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	MHL058-022	A. BUILDING: _____ B. WING _____	R-C 02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMANI RESIDENTIAL/HUMAN SERVICES, INC	105 ROBERSON DRIVE WILLIAMSTON, NC 27892

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on February 2, 2022. The complaint (intake #NC00182325) was substantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents This survey sample consisted of audits of 2 current clients and 1 former client.	V 000	The following measures will be put in place to correct the deficient areas: -V109: A new LP was hired on 1/1/22 to bring agency into compliance. A new QP was selected, application reviewed, education verified, and a thorough interview conducted by the LP and the CCO and hired as of February 1, 2022. To check the competence of the new QP, including the interview, the new QP completed an acceptable mock PCP and transition/discharge plan, was asked real life scenarios and how they would respond, and QP completed a self-assessment which was reviewed by the LP & CCO to ensure that he demonstrated knowledge, skills, abilities, and the competence required to work with Level III consumers. The new QP will supervise both AP's to ensure compliance through supervision contracts, plans, and documentation of supervision. There is a 90-day probationary employment period and then there will be a performance evaluation by the LP to determine ongoing employment of this position. The following measures will be put in place to prevent the problem from happening again: Effective immediately, the new LP that was hired on 1/1/22 will supervise the new QP that was hired on 2/1/22. The LP will provide weekly supervision to QP, APs, and PPs and report to the Director monthly or more if needed to ensure agency compliance, proper treatment planning and updates as needed, competence, compliance, and effective delivery of service. This will be documented accordingly thru the LP's progress notes and other supervision documentation. Treatment plans will be developed by the QP, reviewed by the LP, and updated as necessary and upon any new consistent behaviors of consumer(s). Amani is in the process of integrating a new electronic health record system to assist with ongoing monitoring to ensure treatment plans are updated in a timely manner, address consumer's specific issues/ behaviors, and specific interventions are customized per consumer.	3/15/22
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based	V 109		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Andrea M. Green | Corporate Compliance Officer-QA & QI/Trainer | 2/25/22

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V 109	Continued From page 1 employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 of 1 Owner/Director/Qualified Professional (O/D/QP) demonstrated knowledge, skills and abilities required by the population served. The findings are: Review on 2/2/22 of the O/D/QP's job description dated 12/13/06 revealed: - hire date 2006 - job title: Director - "...participation in treatment planning meetings, coordination of each child or adolescent's treatment plan...basic provision of case management functions..." A. The O/D/QP did not develop or implement FC#3's treatment plan: Refer to V112 regarding a client's treatment plan in the development of goals and implementation: - FC#3 was admitted in July 2021 with a history of elopement and criminal behaviors	V 109		

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V 109	Continued From page 2 - FC#3 continued elopement with criminal behaviors during his time at the facility - no goals or strategies were developed or implemented to address his elopement behaviors & criminal history During interview on 2/1/22 the O/D/QP reported: - he was responsible for the development, revision & implementation of FC#3's treatment plan B. The O/D/QP failed to ensure physician's orders were obtained for medications at the facility: Refer to V118 regarding details of medications being administered without physician's orders: - clients #1 & #2 were admitted in June 2021 - physician's orders were not obtained until July 2021 During interview on 2/2/22 the O/D/QP reported: - he was responsible for ensuring physician orders were obtained for medications C. The O/D/QP failed to ensure 6 month drug regimen reviews were completed: Refer to V121 regarding psychotropic drug regimen reviews - clients #1 & #2 were admitted June 2021 - both were on psychotropic medications - drug regimen reviews were not completed until 1/26/22 During interview on 2/1/22 the O/D/QP reported: - he was responsible for drug regimen reviews being completed within 6 month time frames This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V293) for a Type A1	V 109		

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V 109	Continued From page 3 rule violation and must be corrected within 23 days.	V 109		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by:	V 112	The following measures will be put in place to correct the deficient areas: Amani's new QP will demonstrate competence by appropriately developing the treatment plan within 30 days of admission of a new consumer based on the assessment. The treatment plan will be updated monthly and changes will be made as necessary as well as anytime a client is having consistent behaviors. The following measures will be put in place to prevent the problem from happening again: The LP will monitor this process to ensure the integration of an electronic health record system with ongoing monitoring to ensure treatment planning is updated and appropriate to address consumer's issues and behaviors.	3/15/22

