."
Describe your plans to make sure the above happens. " Agency will ensure that staff monitor through video monitoring and room check checklist. Agency will review documented checklist of consumer personal items at admission and complete search of consumer's pockets, bookbags, suitcase, etc. Agency will maintain documentation of staff trainings. Agency QP (Qualified Professional) will complete Admission Assessment and ensure that appropriate assessments and clinical services are in place."

The facility served clients with diagnoses that included Substance Abuse, Attention Deficit Hyperactivity Disorder, Intermittent Explosive Disorder, Depressive Disorder, Impulse Control Disorder, Conduct Disorder and Disruptive Mood Dysregulation Disorder. The clients age ranged between 14 and 16 years of age. FC #3 and DC #4 lived at the group home for about two weeks. According to the Program Director client #2 informed her DC #4 said he wanted to get high about a week before he passed away. DC #4's mother told Program Director he would occasionally smoke marijuana. FC #3 had a history of substance abuse and group staff were all aware. Third shift staff were not required to do any additional monitoring of clients once they go into their bedrooms. DC #4 talked staff #2 into letting him sleep in the bedroom with FC #3. It was reported to staff #1 by FC #3 on 10/28/21 around 10:00 am that DC #4 was unresponsive. Staff #1 called EMS and attempted CPR on DC

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| V 115 | Continued From page 14<br>#4. EMS staff pronounced DC #4 was deceased and saw signs of rigor mortis. FC #3 informed the Qualified Professional he and DC #4 were smoking tobacco with a vape pen on 3/27/21. He informed the Qualified Professional the vape pen was possibly laced with "Molly." The autopsy revealed DC #4 passed away as a result of cocaine and fentanyl toxicity.<br>This deficiency constitutes a Type A1 rule violation for serious harm and neglect and must be corrected within 23 days. An administrative penalty of $10,000 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 115 | | |
| V 118 | 27G .0209 (C) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(c) Medication administration:<br>(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.<br>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.<br>(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.<br>(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: | V 118 | | |

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(A) client's name;
(B) name, strength, and quantity of the drug;
(C) instructions for administering the drug;
(D) date and time the drug is administered; and
(E) name or initials of person administering the drug.
(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to keep the MAR current and failed to ensure staff followed the physician's order affecting one of one deceased client (DC #4). The findings are:

The following is evidence the facility failed to keep the MAR current.

Review on 4/7/21 of DC #4's record revealed:
-Admission date of 3/17/21.
-Diagnoses of Intermittent Explosive Disorder, Depressive Disorder, Impulse Control Disorder, Conduct Disorder and Attention Deficit Hyperactivity Disorder.
-DC #4 died on 3/28/21.
-DC #4 was 15 years old.

Review of physician's orders on 4/9/21 for DC #4 revealed:
-Order dated 3/26/21 for Guanfacine 1 milligram (mg), one tablet in the morning and Risperidone

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0.5 mg, take ½ tablet at bedtime.

Review on 4/9/21 of a Medication Administration Record (MAR) for DC #4 revealed:
-March 2021-Guanfacine 1 mg was not listed. Staff documented the Risperidone 0.5 mg am dose was administered on 3/27. There was a blank box on 3/27 pm dose for the Risperidone 0.5 mg.

"Due to the failure to accurately document medication administration it could not be determined if
clients received their medications as ordered by the physician"

The following is evidence the facility failed to follow the physician's order.

Review of physician's orders on 4/9/21 for DC #4 revealed:
-Order dated 3/26/21 for Guanfacine 1 mg one tablet in the morning and Risperidone 0.5 mg, take ½ tablet at bedtime.

Review on 4/9/21 of a MAR for DC #4 revealed:
-March 2021-The morning dose of Guanfacine 1 mg and was not administered to DC #4 on 3/27. The bedtime dose of Risperidone 0.5 mg was not administered to DC #4 on 3/27.

Interview with staff #1 on 4/12/21 revealed:
-He did administer DC #4's medications on the morning and evening of 3/27/21.
-He found out on the evening of 3/27/21 that DC #4 had changes to his morning medication.
-DC #4 said his morning medication made him sleepy, the doctor changed it so he could take that medication at bedtime.
-He saw a sticky note that staff left in DC #4's

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record which indicated there was a medication change. He has already given the medication when he saw the sticky note left by staff.
-He confirmed staff failed to keep the MAR current for DC #4.
-He confirmed facility staff failed to follow the physician's order for DC #4.

Interview with staff #3 on 4/12/21 revealed:
-He took DC #4 to see his physician on 3/26/21.
-The physician made a change to the Risperidone medication for DC #4.
-DC #4 told the physician the medication was making him sleepy during the day. The physician changed the Risperidone medication to be given at bedtime only.
-He thought another medication was added, however he could not remember the name of that medication.
-The order was faxed over to pharmacy by the physician's office. When he went to the pharmacy the order was not filled, he did not get the Risperidone medication for DC #4.
-When he returned to the group home he did not change MAR because he had no medication.
-He left a sticky note for staff on some documents in the pocket of DC #4's record book.
-He was not sure if he verbally told staff about the change to DC #4's medications.
-He was in a rush because he had a family emergency.
-He confirmed staff failed to keep the MAR current for DC #4.
-He confirmed facility staff failed to follow the physician's order for DC #4.

