Division of Health Service Regulation

PRINTED: 07/16/2021
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411172	A. BUILDING: _____ B. WING _____	07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUCCESSFUL VISIONS, LLC	1906 GREENSTONE PLACE HIGH POINT, NC 27265

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V 000	INITIAL COMMENTS An annual survey was completed on July 14, 2021. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children and Adolescents.	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 (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	V 107		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa Morrison TITLE: Executive Director (X6) DATE: 8/5/2021

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V 107	Continued From page 1 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 reviews and interviews, the facility failed to ensure 3 of 7 audited staff (#1, #2 and the Qualified Professional #2 (QP #2)) had a written and signed job description and verification to meet the minimum level of education. The findings are: Review on 7/13/21 of staff #1's record revealed: -A hire date of 7/6/21 -No written and signed job description -No documentation of verified education Review on 7/13/21 of staff #2's record revealed: -A hire date of 8/28/20 -No written and signed job description -No documentation of verified education Review on 7/13/21 of the Qualified Professional	V 107		

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V 107	Continued From page 2 #2 (QP #2) record revealed: -A hire date of 6/9/21 -No written and signed job description Interview on 7/13/21 with QP #1 revealed: -The Licensee was responsible for maintaining the staffs' records. -The Licensee was responsible for ensuring the staff met the minimum level of education for the position Interview on 7/14/21 with the Licensee revealed: -Was responsible for ensuring all staff had a written and signed job description. -Was responsible for ensuring the staff met the minimum level of education for the position	V 107	Trainings have been scheduled for staff for 8/11/2021, and the highest level of education has been placed in all files along with signed jobs descriptions.	8/11/2021
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	V 108		

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V 108	Continued From page 3 including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and 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 reviews and interviews, the facility failed to ensure 3 of 7 audited staff (#1, #2 and the Qualified Professional #2 (QP #2)) were trained on client right's, confidentiality, Blood Bourne Pathogens (BBP) and training to meet the MR/DD needs of the clients as specified in the treatment/habilitation plans. The findings are: Review on 7/13/21 of staff #1's record revealed: -A hire date of 8/27/20 -No documentation of training to meet the MR/DD needs of the clients Review on 7/13/21 of staff #2's record revealed: -A hire date of 8/28/20 -No documentation of training on client rights -No documentation of training on Confidentiality/HIPPA -No documentation of training to meet the MR/DD needs of the clients Review on 7/13/21 of the Qualified Professional	V 108		

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V 108	Continued From page 4 #2 (QP #2)'s record revealed: -A hire date of 6/9/2021 -No documentation of training on client rights -No documentation of training on Confidentiality/HIPPA -No documentation of training to meet the MR/DD needs of the clients Interview on 7/13/21 with the Licensee revealed: -She was responsible for ensuring all staff had the required trainings.	V 108	Staff has reincorporated supervisions the last supervisions were completed on July 14th, 2021 and the next supervision will be held on August 11, 2021.	8/11/2021
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) 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.	V 110		

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V 110	Continued From page 5 (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record reviews and interviews, 1 of 7 audited staff (the Licensee (L)) failed to demonstrate the knowledge, skills and abilities required by the population served and 4 of 7 audited staff failed to have individualized supervision plans. The findings are: Review on 7/13/21 of the L's record revealed: -A hire date of 7/1/2018 -No documentation of a supervision plan Review on 7/13/21 of staff #1's record revealed: -A hire date of 7/6/21 -No documentation of a supervision plan Review on 7/13/21 of staff #2's record revealed: -A hire date of 8/28/20 -No documentation of a supervision plan Review on 7/13/21 of the Qualified Professional #2 (QP #2)'s record revealed: -A hire date of 6/9/21 -No documentation of a supervision plan Interview on 7/12/21 with staff #1 revealed: -The Licensee was responsible for all the staff trainings and maintaining the staff's records. -Did not have an individualized supervision plan	V 110		

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V 110	Continued From page 6 with an Associate Professional (AP) or a Qualified Professional (QP). Interviews on 7/12/21 with the AP revealed: -The Licensee was responsible for all the staff trainings and maintaining the staff's records. -Did not have an individualized supervision plan with a QP. Interviews on 7/13/21 and 7/14/21 with staff #2 revealed: -The Licensee was responsible for all the staff trainings and maintaining the staff's records. -Had not had any supervision yet. Interviews on 7/13/21 and 7/14/21 with the L revealed: -Had no explanation as to why all of the facility staff had not been trained in client right's, confidentiality, Blood Bourne Pathogens (BBP) and training to meet the MR/DD needs of the clients as specified in the treatment/habilitation plans. - Had no explanation as to why all of the facility staff did not have written and signed job descriptions and verification to meet the minimum level of education. -Was responsible for ensuring all staff had their required trainings, job descriptions and supervision plans -Was aware of client #4's sexualized behaviors -Was not sure why client #4's sexualized behaviors had not been addressed but it had been mentioned to an outside therapist -Had only conducted one fire drills in the last 12 months -Had conducted no disaster drills in the last 12 months -"I know one fire drill has been done." - Had no explanation as to why the drills were not	V 110		

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V 110	Continued From page 7 conducted in the last 12 months -When asked about re-dispensing medications into containers that did not have the required information on them, the Licensee stated "I thought it would be easier for some staff. We are making calls today to switch pharmacies ..." -Was recently made aware the clients' MARs had blanks on them -"I know they are getting their medications. I am supposed to check the MARs monthly, but not for this month (July 2021). I guess staff is not documenting on the MARs after giving the clients their medications." -Had only completed one level II incident report in the last 12 months. -"I am aware the police came out for a discharged client." -When asked why QP #1 was not in the facility 70% of the time were clients were awake and present, the Licensee stated "he usually works on the Comprehensive Clinical Assessments (CCA) and the treatment plans off site. He also has anther job. I plan to have [QP #2] work in the facility, Monday through Friday" -When asked about the client/staff ratio, the Licensee stated she was aware the client/staff ratio was a minimum of 2 staff for every 4 clients. -"With COVID, it was hard to keep staff. We have had a lot of turn over." -Was aware some of the staff had not had trainings on preventative and restrictive interventions, the Licensee stated, "I have contacted the instructor, so the staff will be trained within the next two weeks." -When asked about physical plant issues outside and inside the facility, including the mouse traps and mouse droppings, the Licensee stated she was aware there were mice outside the facility. -"I was not aware there were mouse droppings in the kitchen drawers. This is an old house. I am	V 110		

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V 110	Continued From page 8 currently looking to move the facility to another location ..." -When asked about the portable space heaters, the Licensee stated "I was not aware space heaters were not allowed in the facility ..."	V 110	We are reviewing the requirements of the paraprofessionals with staff and training them on any questions they have within the job requirements and/or duties.	8/11/2021
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 9 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility staff failed to develop and implement strategies in 1 of 4 client (#4)'s treatment plans to address the needs of the clients. The findings are: Review on 7/13/21 of client #4's record revealed: -An admission date of 9/23/20 -Diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Disruptive Mood Dysregulation Disorder -Age 15 -An assessment dated 10/26/20 noting "was previously at a PRTF for past 5 months due to severe physical and mental aggression towards his mother and out of control behaviors. Mother signed over parental rights to [a local Department of Social Services (DSS) in May 2019, had problems with sleeping at night, disruptive behaviors since being at group home, had been bulling peers, was disrespectful to staff and was manipulative." -A treatment plan dated 5/13/21 noting "client will learn to express his frustration in a healthy way by reducing incidents of cursing, yelling and threatening. He will verbalize his feelings appropriately and use coping skills to manage his emotions per reports from self, family school staff, DSS and other team members. Client will follow instructions with no more than 2 verbal prompts by staying on assigned tasks following expectations/rules and completing daily chores/regimen per reports from self, family, school, staff, DSS and other team members. Client will be transported by one staff to and from appointments as needed. He will follow all recommendations from his therapist and other	V 112		

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V 112	Continued From page 10 professional providing services. Client will engage in appropriate boundaries and accept responsibility for his actions by refraining from exhibiting manipulative behaviors and embellishing accounts as measured by observations and documentation per reports; Client will develop healthy social skills by expressing negative feelings through positive communication skills using direct eye contact, positive language, improved social interactions with others (peers, adults, family members) and identification of supports per reports, client will learn to verbally identify triggers to his anger and replace his thoughts that produce unwanted behaviors, Will be encouraged to keep a journal to record his feelings and triggers, Will develop an awareness of his physical and cognitive response to triggers of his emotions, Will recognize and verbalize how unpleasant or negative emotions are connected to disruptive, antagonistic, or negative, attention seeking behaviors and Will participate in individual and group therapy sessions." -A Child and Family Team (CFT) meeting was held on 1/4/21 noting, " ... He engages in smacking other peers on the butt, often wants hugs from others and staff. Staff has had to put limitations in place to prevent something happening. There was an incident in where a male staff felt like he intentional grabbed their private parts when they were playing. Client reported that it was an accident. The team plans to address these concerns and possible need for additional services including possible forensic interviewing to see if there may be some things that have happened to him when he was younger that he has not fully expressed ..." -Another CFT was held on 3/11/21 where it was reported that there were several incidents of him having inappropriate sexual communications	V 112		

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V 112	Continued From page 11 towards others in the group home. They have responded in feeling uncomfortable and it has resulted in altercations in which staff had to intervene. Client has reported that he hears other masturbating in their rooms and beds shaking. He frequently makes comments ' that's why country people have been molested' in reference to another client that is from the country and has a history of sexual abuse when younger. Client has also asked other peers to 'suck in d**k', in front of staff. Staff is having to monitor and intervene in situations with him and others. The team is concerned regarding client's inability to control his urges/impulses in efforts to prevent from expressing inappropriate things and engaging in inappropriate touching others or invading others personal space. Team has discussed upcoming plans to have him participate in a possible forensic evaluation to assess these symptoms along with providing possible reconditions for treatment." -No documentation to address client #4's sexualized behaviors/comments/gestures Interview on 7/13/21 with the Licensee revealed: -Was aware of client #4's sexualized behaviors -Was not sure why client #4's sexualized behaviors/gestures/comments had not been addressed. -Would meet with both QP's to develop and implement strategies to address these behaviors in client #4's treatment plan. -Had met with the treatment team to discuss sexualized behaviors and comments from client #4 to his peers and to staff. -Stated client #4 refuses to participate in treatment. -Had brought these concerns to the attention of an outside therapist, recently -Felt client #4 needed a sex offender evaluation.	V 112		

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V 112	Continued From page 12 -Stated the Guardian Ad Litem (GAL) attorney did not want client #4 to participate in any therapy as it related to his sexualized behaviors/gestures/comments	V 112	We have collaborated to create new goals to target consumers specific needs and also created a safety plan to ensure other consumers in the group home are safe from sed consumer.	8/20/2021
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 beposted 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 reviews and interviews, the facility staff failed to ensure fire and disaster drills were conducted once per shift per quarter. The findings are: Review on 7/13/21 of the facility's fire and disaster drills from 7/2020 to 7/2021 revealed: -1/21/10 at 6:45pm on second shift with 2 clients present. "staff yelled fire and the clients went out the front door with staff at the end of the driveway/mailbox in a timely manner" -No other documentation was provided	V 114		

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V 114	Continued From page 13 Interview on 7/12/21 with client #1 revealed: -Had been at the facility for 2 weeks -Had not participated in any fire drills; -Had not participated in any disaster drills. Interview on 7/12/21 with client #2 revealed: -Had been at the facility for 5 months -Had not participated in any fire drills; -Had not participated in any disaster drills. Interview on 7/12/21 with client #3 revealed: -Had been at the facility for 6 months -Had not participated in any fire drills; -Had not participated in any disaster drills. Interview on 7/12/21 with client #4 revealed: -Had been at the facility for 10 months -Had not participated in any fire drills; -Had not participated in any disaster drills. Interview 7/12/22 with staff #1 revealed: -Worked first shift at the facility -Worked from 8am until 4pm. -When asked about drills, she stated "we have not done any recently. I will have to discuss them with [the Licensee (L)]. I think they are supposed to be done every 3 months ..." Interview on 7/12/21 with the Associate Professional (AP) revealed: -When asked if the facility staff were conducting fire and disaster drills, the AP stated "I have only been here five days. No ma'am. The staff have not conducted any drills." Interview on 7/13/21 with the Licensee revealed: -"I have one drill that I did do."	V 114	Staff has created and implemented a fire drill and disaster drill schedule once per shift per quarter.	8/30/2021

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V 117	Continued From page 14	V 117		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure prescription medications were dispensed with the prescriber's	V 117		

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V 117	Continued From page 15 name, the current dispensing date, the name, strength, quantity and expiration date of the prescribed medication, the name, address and phone number of the pharmacy and the name of the dispensing Practitioner for 4 of 4 clients (#1, #2, #3 and #4). The findings are: Observations on 7/12/21, from approximately 12:30pm to 2:10pm, the medication revealed: -4 clear, individual dispensing personal pill packets for 7 days -No documentation of the prescriber's name, address and phone number of the pharmacy -No documentation of the current dispensing date -No documentation of the name, strength, quantity and expiration date of the prescribed medication -No documentation of the name of the dispensing Practitioner Interviews on 7/12/21 with clients #1, #2, #3 and #4 revealed: -Sometimes their medications were administered in clear, individual dispensing personal pill packets by facility staff. Interview on 7/13/21 with the staff #1 revealed: -Had dispensed medications out of the personal pill packets for the clients. -She was instructed to do so from the Licensee. Interview on 7/13/21 with the staff #2 revealed: -Had dispensed medications out of the personal pill packets for the clients. -She was instructed to do so from the Licensee. Interview on 7/13/21 with the Licensee revealed: -Some of the facility staff found it difficult to administer the clients' medications from the prescription bottles	V 117		

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V 117	Continued From page 16 -"I thought it would be easier for staff to put the medications in the individual packets for the clients. I asked the staff to administer the medications that way." -Was aware of the needed requirements/information to have on prescription medications when they are administered -Would ensure facility staff had re-certified medication administration with a Registered Nurse.	V 117	Staff held a medication training for employees on July 14th 2021, to address medication management requirements. Staff also implemented new policies about Medical Records Administration and the consequences if not properly followed.	7/14/2021
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; (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.	V 118		

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V 118	Continued From page 17 (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 reviews and interviews, the facility staff failed to ensure medications were immediately recorded after administration for 4 of 4 current clients (#1, #2, #3 and #4). The findings are: Review on 7/13/21 of client #1's record revealed: -An admission date of 7/1/21 -Diagnoses of Diagnoses of Oppositional Defiant Disorder, Unspecified, Attention Deficit Hyperactivity Disorder (ADHD), Other Specified Trauma and Stressor Related Disorder, Other Specified Schizophrenia Spectrum Disorder. -A physician's order, dated 6/22/21, for the following medications: Latuda 20mg, 1poqhs dinner every night Guanfacine ER, 3mg, 1po q5pm and Amantadine 100mg 2 poqam and 1poqhs 1:00pm. Review on 7/13/21 of client #1's MAR for July 2021 revealed: -Blanks on the MAR for Guanfacine 3mg tablets on the following dates: 7/1, 72, 7/4, 7/5, 7/6 and 7/8 -Blanks on the MAR for Amantadine 100mg on the following dates: 7/1, 7/2, 7/4, 7/5, 7/6, 7/11 -Blanks on the MAR for Latuda 30mg on the	V 118		

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V 118	Continued From page 18 following dates:7/1, 7/4, 7/6, 7/8, 7/11 Review on 7/13/21 of client #2's record revealed: -An admission date of 2/12/21 -Diagnoses of Unspecified Schizophrenia Spectrum and other Psychotic Disorder, Conduct Disorder; Childhood-Onset Type, Disruptive Mood Dysregulation Disorder (DMDD), Post-Traumatic Stress Disorder (PTSD) and Obsessive-Compulsive Disorder (OCD), Unspecified. -Physician's order dated 2/10/21 for the following medications: Trazodone 150mg, 1poqhs -Physician's order dated 2/12/21 for the following medications: Vitamin D, 2,000 Units, 1poqd -Physician's order dated 3/17/21 for the following medications: Aripiprazole 5mg, 1poqhs, for DMDD and Lamotrigine 100mg, ½ pobid for DMDD. Review on 7/13/21 of client #2's MARs, from 7/1/21 to 7/12/21 revealed: -Blanks on the MAR for Trazodone 150mg from 7/2 to 7/6, 7/8 and 7/11 -Blanks on the MAR for Aripiprazole 5mg from 7/2 to 7/6, 7/8 and 7/11 -Blanks on the MAR for Lamotrigine 100mg from 7/2 to 7/6, 7/8, 7/10 and 7/11 Review of client #3's record revealed: -An admission date of 4/26/21 -Diagnoses of Conduct Disorder Childhood-Onset Type, Disruptive Mood Dysregulation Disorder, Schizoaffective Disorder, Bipolar Type, Transvestic Fetishism, ADHD, Combined Type. -A physician's orders dated 6/22/21 for the following medications: Guanfacine 2pmg, 1poq5pm, Vistaril 25mg, 1poq5pm, Jornay 40mg, 1poq5pm, Olanzapine 30mg, 1poqd, and Melatonin 3mg, 4poq5pm (12mg)	V 118		

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V 118	Continued From page 19 Review on 7/13/21 of client #3's MARs, from 5/1/21 to 7/12/21 revealed: -Blanks on the MARs for all medications on 5/1 to 5/3, 5/8 and 5/9 --Blanks on the MARs for all medications on 7/2 through 7/6 and on 7/8 and 7/11 Review of client #4's record revealed: -An admission date of 9/23/20 -Diagnoses of ODD, ADHD and DMDD -A physician's order dated 9/20/20 for the following medications: Clonidine 0.2mg, 1poqhs Review on 7/13/21 of client #4's MARs, from 6/1/21 to 7/12/21 revealed: -Blanks on the MARs for Clonidine 0.2mg 6/19, 6/20 and 6/26 -Blanks on the MARs for Clonidine 0.2mg on 7/3 to 7/6, 7/8 and 7/11 Interviews on 7/12/21 with clients #1, #2, #3 and #4 revealed: -Their medications were administered to them by staff. Interviews on 7/14/21 with staff #2 revealed: -Medications are kept in a locked cabinet -You were not to touch the medications, but you can put in them in a cup -Qualified Professional #2 (QP #2) was notified when there were blanks on the MARs. -When asked if he had seen blanks on the MARs recently, staff #2 stated "yes, but I do not want to get anyone in trouble ..." Interview on 7/12/21 with the Associate Professional (AP) revealed: -Had noticed blanks on the client's MARs. -"There were no initials, so I am not sure whether	V 118		

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V 118	Continued From page 20 or not medications were given." -She was sure the clients were getting their medications, "but I think I staff are just forgetting to document" -Seeing the individual pill packets was new to her. -"It is not the best form (to administer medications). It was an automatic red flag for me ..." Interview on 7/13/21 with Qualified Professional (QP #2) revealed: -"I am working on the MARs. I know you have seen them. I do not like the pharmacy (current). [The Licensee] was calling another pharmacy right now to get them switched (to a new pharmacy) ..." Interviews on 7/13/21 and 7/14/21 with the Licensee revealed: -Was responsible for reviewing the MARs monthly to ensure there were no issues. -"It's our policy for me to review the MARs, but I have not reviewed them this month." -It was recently brought to her attention there were blanks on the MARs. -Would ensure facility staff was retrained on Medication Administration	V 118	Staff held a medication training for employees on July 14th, 2021, to address medication management requirements. Staff also implemented new policies about Medical Records Administration and the consequences if not properly followed.	7/14/2021
V 294	27G .1702 Residential Tx. Child/Adol -Req. for Q P 10A NCAC 27G .1702 REQUIREMENTS OF QUALIFIED PROFESSIONALS (a) Each facility shall utilize at least one direct care staff who meets the requirements of a qualified professional as set forth in 10A NCAC 27G .0104(18). In addition, this qualified professional shall have two years of direct client care experience. (b) For each facility of five or less beds:	V 294		