Interview with the Program Director on 4/12/21 revealed:
-There were some medication errors with DC #4's March 2021 MAR.

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| V 118 | Continued From page 18<br>-Staff #3 took DC #4 to see his physician on 3/26/21. DC #4 had some changes to his medication.<br>-She was told DC #4 was no longer taking morning medications.<br>-The March MAR did not reflect the recent medication changes for DC #4. Staff did not add the Guanfacine medication to the March MAR.<br>-Staff #1 told her he gave DC #4 his morning medications on 3/27/21. Staff #1 said he was not aware of any medication changes.<br>-Staff #3 said he told staff #1 about the medication changes for DC #4 on the evening of 3/27/21.<br>-She was not sure why staff didn't document they gave DC #4 the Risperidone on 3/27/21.<br>-She confirmed staff failed to keep the MAR current for DC #4.<br>-She confirmed facility staff failed to follow the physician's order for DC #4. | V 118 | | |
| V 367 | 27G .0604 Incident Reporting Requirements<br><br>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS<br>(a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic | V 367 | | |

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| V 367 | Continued From page 19<br>means. The report shall include the following information:<br>(1) reporting provider contact and identification information;<br>(2) client identification information;<br>(3) type of incident;<br>(4) description of incident;<br>(5) status of the effort to determine the cause of the incident; and<br>(6) other individuals or authorities notified or responding.<br>(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:<br>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or<br>(2) the provider obtains information required on the incident form that was previously unavailable.<br>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:<br>(1) hospital records including confidential information;<br>(2) reports by other authorities; and<br>(3) the provider's response to the incident.<br>(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 | V 367 | | |

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or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:
(1) medication errors that do not meet the definition of a level II or level III incident;
(2) restrictive interventions that do not meet the definition of a level II or level III incident;
(3) searches of a client or his living area;
(4) seizures of client property or property in the possession of a client;
(5) the total number of level II and level III incidents that occurred; and
(6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.

This Rule is not met as evidenced by:
Based on record review and interview facility staff failed to include the required documentation for Level III incidents. The findings are:

Review of facility records on 3/30/21 revealed:
-There was an incident report dated 3/28/21 for deceased client (DC #4). Staff wrote DC #4's

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| V 367 | Continued From page 21<br>cause of death was unknown.<br>-The incident report had no description of the incident.<br>-The incident report had no status of the effort to determine the cause of the incident.<br><br>Interview with the Program Director on 11/30/21 revealed:<br>-She did not realize the incident report for DC #4 did not include all of the required information.<br>-The Qualified Professional and another staff were responsible for completing the incident report in the Incident Response Improvement System (IRIS) for DC #4.<br>-She knew staff #1 wrote up the incident after DC #4 died. She thought the Qualified Professional added that information into the IRIS system. | V 367 | | |
| V 736 | 27G .0303(c) Facility and Grounds Maintenance<br><br>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interviews, the facility failed to ensure facility grounds were maintained in a safe, clean, attractive and orderly manner.<br>The findings are:<br><br>Observation on 4/1/21 at approximately 10:15 am of the facility revealed: | V 736 | | |

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-Den area-The storm door had approximately 12 inches of black tape over it.
-The empty bedroom-The blinds were broken. The outer double pane window had shattered glass and inner portion of the window had approximately 7 pieces of tape on it.
-Kitchen area-Walls had food debris and grease stains. The handle to refrigerator was loose and had tape around it.
-Client #1's bedroom-There was a dime sized crack in the bedroom door. The bedroom door had peeling paint and the frame of the door was cracked. The closet door had a hole about the size of a grapefruit size.
-Client #2's bedroom-The blinds were broken. The walls were stained . The bedroom door broken would not close properly.
-Th hallway area-The walls were stained and had dark markings.
-Bathroom-There was a white putty like substance on the wall.

Interview with staff #5 on 4/1/21 revealed:
-He did a lot of the maintenance repairs for the home. He was aware of most of the maintenance issues with the home.
-He knew the window and doors had to be replaced throughout the home. The windows and doors were already ordered, they were just late arriving.
-He confirmed the facility failed to ensure facility grounds were maintained in a safe, clean, attractive and orderly manner.

Interview with staff #6 on 4/1/21 revealed:
-Management was aware of most of the maintenance issues with the home.
-The window in the empty bedroom just broke a few days ago, no one was residing in that room when the window broke.

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-The front door was taped because a basketball hit it about a week ago.
-He confirmed the facility failed to ensure facility grounds were maintained in a safe, clean, attractive and orderly manner.

Interview with the Program Director on 4/5/21 revealed:
-Staff #5 would normally take care of any maintenance issues with the group home.
-She visited the group home on a regular basis. She was aware the group home needed some repairs.
-She confirmed the facility failed to ensure facility grounds were maintained in a safe, clean, attractive and orderly manner.

This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.