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V 294	Continued From page 21 (1) the qualified professional specified in Paragraph (a) of this Rule shall perform clinical and administrative responsibilities a minimum of 10 hours each week; and (2) 70% of the time shall occur when children or adolescents are awake and present in the facility. (c) For each facility of six or more beds: (1) the qualified professional specified in Paragraph (a) of this Rule shall perform clinical and administrative responsibilities a minimum of 32 hours each week; and (2) 70% of the time shall occur when children or adolescents are awake and present in the facility. (d) The governing body responsible for each facility shall develop and implement written policies that specify the clinical and administrative responsibilities of its qualified professional(s). At a minimum these policies shall include: (1) supervision of its associate professional(s) as set forth in Rule .1703 of this Section; (2) oversight of emergencies; (3) provision of direct psychoeducational services to children or adolescents; (4) participation in treatment planning meetings; (5) coordination of each child or adolescent's treatment plan; and (6) provision of basic case management functions. This Rule is not met as evidenced by:	V 294		

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V 294	Continued From page 22 Based on record reviews and interviews, 1 of 2 Qualified Professionals (QP #1) failed to perform clinical and administrative responsibilities 70% of the time when children or adolescents were awake and present at the facility. The findings are: Review on 7/13/21 of the QP #1's record revealed: -A hire date of 8/28/20 -A job description of a QP Interviews on 7/12/21 with clients #1, #2, #3 and #4 revealed: -They did not know the QP #1's name when asked. -"Who is that? I haven't ever seen him here." Interview on 7/14/21 with QP #1 revealed: -Had previously been through the survey process. -"I know how the state comes in and tells you the things you need to do as well ..." -Stated he was rarely at the facility in person -"But I have been there for a couple of hours a week. I mainly do things over the phone. We have had a lot of turn over. I have not been at the facility since I recently got a new job. Now that [the Qualified Professional #2 (QP #2)] has been hired, she would be at the facility Monday through Friday." -When asked about documentation and meeting with the clients, he stated, "hmmm there have been notes but none recently. We share responsibility with [the other QP (#2)] ..." -Stated before QP #2 took the position, he would be at the facility a couple of hours per week. Interview on 7/13/21 with the Licensee revealed: -Was aware QP #1 was not coming to the facility when clients were present 70% of the time	V 294		

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V 294	Continued From page 23 -"It was due to COVID. I have hired [QP #2] to be at the facility Monday through Friday."	V 294	QP will be at the facility 32 hours while the children are awake.	8/30/2021
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 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	V 296		

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V 296	Continued From page 24 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 observations and interviews, the facility failed to ensure the two direct care staff were present for one, two, three or four children or adolescents. The findings are: Observations on 7/12/21, from approximately 9:50am to 10:14am, revealed: -The Associate Professional (AP) was alone at the facility with 4 clients -Staff #1 arrived on shift at 10:14am Further observations on 7/12/21, at approximately 1:26pm revealed: -Staff #1 went outside in the front yard of the facility to use her phone -The AP remained in the office area -At 1:39pm, the clients were in the back yard on the deck. -Staff #1 was in the back yard, on her phone, and was not supervising the clients -A loud noise was heard at which time the AP went outside -The AP took staff #1's cell phone and went into the facility with it.	V 296		

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V 296	Continued From page 25 Observations on 7/13/21, from approximately 2:44pm, revealed: -Clients were in the living room and hallway, playing around with no supervision -All 3 of the staff present remained in the office. -Client #2 and client #4 were in the hallway horse playing -Client #1 stood at the office door, talking with 3 staff. -Client #3 arrived at the facility and asked the Licensee if he could go outside. -All 4 clients went in the front yard/driveway -2 staff remained in the office working on files -The Licensee was being interviewed -All 4 clients remained unsupervised outside. On 7/13/21, one of the surveyors observed all four clients were not in sight given the position of where the 2 staff were sitting in the office. Interview on 7/12/21 with client #1 revealed: -Usually there were 2 staff at the facility on each shift. -Sometimes client #1 wakes up during the night -"When I wake up at night, there is usually only 1 staff. Last night (7/11/21) there was only 1 staff on third shift. It happens a lot ..." Interview on 7/12/21 with client #2 revealed: -"At night, there was only (staff) here (at the facility). It is usually [staff #7] or [staff #8] ..." Interview on 7/12/21 with client #3 revealed: -When asked about client/staff ratios at the facility, client #3 stated "there is usually either 1 or 2 staff on the shifts. But this morning, there was only one until [staff #1] got here ..." Interview on 7/12/21 with client #4 revealed:	V 296		

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V 296	Continued From page 26 -There were usually two staff working at the facility -Had gotten up one night "and there was only 1 staff here." Interview on 7/12/21 with staff #1 revealed: -Was on the schedule to work first shift, 8am to 4pm, on 7/12/21 -He son was having surgery on 7/12/21 Interview on 7/12/21 with the AP revealed: -She had only been working at the facility for 5 days -Her shift was Monday through Friday from 8am to 4pm -Staff #1 was scheduled to work first shift on 7/12/21 -"She called to say her son was having surgery and [staff #2] was on his way ..." Interview on 7/14/21 with the Qualified Professional #1 -The client/staff ratio was 2 staff to every 1, 2, 3, 4 clients. -Was not sure why there was only 1 staff present when the surveyors arrived at the facility. Interview on 7/14/21 with the Licensee revealed: -Was aware the client/staff ratio was a minimum of 2 staff for every 4 clients. -She was not aware staff #1 would be out on 7/12/21 -With COVID it was hard to keep staff. -"We have had a lot of turn over."	V 296	Staff has completed hiring to reflect 2 staff on each shift.	7/14/2021
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR	V 367	Staff will report each Level 1 incident in an incident log within the facility. Staff will complete each level 2 incident within IRIS, all incidents' reports whether 1 or 2 will be submitted quarterly (any time the police come out the incident report will be completed in iris).	8/23/2021

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V 367	Continued From page 27 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 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:	V 367		

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V 367	Continued From page 28 (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 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.	V 367		

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V 367	Continued From page 29 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to Level II incident reports were submitted to the Local Management Entity (LME) within 72 hours as required. The findings are. Review on 7/12/21 of the Incident Response Improvement System (IRIS) revealed no Level II incidents in the last 6 months. Interview on 7/12/21 with client #2 revealed: -The police came out to the facility. -"They come out because of another client. He already left. He ran away and he threatened staff." Interview on 7/12/21 with staff #1 revealed: -Acknowledged police had come to the facility this year (2021) -Stated it was for a previous client that was no longer at the facility. -Denied completing any incident reports Interview on 7/14/21 with staff #2 revealed: -He had called the police in the past. -Had not completed any incident reports -Had called the police to come and speak with the former client Interview on 7/14/21 with Qualified Professional #1 revealed: -When asked about incidents, she stated "I would assume the person here during the incident	V 367		

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V 367	Continued From page 30 would write the report ...I don't have any experience with IRIS ..." Interview on 7/14/21 with the Licensee revealed: -The only incident report submitted into IRIS was an incident that occurred with a former client in November 2020. -Was aware the police came to the facility recently.	V 367	Staff will report each Level 1 incident in an incident log within the facility. Staff will complete each level 2 incident within IRIS, all incidents' reports whether 1 or 2 will be submitted quarterly (any time the police come out the incident report will be completed in iris).	
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. (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	V 536		

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V 536	Continued From page 31 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). (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	V 536		

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V 536	Continued From page 32 (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, 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.	V 536		

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V 536	Continued From page 33 (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 reviews and interviews, the facility failed to ensure staff had initial training on alternatives to restrictive interventions. The findings are: Review on 7/12/21 of the Associate Professional (AP)'s record revealed: -No documentation of initial training on alternatives to restrictive interventions.	V 536		

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V 536	Continued From page 34 Review on 7/12/21 of the Qualified Professional #1 revealed: -No documentation of initial training on alternatives to restrictive interventions. Interview on 7/12/21 with the AP revealed: -The facility had not provided training on alternatives to restrictive interventions. -The Licensee had scheduled the training 2 weeks from today's date. Interview on 7/13/21 with the Licensee revealed: -The agency worked very hard in using verbal de-escalation with the clients. -Had reached out to the instructor whom provided the training. -In approximately two weeks, staff that are not training in alternatives to restrictive interventions, would be trained.	V 536	Training on client de-escalation and NCI will be held on 8/11/2021	8/11/2021
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or	V 537		

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volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated.
(c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions.
(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 plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.
(g) Acceptable training programs shall include, but are not limited to, presentation of:
(1) refresher information on alternatives to the use of restrictive interventions;
(2) guidelines on when to intervene (understanding imminent danger to self and others);
(3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention);
(4) strategies for the safe implementation of restrictive interventions;
(5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe

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V 537	Continued From page 36 use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (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 Qualification 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 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) 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. (5) 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 (j)(6) of this Rule.	V 537		

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V 537	Continued From page 37 (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) 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 outcome (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. (l) 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.	V 537		

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V 537	Continued From page 38 (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure staff were trained in seclusion, physical restraint and isolation time-out. The findings are: Review on 7/13/21 of the Associate Professional (AP)'s record revealed: -No documentation of training in seclusion, physical restraint and isolation time-out Review on 7/13/21 of the Qualified Professional #1's record revealed: -No documentation of training in seclusion, physical restraint and isolation time-out Interview on 7/12/21 with the AP revealed: -She had not had training in seclusion, physical restraint and isolation time-out -"[The Licensee] told me she has someone that can provide the training." Interview on 7/13/21 with the Licensee revealed: -Had reached out to the instructor whom provided the training. -In approximately two weeks, staff that are not training in alternatives to restrictive interventions, would be trained.	V 537	Staff has scheduled the training on clients' rights on 8/11/2021, training will be completed by Licensed Professional.	8/11/2021

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V 736	Continued From page 39	V 736		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observations and interviews, the facility staff failed to ensure the facility and its grounds were maintained in a safe, clean, orderly and attractive manner. The findings are: Observations on 7/12/21, at approximately 10:50am, of the outside of the facility revealed: -The grass against the facility's outside walls was approximately 18 inches tall. -There were 3 rodent traps around the home. -There was a hole, approximately 18 ½ inches by 12 inches, in the middle of the deck. -Vines had grown against the facility in both the back of the facility and on the and deck -There were two unidentified tanks on the side of the home -Several tree limbs were down in and around the yard. -Debris was in the outside of the facility's windows Observations on 7/12/21, at approximately 11:05am, of the inside of the facility revealed: -Mouse dropping were located inside the right kitchen drawer near the sink. -The garbage disposal was leaking under the sink	V 736		

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V 736	Continued From page 40	V 736		
	and a pot had been placed under it to catch the water. -The cleaning supply closet had no lock on it. -A light bulb was missing over the mirror in the clients' bathroom. -There was no toilet paper in the clients' bathroom. -There was cleaner under the sink in the clients' bathroom. -The blinds were broken in client #3 and #4's bedroom -Blinds were also broken in the kitchen. Interview on 7/12/21 with staff #1 revealed: -Was not aware of mouse droppings in the kitchen drawer -Had not seen any mice or bugs in the facility. -"All I know is that the pest control comes out every 2 or 3 weeks to spray inside and outside the facility." -The Licensee was aware of the hole in the deck. -When asked about the two tanks, staff #1 stated "I don't know what the tanks are" Interview on 7/14/21 with staff #2 revealed: -"We had an issue with mice about 4 months ago. When the weather started breaking ... -Had heard there were mice outside, "but I didn't see them personally ..." -Pest control had been out to the facility and put 3 boxes outside of the facility and one in the kitchen. -" I haven't seen nothing inside of the home. I don't use two of the drawers in the kitchen. I use the one by the stove and by the sink" -Stated the facility was "suitable" for a group home Interview on 7/12/21 with the Associate Professional (AP) revealed:			

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	MHL0411172	A. BUILDING: _____ B. WING _____	07/14/2021

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V 736	Continued From page 41	V 736		
	-During the walk through of the facility with the AP, she stated "rodent dropping? No, No ma'am. Do you mean like feces? I didn't know about that. My goodness." -Had not noticed the rodent traps outside of the home. -Had noticed the hole in the deck -When asked about the tanks located in the back yard, the AP stated "I don't know about these tanks" Interview on 7/12/21 with the Qualified Professional #1 (QP #1) revealed: -Hasn't seen any mice, "but [the Licensee] talked with him (pest control) about it. [The Licensee] was coordinating with professions to come and address that. -Construction was being done, nearby, and felt that was why some mice have been coming to the home. -After talking with the Licensee, he was aware that mice droppings had been seen in the home. Interview on 7/12/21 with the QP #2 revealed: -"I really don't know about the mouse droppings. The home is pretty old, and the owner needs to do some work on the home. We are actually looking for a new place." Interview on 7/12/21 with the Licensed Professional (LP) revealed: -When asked if she had seen any mice in the facility, the LP stated "Oh no. I do to into the clients' room to see how they are keeping their space. I go throughout the house. I go to the bathrooms to see if they are doing their chores. I go outside. I have not noticed the mouse traps outside."			

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Division of Health Service Regulation

V 736	Continued From page 42 Interview on 7/12/21 with the Licensee revealed: -Was aware there were mice outside the facility. -"The exterminator placed the black boxes outside to trap the mice and keeping them under control." -Was not aware one of the drawers in the kitchen had mouse droppings in it. -Would be talking to the landlord to see about making the needed repairs both inside and outside of the facility. -"This is an old house. I am currently looking to move the facility to another location. A house that is newer and in a better neighborhood."	V 736	Staff has contacted the owner of the home and gotten him to fix everything that was insufficient such as (mice droppings, dripping water from sink, wooden deck, residue from window).	8/30/2021
V 744	27G .0304(b) Safety 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. This Rule is not met as evidenced by: Based on observations and interviews, the staff failed to ensure the facility was designed, constructed and equipped in a manner that ensured the physical safety of clients, staff and visitors. The findings are: Observation on 7/12/21, at approximately 10:35am, of the inside of the facility revealed: -At the foot of client #2's bed, there was a space heater -Client #4 had a space heater located in between his bed and a table.	V 744		

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V 744	Continued From page 43 Interview on 7/14/21 with the Department of Health and Human Service's Engineer Plan Reviewer revealed: -Since the facility was considered a residential care facility with more than 3 people, "the facility had to follow the building code sections which prevented portable space heaters." -"If the staff are using portable space heaters in the facility, they are not following the building codes." Interviews on 7/12/21 with client #2 revealed: -When asked about space heaters in the facility, client #2 stated "the space heaters have been here since I have been here." Interview on 7/14/21 with the Licensee revealed: -Was not aware space heaters were not allowed in the facility -Would immediately ensure all the space heaters were removed from the facility.	V 744	Staff has removed space heaters from the facility.	7/14/2021

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V 000	INITIAL COMMENTS An annual survey was completed on July 14, 2021. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children and Adolescents.	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 (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	V 107	DHSR - Mental Health DEC 10 2021 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lisa Monsom — TITLE: Executive Director — (X6) DATE: 8/5/2021

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V 107	Continued From page 1 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 reviews and interviews, the facility failed to ensure 3 of 7 audited staff (#1, #2 and the Qualified Professional #2 (QP #2)) had a written and signed job description and verification to meet the minimum level of education. The findings are: Review on 7/13/21 of staff #1's record revealed: -A hire date of 7/6/21 -No written and signed job description -No documentation of verified education Review on 7/13/21 of staff #2's record revealed: -A hire date of 8/28/20 -No written and signed job description -No documentation of verified education Review on 7/13/21 of the Qualified Professional	V 107		

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V 107	Continued From page 2 #2 (QP #2) record revealed: -A hire date of 6/9/21 -No written and signed job description Interview on 7/13/21 with QP #1 revealed: -The Licensee was responsible for maintaining the staffs' records. -The Licensee was responsible for ensuring the staff met the minimum level of education for the position Interview on 7/14/21 with the Licensee revealed: -Was responsible for ensuring all staff had a written and signed job description. -Was responsible for ensuring the staff met the minimum level of education for the position	V 107	Trainings have been scheduled for staff for 8/11/2021, and the highest level of education has been placed in all files along with signed jobs descriptions.	8/11/2021
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	V 108		

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V 108	Continued From page 3 including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and 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 reviews and interviews, the facility failed to ensure 3 of 7 audited staff (#1, #2 and the Qualified Professional #2 (QP #2)) were trained on client right's, confidentiality, Blood Bourne Pathogens (BBP) and training to meet the MR/DD needs of the clients as specified in the treatment/habilitation plans. The findings are: Review on 7/13/21 of staff #1's record revealed: -A hire date of 8/27/20 -No documentation of training to meet the MR/DD needs of the clients Review on 7/13/21 of staff #2's record revealed: -A hire date of 8/28/20 -No documentation of training on client rights -No documentation of training on Confidentiality/HIPPA -No documentation of training to meet the MR/DD needs of the clients Review on 7/13/21 of the Qualified Professional	V 108		

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V 108	Continued From page 4 #2 (QP #2)'s record revealed: -A hire date of 6/9/2021 -No documentation of training on client rights -No documentation of training on Confidentiality/HIPPA -No documentation of training to meet the MR/DD needs of the clients Interview on 7/13/21 with the Licensee revealed: -She was responsible for ensuring all staff had the required trainings.	V 108	Staff has reincorporated supervisions the last supervisions were completed on July 14th, 2021 and the next supervision will be held on August 11, 2021.	8/11/2021
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) 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.	V 110		

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V 110	Continued From page 5 (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record reviews and interviews, 1 of 7 audited staff (the Licensee (L)) failed to demonstrate the knowledge, skills and abilities required by the population served and 4 of 7 audited staff failed to have individualized supervision plans. The findings are: Review on 7/13/21 of the L's record revealed: -A hire date of 7/1/2018 -No documentation of a supervision plan Review on 7/13/21 of staff #1's record revealed: -A hire date of 7/6/21 -No documentation of a supervision plan Review on 7/13/21 of staff #2's record revealed: -A hire date of 8/28/20 -No documentation of a supervision plan Review on 7/13/21 of the Qualified Professional #2 (QP #2)'s record revealed: -A hire date of 6/9/21 -No documentation of a supervision plan Interview on 7/12/21 with staff #1 revealed: -The Licensee was responsible for all the staff trainings and maintaining the staff's records. -Did not have an individualized supervision plan	V 110		

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V 110	Continued From page 6 with an Associate Professional (AP) or a Qualified Professional (QP). Interviews on 7/12/21 with the AP revealed: -The Licensee was responsible for all the staff trainings and maintaining the staff's records. -Did not have an individualized supervision plan with a QP. Interviews on 7/13/21 and 7/14/21 with staff #2 revealed: -The Licensee was responsible for all the staff trainings and maintaining the staff's records. -Had not had any supervision yet. Interviews on 7/13/21 and 7/14/21 with the L revealed: -Had no explanation as to why all of the facility staff had not been trained in client right's, confidentiality, Blood Bourne Pathogens (BBP) and training to meet the MR/DD needs of the clients as specified in the treatment/habilitation plans. - Had no explanation as to why all of the facility staff did not have written and signed job descriptions and verification to meet the minimum level of education. -Was responsible for ensuring all staff had their required trainings, job descriptions and supervision plans -Was aware of client #4's sexualized behaviors -Was not sure why client #4's sexualized behaviors had not been addressed but it had been mentioned to an outside therapist -Had only conducted one fire drills in the last 12 months -Had conducted no disaster drills in the last 12 months -"I know one fire drill has been done." - Had no explanation as to why the drills were not	V 110		

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V 110	Continued From page 7 conducted in the last 12 months -When asked about re-dispensing medications into containers that did not have the required information on them, the Licensee stated "I thought it would be easier for some staff. We are making calls today to switch pharmacies ..." -Was recently made aware the clients' MARs had blanks on them -"I know they are getting their medications. I am supposed to check the MARs monthly, but not for this month (July 2021). I guess staff is not documenting on the MARs after giving the clients their medications." -Had only completed one level II incident report in the last 12 months. -"I am aware the police came out for a discharged client." -When asked why QP #1 was not in the facility 70% of the time were clients were awake and present, the Licensee stated "he usually works on the Comprehensive Clinical Assessments (CCA) and the treatment plans off site. He also has anther job. I plan to have [QP #2] work in the facility, Monday through Friday" -When asked about the client/staff ratio, the Licensee stated she was aware the client/staff ratio was a minimum of 2 staff for every 4 clients. -"With COVID, it was hard to keep staff. We have had a lot of turn over." -Was aware some of the staff had not had trainings on preventative and restrictive interventions, the Licensee stated, "I have contacted the instructor, so the staff will be trained within the next two weeks." -When asked about physical plant issues outside and inside the facility, including the mouse traps and mouse droppings, the Licensee stated she was aware there were mice outside the facility. -"I was not aware there were mouse droppings in the kitchen drawers. This is an old house. I am	V 110		

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V 110	Continued From page 8 currently looking to move the facility to another location ..." -When asked about the portable space heaters, the Licensee stated "I was not aware space heaters were not allowed in the facility ..."	V 110	We are reviewing the requirements of the paraprofessionals with staff and training them on any questions they have within the job requirements and/or duties.	8/11/2021
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 9 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility staff failed to develop and implement strategies in 1 of 4 client (#4)'s treatment plans to address the needs of the clients. The findings are: Review on 7/13/21 of client #4's record revealed: -An admission date of 9/23/20 -Diagnoses of Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Disruptive Mood Dysregulation Disorder -Age 15 -An assessment dated 10/26/20 noting "was previously at a PRTF for past 5 months due to severe physical and mental aggression towards his mother and out of control behaviors. Mother signed over parental rights to [a local Department of Social Services (DSS) in May 2019, had problems with sleeping at night, disruptive behaviors since being at group home, had been bulling peers, was disrespectful to staff and was manipulative." -A treatment plan dated 5/13/21 noting "client will learn to express his frustration in a healthy way by reducing incidents of cursing, yelling and threatening. He will verbalize his feelings appropriately and use coping skills to manage his emotions per reports from self, family school staff, DSS and other team members. Client will follow instructions with no more than 2 verbal prompts by staying on assigned tasks following expectations/rules and completing daily chores/regimen per reports from self, family, school, staff, DSS and other team members. Client will be transported by one staff to and from appointments as needed. He will follow all recommendations from his therapist and other	V 112		

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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 10 professional providing services. Client will engage in appropriate boundaries and accept responsibility for his actions by refraining from exhibiting manipulative behaviors and embellishing accounts as measured by observations and documentation per reports; Client will develop healthy social skills by expressing negative feelings through positive communication skills using direct eye contact, positive language, improved social interactions with others (peers, adults, family members) and identification of supports per reports, client will learn to verbally identify triggers to his anger and replace his thoughts that produce unwanted behaviors, Will be encouraged to keep a journal to record his feelings and triggers, Will develop an awareness of his physical and cognitive response to triggers of his emotions, Will recognize and verbalize how unpleasant or negative emotions are connected to disruptive, antagonistic, or negative, attention seeking behaviors and Will participate in individual and group therapy sessions." -A Child and Family Team (CFT) meeting was held on 1/4/21 noting, " ... He engages in smacking other peers on the butt, often wants hugs from others and staff. Staff has had to put limitations in place to prevent something happening. There was an incident in where a male staff felt like he intentional grabbed their private parts when they were playing. Client reported that it was an accident. The team plans to address these concerns and possible need for additional services including possible forensic interviewing to see if there may be some things that have happened to him when he was younger that he has not fully expressed ..." -Another CFT was held on 3/11/21 where it was reported that there were several incidents of him having inappropriate sexual communications	V 112		

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V 112	Continued From page 11 towards others in the group home. They have responded in feeling uncomfortable and it has resulted in altercations in which staff had to intervene. Client has reported that he hears other masturbating in their rooms and beds shaking. He frequently makes comments ' that's why country people have been molested' in reference to another client that is from the country and has a history of sexual abuse when younger. Client has also asked other peers to 'suck in d**k', in front of staff. Staff is having to monitor and intervene in situations with him and others. The team is concerned regarding client's inability to control his urges/impulses in efforts to prevent from expressing inappropriate things and engaging in inappropriate touching others or invading others personal space. Team has discussed upcoming plans to have him participate in a possible forensic evaluation to assess these symptoms along with providing possible reconditions for treatment." -No documentation to address client #4's sexualized behaviors/comments/gestures Interview on 7/13/21 with the Licensee revealed: -Was aware of client #4's sexualized behaviors -Was not sure why client #4's sexualized behaviors/gestures/comments had not been addressed. -Would meet with both QP's to develop and implement strategies to address these behaviors in client #4's treatment plan. -Had met with the treatment team to discuss sexualized behaviors and comments from client #4 to his peers and to staff. -Stated client #4 refuses to participate in treatment. -Had brought these concerns to the attention of an outside therapist, recently -Felt client #4 needed a sex offender evaluation.	V 112		

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V 112	Continued From page 12 -Stated the Guardian Ad Litem (GAL) attorney did not want client #4 to participate in any therapy as it related to his sexualized behaviors/gestures/comments	V 112	We have collaborated to create new goals to target consumers specific needs and also created a safety plan to ensure other consumers in the group home are safe from sed consumer.	8/20/2021
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 beposted 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 reviews and interviews, the facility staff failed to ensure fire and disaster drills were conducted once per shift per quarter. The findings are: Review on 7/13/21 of the facility's fire and disaster drills from 7/2020 to 7/2021 revealed: -1/21/10 at 6:45pm on second shift with 2 clients present. "staff yelled fire and the clients went out the front door with staff at the end of the driveway/mailbox in a timely manner" -No other documentation was provided	V 114		

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V 114	Continued From page 13 Interview on 7/12/21 with client #1 revealed: -Had been at the facility for 2 weeks -Had not participated in any fire drills; -Had not participated in any disaster drills. Interview on 7/12/21 with client #2 revealed: -Had been at the facility for 5 months -Had not participated in any fire drills; -Had not participated in any disaster drills. Interview on 7/12/21 with client #3 revealed: -Had been at the facility for 6 months -Had not participated in any fire drills; -Had not participated in any disaster drills. Interview on 7/12/21 with client #4 revealed: -Had been at the facility for 10 months -Had not participated in any fire drills; -Had not participated in any disaster drills. Interview 7/12/22 with staff #1 revealed: -Worked first shift at the facility -Worked from 8am until 4pm. -When asked about drills, she stated "we have not done any recently. I will have to discuss them with [the Licensee (L)]. I think they are supposed to be done every 3 months ..." Interview on 7/12/21 with the Associate Professional (AP) revealed: -When asked if the facility staff were conducting fire and disaster drills, the AP stated "I have only been here five days. No ma'am. The staff have not conducted any drills." Interview on 7/13/21 with the Licensee revealed: -"I have one drill that I did do."	V 114	Staff has created and implemented a fire drill and disaster drill schedule once per shift per quarter.	8/30/2021

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V 117	Continued From page 14	V 117		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure prescription medications were dispensed with the prescriber's	V 117		

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V 117	Continued From page 15 name, the current dispensing date, the name, strength, quantity and expiration date of the prescribed medication, the name, address and phone number of the pharmacy and the name of the dispensing Practitioner for 4 of 4 clients (#1, #2, #3 and #4). The findings are: Observations on 7/12/21, from approximately 12:30pm to 2:10pm, the medication revealed: -4 clear, individual dispensing personal pill packets for 7 days -No documentation of the prescriber's name, address and phone number of the pharmacy -No documentation of the current dispensing date -No documentation of the name, strength, quantity and expiration date of the prescribed medication -No documentation of the name of the dispensing Practitioner Interviews on 7/12/21 with clients #1, #2, #3 and #4 revealed: -Sometimes their medications were administered in clear, individual dispensing personal pill packets by facility staff. Interview on 7/13/21 with the staff #1 revealed: -Had dispensed medications out of the personal pill packets for the clients. -She was instructed to do so from the Licensee. Interview on 7/13/21 with the staff #2 revealed: -Had dispensed medications out of the personal pill packets for the clients. -She was instructed to do so from the Licensee. Interview on 7/13/21 with the Licensee revealed: -Some of the facility staff found it difficult to administer the clients' medications from the prescription bottles	V 117		

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V 117	Continued From page 16 -"I thought it would be easier for staff to put the medications in the individual packets for the clients. I asked the staff to administer the medications that way." -Was aware of the needed requirements/information to have on prescription medications when they are administered -Would ensure facility staff had re-certified medication administration with a Registered Nurse.	V 117	Staff held a medication training for employees on July 14th 2021, to address medication management requirements. Staff also implemented new policies about Medical Records Administration and the consequences if not properly followed.	7/14/2021
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; (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.	V 118		

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V 118	Continued From page 17 (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 reviews and interviews, the facility staff failed to ensure medications were immediately recorded after administration for 4 of 4 current clients (#1, #2, #3 and #4). The findings are: Review on 7/13/21 of client #1's record revealed: -An admission date of 7/1/21 -Diagnoses of Diagnoses of Oppositional Defiant Disorder, Unspecified, Attention Deficit Hyperactivity Disorder (ADHD), Other Specified Trauma and Stressor Related Disorder, Other Specified Schizophrenia Spectrum Disorder. -A physician's order, dated 6/22/21, for the following medications: Latuda 20mg, 1poqhs dinner every night Guanfacine ER, 3mg, 1po q5pm and Amantadine 100mg 2 poqam and 1poqhs 1:00pm. Review on 7/13/21 of client #1's MAR for July 2021 revealed: -Blanks on the MAR for Guanfacine 3mg tablets on the following dates: 7/1, 72, 7/4, 7/5, 7/6 and 7/8 -Blanks on the MAR for Amantadine 100mg on the following dates: 7/1, 7/2, 7/4, 7/5, 7/6, 7/11 -Blanks on the MAR for Latuda 30mg on the	V 118		

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V 118	Continued From page 18 following dates:7/1, 7/4, 7/6, 7/8, 7/11 Review on 7/13/21 of client #2's record revealed: -An admission date of 2/12/21 -Diagnoses of Unspecified Schizophrenia Spectrum and other Psychotic Disorder, Conduct Disorder; Childhood-Onset Type, Disruptive Mood Dysregulation Disorder (DMDD), Post-Traumatic Stress Disorder (PTSD) and Obsessive-Compulsive Disorder (OCD), Unspecified. -Physician's order dated 2/10/21 for the following medications: Trazodone 150mg, 1poqhs -Physician's order dated 2/12/21 for the following medications: Vitamin D, 2,000 Units, 1poqd -Physician's order dated 3/17/21 for the following medications: Aripiprazole 5mg, 1poqhs, for DMDD and Lamotrigine 100mg, ½ pobid for DMDD. Review on 7/13/21 of client #2's MARs, from 7/1/21 to 7/12/21 revealed: -Blanks on the MAR for Trazodone 150mg from 7/2 to 7/6, 7/8 and 7/11 -Blanks on the MAR for Aripiprazole 5mg from 7/2 to 7/6, 7/8 and 7/11 -Blanks on the MAR for Lamotrigine 100mg from 7/2 to 7/6, 7/8, 7/10 and 7/11 Review of client #3's record revealed: -An admission date of 4/26/21 -Diagnoses of Conduct Disorder Childhood-Onset Type, Disruptive Mood Dysregulation Disorder, Schizoaffective Disorder, Bipolar Type, Transvestic Fetishism, ADHD, Combined Type. -A physician's orders dated 6/22/21 for the following medications: Guanfacine 2pmg, 1poq5pm, Vistaril 25mg, 1poq5pm, Jornay 40mg, 1poq5pm, Olanzapine 30mg, 1poqd, and Melatonin 3mg, 4poq5pm (12mg)	V 118		

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V 118	Continued From page 19 Review on 7/13/21 of client #3's MARs, from 5/1/21 to 7/12/21 revealed: -Blanks on the MARs for all medications on 5/1 to 5/3, 5/8 and 5/9 --Blanks on the MARs for all medications on 7/2 through 7/6 and on 7/8 and 7/11 Review of client #4's record revealed: -An admission date of 9/23/20 -Diagnoses of ODD, ADHD and DMDD -A physician's order dated 9/20/20 for the following medications: Clonidine 0.2mg, 1poqhs Review on 7/13/21 of client #4's MARs, from 6/1/21 to 7/12/21 revealed: -Blanks on the MARs for Clonidine 0.2mg 6/19, 6/20 and 6/26 -Blanks on the MARs for Clonidine 0.2mg on 7/3 to 7/6, 7/8 and 7/11 Interviews on 7/12/21 with clients #1, #2, #3 and #4 revealed: -Their medications were administered to them by staff. Interviews on 7/14/21 with staff #2 revealed: -Medications are kept in a locked cabinet -You were not to touch the medications, but you can put in them in a cup -Qualified Professional #2 (QP #2) was notified when there were blanks on the MARs. -When asked if he had seen blanks on the MARs recently, staff #2 stated "yes, but I do not want to get anyone in trouble ..." Interview on 7/12/21 with the Associate Professional (AP) revealed: -Had noticed blanks on the client's MARs. -"There were no initials, so I am not sure whether	V 118		

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V 118	Continued From page 20 or not medications were given." -She was sure the clients were getting their medications, "but I think I staff are just forgetting to document" -Seeing the individual pill packets was new to her. -"It is not the best form (to administer medications). It was an automatic red flag for me ..." Interview on 7/13/21 with Qualified Professional (QP #2) revealed: -"I am working on the MARs. I know you have seen them. I do not like the pharmacy (current). [The Licensee] was calling another pharmacy right now to get them switched (to a new pharmacy) ..." Interviews on 7/13/21 and 7/14/21 with the Licensee revealed: -Was responsible for reviewing the MARs monthly to ensure there were no issues. -"It's our policy for me to review the MARs, but I have not reviewed them this month." -It was recently brought to her attention there were blanks on the MARs. -Would ensure facility staff was retrained on Medication Administration	V 118	Staff held a medication training for employees on July 14th, 2021, to address medication management requirements. Staff also implemented new policies about Medical Records Administration and the consequences if not properly followed.	7/14/2021
V 294	27G .1702 Residential Tx. Child/Adol -Req. for Q P 10A NCAC 27G .1702 REQUIREMENTS OF QUALIFIED PROFESSIONALS (a) Each facility shall utilize at least one direct care staff who meets the requirements of a qualified professional as set forth in 10A NCAC 27G .0104(18). In addition, this qualified professional shall have two years of direct client care experience. (b) For each facility of five or less beds:	V 294		

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V 294	Continued From page 21 (1) the qualified professional specified in Paragraph (a) of this Rule shall perform clinical and administrative responsibilities a minimum of 10 hours each week; and (2) 70% of the time shall occur when children or adolescents are awake and present in the facility. (c) For each facility of six or more beds: (1) the qualified professional specified in Paragraph (a) of this Rule shall perform clinical and administrative responsibilities a minimum of 32 hours each week; and (2) 70% of the time shall occur when children or adolescents are awake and present in the facility. (d) The governing body responsible for each facility shall develop and implement written policies that specify the clinical and administrative responsibilities of its qualified professional(s). At a minimum these policies shall include: (1) supervision of its associate professional(s) as set forth in Rule .1703 of this Section; (2) oversight of emergencies; (3) provision of direct psychoeducational services to children or adolescents; (4) participation in treatment planning meetings; (5) coordination of each child or adolescent's treatment plan; and (6) provision of basic case management functions. This Rule is not met as evidenced by:	V 294		

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V 294	Continued From page 22 Based on record reviews and interviews, 1 of 2 Qualified Professionals (QP #1) failed to perform clinical and administrative responsibilities 70% of the time when children or adolescents were awake and present at the facility. The findings are: Review on 7/13/21 of the QP #1's record revealed: -A hire date of 8/28/20 -A job description of a QP Interviews on 7/12/21 with clients #1, #2, #3 and #4 revealed: -They did not know the QP #1's name when asked. -"Who is that? I haven't ever seen him here." Interview on 7/14/21 with QP #1 revealed: -Had previously been through the survey process. -"I know how the state comes in and tells you the things you need to do as well ..." -Stated he was rarely at the facility in person -"But I have been there for a couple of hours a week. I mainly do things over the phone. We have had a lot of turn over. I have not been at the facility since I recently got a new job. Now that [the Qualified Professional #2 (QP #2)] has been hired, she would be at the facility Monday through Friday." -When asked about documentation and meeting with the clients, he stated, "hmmm there have been notes but none recently. We share responsibility with [the other QP (#2)] ..." -Stated before QP #2 took the position, he would be at the facility a couple of hours per week. Interview on 7/13/21 with the Licensee revealed: -Was aware QP #1 was not coming to the facility when clients were present 70% of the time	V 294		

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V 294	Continued From page 23 -"It was due to COVID. I have hired [QP #2] to be at the facility Monday through Friday."	V 294	QP will be at the facility 32 hours while the children are awake.	8/30/2021
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 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	V 296		

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	MHL0411172	A. BUILDING: _____ B. WING _____	07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUCCESSFUL VISIONS, LLC	1906 GREENSTONE PLACE HIGH POINT, NC 27265

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V 296	Continued From page 24 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 observations and interviews, the facility failed to ensure the two direct care staff were present for one, two, three or four children or adolescents. The findings are: Observations on 7/12/21, from approximately 9:50am to 10:14am, revealed: -The Associate Professional (AP) was alone at the facility with 4 clients -Staff #1 arrived on shift at 10:14am Further observations on 7/12/21, at approximately 1:26pm revealed: -Staff #1 went outside in the front yard of the facility to use her phone -The AP remained in the office area -At 1:39pm, the clients were in the back yard on the deck. -Staff #1 was in the back yard, on her phone, and was not supervising the clients -A loud noise was heard at which time the AP went outside -The AP took staff #1's cell phone and went into the facility with it.	V 296		

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V 296	Continued From page 25 Observations on 7/13/21, from approximately 2:44pm, revealed: -Clients were in the living room and hallway, playing around with no supervision -All 3 of the staff present remained in the office. -Client #2 and client #4 were in the hallway horse playing -Client #1 stood at the office door, talking with 3 staff. -Client #3 arrived at the facility and asked the Licensee if he could go outside. -All 4 clients went in the front yard/driveway -2 staff remained in the office working on files -The Licensee was being interviewed -All 4 clients remained unsupervised outside. On 7/13/21, one of the surveyors observed all four clients were not in sight given the position of where the 2 staff were sitting in the office. Interview on 7/12/21 with client #1 revealed: -Usually there were 2 staff at the facility on each shift. -Sometimes client #1 wakes up during the night -"When I wake up at night, there is usually only 1 staff. Last night (7/11/21) there was only 1 staff on third shift. It happens a lot ..." Interview on 7/12/21 with client #2 revealed: -"At night, there was only (staff) here (at the facility). It is usually [staff #7] or [staff #8] ..." Interview on 7/12/21 with client #3 revealed: -When asked about client/staff ratios at the facility, client #3 stated "there is usually either 1 or 2 staff on the shifts. But this morning, there was only one until [staff #1] got here ..." Interview on 7/12/21 with client #4 revealed:	V 296		

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V 296	Continued From page 26 -There were usually two staff working at the facility -Had gotten up one night "and there was only 1 staff here." Interview on 7/12/21 with staff #1 revealed: -Was on the schedule to work first shift, 8am to 4pm, on 7/12/21 -He son was having surgery on 7/12/21 Interview on 7/12/21 with the AP revealed: -She had only been working at the facility for 5 days -Her shift was Monday through Friday from 8am to 4pm -Staff #1 was scheduled to work first shift on 7/12/21 -"She called to say her son was having surgery and [staff #2] was on his way ..." Interview on 7/14/21 with the Qualified Professional #1 -The client/staff ratio was 2 staff to every 1, 2, 3, 4 clients. -Was not sure why there was only 1 staff present when the surveyors arrived at the facility. Interview on 7/14/21 with the Licensee revealed: -Was aware the client/staff ratio was a minimum of 2 staff for every 4 clients. -She was not aware staff #1 would be out on 7/12/21 -With COVID it was hard to keep staff. -"We have had a lot of turn over."	V 296	Staff has completed hiring to reflect 2 staff on each shift.	7/14/2021
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR	V 367	Staff will report each Level 1 incident in an incident log within the facility. Staff will complete each level 2 incident within IRIS, all incidents' reports whether 1 or 2 will be submitted quarterly (any time the police come out the incident report will be completed in iris).	8/23/2021

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V 367	Continued From page 27 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 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:	V 367	

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V 367	Continued From page 28 (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 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.	V 367		

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V 367	Continued From page 29	V 367	

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to Level II incident reports were submitted to the Local Management Entity (LME) within 72 hours as required. The findings are.

Review on 7/12/21 of the Incident Response Improvement System (IRIS) revealed no Level II incidents in the last 6 months.

Interview on 7/12/21 with client #2 revealed:
-The police came out to the facility.
-"They come out because of another client. He already left. He ran away and he threatened staff."

Interview on 7/12/21 with staff #1 revealed:
-Acknowledged police had come to the facility this year (2021)
-Stated it was for a previous client that was no longer at the facility.
-Denied completing any incident reports

Interview on 7/14/21 with staff #2 revealed:
-He had called the police in the past.
-Had not completed any incident reports
-Had called the police to come and speak with the former client

Interview on 7/14/21 with Qualified Professional #1 revealed:
-When asked about incidents, she stated "I would assume the person here during the incident

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V 367	Continued From page 30 would write the report ...I don't have any experience with IRIS ..." Interview on 7/14/21 with the Licensee revealed: -The only incident report submitted into IRIS was an incident that occurred with a former client in November 2020. -Was aware the police came to the facility recently.	V 367	Staff will report each Level 1 incident in an incident log within the facility. Staff will complete each level 2 incident within IRIS. all incidents' reports whether 1 or 2 will be submitted quarterly (any time the police come out the incident report will be completed in iris).
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. (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	V 536	

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V 536	Continued From page 31 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). (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	V 536		

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V 536	Continued From page 32 (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, 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.	V 536		

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V 536	Continued From page 33 (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 reviews and interviews, the facility failed to ensure staff had initial training on alternatives to restrictive interventions. The findings are: Review on 7/12/21 of the Associate Professional (AP)'s record revealed: -No documentation of initial training on alternatives to restrictive interventions.	V 536		

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V 536	Continued From page 34 Review on 7/12/21 of the Qualified Professional #1 revealed: -No documentation of initial training on alternatives to restrictive interventions. Interview on 7/12/21 with the AP revealed: -The facility had not provided training on alternatives to restrictive interventions. -The Licensee had scheduled the training 2 weeks from today's date. Interview on 7/13/21 with the Licensee revealed: -The agency worked very hard in using verbal de-escalation with the clients. -Had reached out to the instructor whom provided the training. -In approximately two weeks, staff that are not training in alternatives to restrictive interventions, would be trained.	V 536	Training on client de-escalation and NCI will be held on 8/11/2021	8/11/2021
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or	V 537		

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V 537	Continued From page 35 volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (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 plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe	V 537		

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V 537	Continued From page 36 use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (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 Qualification 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 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) 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. (5) 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 (j)(6) of this Rule.	V 537		

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V 537	Continued From page 37 (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) 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 outcome (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. (l) 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.	V 537	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411172	A. BUILDING: _____ B. WING _____	07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 537	Continued From page 38 (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure staff were trained in seclusion, physical restraint and isolation time-out. The findings are: Review on 7/13/21 of the Associate Professional (AP)'s record revealed: -No documentation of training in seclusion, physical restraint and isolation time-out Review on 7/13/21 of the Qualified Professional #1's record revealed: -No documentation of training in seclusion, physical restraint and isolation time-out Interview on 7/12/21 with the AP revealed: -She had not had training in seclusion, physical restraint and isolation time-out -"[The Licensee] told me she has someone that can provide the training." Interview on 7/13/21 with the Licensee revealed: -Had reached out to the instructor whom provided the training. -In approximately two weeks, staff that are not training in alternatives to restrictive interventions, would be trained.	V 537	Staff has scheduled the training on clients' rights on 8/11/2021, training will be completed by Licensed Professional.	8/11/2021

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V 736	Continued From page 39	V 736		
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.

This Rule is not met as evidenced by:
Based on observations 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:

Observations on 7/12/21, at approximately 10:50am, of the outside of the facility revealed:
-The grass against the facility's outside walls was approximately 18 inches tall.
-There were 3 rodent traps around the home.
-There was a hole, approximately 18 ½ inches by 12 inches, in the middle of the deck.
-Vines had grown against the facility in both the back of the facility and on the and deck
-There were two unidentified tanks on the side of the home
-Several tree limbs were down in and around the yard.
-Debris was in the outside of the facility's windows

Observations on 7/12/21, at approximately 11:05am, of the inside of the facility revealed:
-Mouse dropping were located inside the right kitchen drawer near the sink.
-The garbage disposal was leaking under the sink

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 736	Continued From page 40 and a pot had been placed under it to catch the water. -The cleaning supply closet had no lock on it. -A light bulb was missing over the mirror in the clients' bathroom. -There was no toilet paper in the clients' bathroom. -There was cleaner under the sink in the clients' bathroom. -The blinds were broken in client #3 and #4's bedroom -Blinds were also broken in the kitchen. Interview on 7/12/21 with staff #1 revealed: -Was not aware of mouse droppings in the kitchen drawer -Had not seen any mice or bugs in the facility. -"All I know is that the pest control comes out every 2 or 3 weeks to spray inside and outside the facility." -The Licensee was aware of the hole in the deck. -When asked about the two tanks, staff #1 stated "I don't know what the tanks are" Interview on 7/14/21 with staff #2 revealed: -"We had an issue with mice about 4 months ago. When the weather started breaking ... -Had heard there were mice outside, "but I didn't see them personally ..." -Pest control had been out to the facility and put 3 boxes outside of the facility and one in the kitchen. -" I haven't seen nothing inside of the home. I don't use two of the drawers in the kitchen. I use the one by the stove and by the sink" -Stated the facility was "suitable" for a group home Interview on 7/12/21 with the Associate Professional (AP) revealed:	V 736		

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V 736	Continued From page 41 -During the walk through of the facility with the AP, she stated "rodent dropping? No, No ma'am. Do you mean like feces? I didn't know about that. My goodness." -Had not noticed the rodent traps outside of the home. -Had noticed the hole in the deck -When asked about the tanks located in the back yard, the AP stated "I don't know about these tanks" Interview on 7/12/21 with the Qualified Professional #1 (QP #1) revealed: -Hasn't seen any mice, "but [the Licensee] talked with him (pest control) about it. [The Licensee] was coordinating with professions to come and address that. -Construction was being done, nearby, and felt that was why some mice have been coming to the home. -After talking with the Licensee, he was aware that mice droppings had been seen in the home. Interview on 7/12/21 with the QP #2 revealed: -"I really don't know about the mouse droppings. The home is pretty old, and the owner needs to do some work on the home. We are actually looking for a new place." Interview on 7/12/21 with the Licensed Professional (LP) revealed: -When asked if she had seen any mice in the facility, the LP stated "Oh no. I do to into the clients' room to see how they are keeping their space. I go throughout the house. I go to the bathrooms to see if they are doing their chores. I go outside. I have not noticed the mouse traps outside."	V 736		

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V 736	Continued From page 42 Interview on 7/12/21 with the Licensee revealed: -Was aware there were mice outside the facility. -"The exterminator placed the black boxes outside to trap the mice and keeping them under control." -Was not aware one of the drawers in the kitchen had mouse droppings in it. -Would be talking to the landlord to see about making the needed repairs both inside and outside of the facility. -"This is an old house. I am currently looking to move the facility to another location. A house that is newer and in a better neighborhood."	V 736	Staff has contacted the owner of the home and gotten him to fix everything that was insufficient such as (mice droppings, dripping water from sink, wooden deck, residue from window).	8/30/2021
V 744	27G .0304(b) Safety 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. This Rule is not met as evidenced by: Based on observations and interviews, the staff failed to ensure the facility was designed, constructed and equipped in a manner that ensured the physical safety of clients, staff and visitors. The findings are: Observation on 7/12/21, at approximately 10:35am, of the inside of the facility revealed: -At the foot of client #2's bed, there was a space heater -Client #4 had a space heater located in between his bed and a table.	V 744		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 744	Continued From page 43 Interview on 7/14/21 with the Department of Health and Human Service's Engineer Plan Reviewer revealed: -Since the facility was considered a residential care facility with more than 3 people, "the facility had to follow the building code sections which prevented portable space heaters." -"If the staff are using portable space heaters in the facility, they are not following the building codes." Interviews on 7/12/21 with client #2 revealed: -When asked about space heaters in the facility, client #2 stated "the space heaters have been here since I have been here." Interview on 7/14/21 with the Licensee revealed: -Was not aware space heaters were not allowed in the facility -Would immediately ensure all the space heaters were removed from the facility.	V 744	Staff has removed space heaters from the facility.	7/14/2021

Consumer Name: [redacted] Service Record # [redacted]

Date the Child and Family Team met to develop this discharge/transition plan: 11/24/21

Division of MH/DD/SAS
Division of Medical Assistance

Child/Adolescent Discharge/Transition Plan

This document must be submitted with the completed ITR, the required PCP (i.e. introductory, complete or update) and any other supporting documentation justifying the request for authorization and reauthorization of Residential Levels III and IV. In addition, for reauthorization of Residential Level III and IV, a new comprehensive clinical assessment by a psychiatrist (independent of the residential provider and its provider organization) that includes clinical justification for continued stay at that level of care is required to be submitted. This document is also required for an initial care review for a PRTF only. An incomplete ITR, PCP or lack of Discharge/Transition Plan and a new comprehensive clinical assessment (when applicable) will result in a request being "unable to process".

I. The recipient's expected discharge date from the following service is:

- [x] Residential Level III — Expected Discharge Date: 2/28/22
- [ ] Residential Level IV — Expected Discharge Date: __/__/__
- [ ] PRTF — Date of Initial Care Review Only: __/__/__

II. At time of discharge the recipient will transition and/or continue with the following services. Please indicate both the planned date of admission to each applicable service and the anticipated provider.

☐ Natural and Community Supports		(Provide details in Section III.)
☐ Outpatient Individual Therapy	__/__/__	Provider: Successful Visions
☐ Outpatient Family Therapy	__/__/__	Provider:
☐ Outpatient Group Therapy	__/__/__	Provider: Successful Visions
☐ Medication Management	__/__/__	Provider: Neuropsychiatric Care Center
☐ Respite	__/__/__	Provider:
☐ Intensive In-Home	__/__/__	Provider:
☐ Multisystemic Therapy	__/__/__	Provider:
☐ Substance Abuse Intensive Outpatient	__/__/__	Provider:
☐ Day Treatment	__/__/__	Provider:
☐ Level II Program Type	__/__/__	Provider:
☐ Therapeutic Foster Care	__/__/__	Provider:
☐ PRTF	__/__/__	Provider:
☐ Other Transitional Living	__/__/__	Provider: TBD
☐ Other	__/__/__	Provider:
☐ Other	__/__/__	Provider:

III. The Child and Family Team has engaged the following natural and community supports to both build on the strengths of the recipient and his/her family and meet the identified needs.

Name/Agency [redacted]	Role: Mother	Date: Ongoing
Name/Agency Lisa Morrison	Role: Residential Provider	Date: Ongoing
Name/Agency	Role:	Date: / /
Name/Agency	Role:	Date: / /

IV. Input into the Person-Centered Plan developed by the Child and Family Team was received from the following (Check all that apply):

- [x] Recipient
- [ ] Family/Caregivers
- [ ] Natural Supports
- [ ] Community Supports (e.g. civic & faith based organizations)
- [x] Local Management Entity
- [x] Residential Provider
- [ ] MH/SA TCM Provider
- [ ] Court Counselor
- [ ] School (all those involved)
- [ ] Social Services
- [ ] Medical provider
- [ ] Other

Consumer Name [redacted] Service Record # [redacted]

V. Please explain your plan for transition to new services and supports (i.e. engaging natural and community supports, identification of new providers, visits home or to new residence, transition meetings with new providers, etc.) Who will do what by when?

Activity ResponsibleParty ImplementationDate

Continue Medication Management: Neuropsychiatric Care Center
Continue Individual Therapy - Successful Visions
Continue Group Therapy - Successful Visions
Referral to Transitional Care - Successful Visions

VI. The Child and Family Team updated the Crisis Plan as part of the PCP Revision to include issues of safety at home, at school and in the community.

☐ Yes ☒ No
Please explain: None

VII. For recipients identified as high risk for dangerous or self injurious behaviors the discharge/transition plan includes admission to the appropriate level of care.

☒ Yes ☐ No
Please explain: Boundaries with adults and peers. Client spirals after conversations with mom. He very manipulative and angry with staff and peers.

VIII. The Child and Family Team has identified and addressed the following potential barriers to success of the discharge/transition plan.

[redacted] becomes very agitated we thinks about stepping down from the group home. He stated on many occasions he don't want to live with mom & step dad.

IX. The Child and Family Team will meet again on ___/___/___ in order to follow-up on the discharge/transition plan and address potential barriers.

X Required Signatures

Recipient _____ Date ___/___/___

Legally Responsible Person _____ Date ___/___/___

Qualified Professional [signature] MSW CCSA Date 11/24/21
(Person responsible for the PCP)

☐ I agree with the Child and Family Team recommendation.
☐ I do not agree with the Child and Family Team recommendation.
(*Please note signature below is required by SOC regardless of agreement with recommendation. Signature does not indicate agreement or disagreement of Child and Family Team recommendation, merely review of discharge plan.)

LME SOC/Representative _____ Date ___/___/___
(Required for residential requests only)

Name: [redacted] DOB: [redacted] Medicaid ID: [redacted] Record #: [redacted]

PLAN SIGNATURES

I. PERSON RECEIVING SERVICES:

- [X] I confirm and agree with my involvement in the development of this PCP. My signature means that I agree with the services/supports to be provided.
- [X] I understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for this PCP.
- [ ] For CAP-MR/DD services only, I confirm and understand that I have the choice of seeking care in an intermediate care facility for individuals with mental retardation instead of participating in the Community Alternatives Program for individuals with Mental Retardation/Developmental Disabilities (CAP-MR/DD)

Legally Responsible Person: Self: Yes [ ] No [ ]

Person Receiving Services: (Required when person is his/her own legally responsible person)

Signature: _____ _____ Date: / /
(Print Name)

Legally Responsible Person (Required if other than person receiving Services)

Signature: _____ _____ Date: / /
(Print Name)

Relationship to the Individual: _____

II. PERSON RESPONSIBLE FOR THE PCP: The following signature confirms the responsibility of the QP/LP for the development of this PCP. The signature indicates agreement with the services/supports to be provided.

Signature: [signature] LMSW-LCSW Successful Visions Date: / /
(Person responsible for the PCP) (Name of Case Management Agency)

Child Mental Health Services Only:

For individuals who are less than 21 years of age (less than 18 for State funded services) and who are receiving or in need of enhanced services and who are actively involved with the Department of Juvenile Justice and Delinquency Prevention or the adult criminal court system, the person responsible for the PCP must attest that he or she has completed the following requirements as specified below:

- [ ] Met with the Child and Family Team - Date: / /
- [ ] OR Child and Family Team meeting scheduled for - Date: / /
- [ ] OR Assigned a TASC Care Manager - Date: / /
- [ ] AND conferred with the clinical staff of the applicable LME to conduct care coordination.

If the statements above do not apply, please check the box below and then sign as the Person Responsible for the PCP.

- [ ] This child is not actively involved with the Department of Juvenile Justice and Prevention or the adult criminal court system.

Signature: [signature] LMSW-LCSW Terrence Pearson LMSW-LCSW Date: / /
(Person responsible for the PCP) (Print Name)

III. SERVICE ORDERS: *REQUIRED for all Medicaid funded services; RECOMMENDED for State funded services.*

(SECTION A): For services ordered by one of the Medicaid approved licensed signatories (see Instruction Manual).

My signature below confirms the following: (Check all appropriate boxes.)

- Medical necessity for services requested is present, and constitutes the Service Order(s). [ ] Yes [ ] No
- The licensed professional who signs this service order has had direct contact with the individual. [ ] Yes [ ] No
- The licensed professional who signs this service order has reviewed the individual's assessment. [ ] Yes [ ] No

Signature: _____ _____ License #: _____ Date: / /
(Name/Title Required) (Print Name)

(SECTION B): For Qualified Professionals (QP) / Licensed Professionals (LP) ordering:

- CAP-MR/DD or
- Medicaid Targeted Case Management (TCM) services (if not ordered in Section A) **OR recommended** for any state-funded services not ordered in Section A.

My signature below confirms the following: (Check all appropriate boxes.) Signatory in this section must be a Qualified or Licensed Professional.

- [ ] Medical necessity for the CAP-MR/DD services requested is present, and constitutes the Service Order.
- [ ] Medical necessity for the Medicaid TCM service requested is present, and constitutes the Service Order.
- [ ] Medical necessity for the State-funded service(s) requested is present, and constitutes the Service Order.

Signature: _____ _____ License #: _____ Date: / /
(Name/Title Required) (Print Name) (If Applicable)

IV. SIGNATURES OF OTHER TEAM MEMBERS PARTICIPATING IN DEVELOPMENT OF THE PLAN:

Other Team Member (Name/Relationship): _____ Date: / /

Other Team Member (Name/Relationship): _____ Date: / /

FAX COVER SHEET

TO	NCDHHS
COMPANY	
FAX NUMBER	19197158078
FROM	Lisa Morrison
DATE	2021-12-06 20:01:55 GMT
RE	Successful Visions LLC

COVER MESSAGE

This my be why my License is being held up. I was in Cancun when I faxed it and I'm not sure if it came through. Please let me knoe if this is the issue