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V 112	Continued From page 4 Based on observation, record review and interview the facility failed to develop and implement goals & strategies to meet the needs for 1 of 1 former client (FC#3). The findings are: Review on 1/21/22 of FC#3's record revealed: - admitted 7/14/21 & discharged 1/14/22 - age 16 - diagnosis Post Traumatic Stress Disorder Review on 1/21/22 of FC#3's treatment plan dated 5/3/21 revealed: - updated on 6/30/21 & 9/10/21 - signed by the Owner/Director/Qualified Professional (O/D/QP) & the Department of Social Services (DSS) guardian - goals: decrease frequency of verbal and physically aggressive behavior, identify triggers of anxiety, stress, overwhelming feelings & be accountable for his actions by improving coping skills - crisis plan: "[FC#3] has a history of stealing and elopements. He has felony charges in [county of facility] & extensive criminal history in [nearby county] as a juvenile" - no goals or strategies to address elopement or stealing behaviors Review on 1/20/22 of the Incident Response Improvement System (IRIS) for FC#3 revealed: - "7/27/21...slipped out of his (FC#3) room window around 6am in the morning and was not reported missing by staff during the room checks ...road a bicycle to a local store and stole a cash app card from a lady...purchased food and returned to the facility undiscovered. The police came to the facility stating that the consumer was on camera making a purchase. The incident was investigated and the consumer denied ....staff was questioned and they stated that were making	V 112		

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V 112	Continued From page 5 15 minute checks and it appeared through the crack in his door that he was present ...consumer stated that one staff was asleep and the other awake...cameras were reserviced and reprogrammed ...sensors were placed on the consumers windows to avoid elopement ..." (on duty staff #2 & FS#5(Former staff #5) - "9/30/21 - (no time documented)...deceived residential staff by placing his clothing under his covers so that it would appear that he was in his bed. When staff did regular bed checks saw what they thought was him in bed ...broke the window alarms and went out of the window ...went to the bathroom and locked the door so it would appear he was taking a long bowel movement ...was seen by police and brought back to the facility because they knew that he was a resident at Amani..." (on duty staff #1 & staff #2) - "11/7/21 - 12:30am...slipped out of his bedroom window by deceiving the residential staff by placing his laundry and pillows to resemble himself and disarming the window alarms. When staff performed their regular 15 minutes checks they discovered that he was missing and called police ...was apprehended and brought back to the residential facility ...returned hour in half later ..." (on duty staff #1 & staff #3) Review on 1/26/22 of the facility's sleep log documented by staff revealed: - A (awake) & S (sleep) - 15 minute intervals - 7/27/21 - no documentation of a sleep log - 9/30/21 - 11pm - 1:30am a line drawn through A & from 1:45am - 7am line drawn through S - 11/7/21 - no documentation from 11pm - 2:45am (documented "ran away") & from 3am - 7am line drawn through A	V 112		

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V 112	Continued From page 6 Review on 1/26/22 of a police incident/investigation report in FC#3's record revealed: - "on 7/27/21 at approximately 6:35am arrived at [local store] in reference to a vehicle breaking and entering...made contact with the victim. She informed us that someone went into her car and stole items from it..." - "9/14/21 - charges dismissed...the juvenile will be responsible for $500.00 restitution" Review on 1/27/22 of Google maps revealed the following: - the local store was 11 minutes walking & 3 minutes by bike - the local restaurant was 28 minutes walking & 9 minutes by bike Observation & interview on 1/20/22 of a tour of the facility given by the AP (Associate Professional) between 10:58am - 11:16am revealed: - each current clients' bedroom windows were lifted which caused an alarm to sound - however, an empty bedroom identified as FC#3's bedroom, caused no sound when the window was lifted - cameras were identified in the kitchen, in the hallway near FC#3's bedroom, den area (television room) & outside of the facility During interview on 1/20/22 the AP reported: - he needed to look into why the alarm in FC#3's bedroom did not sound - all cameras had been offline for the last 2 - 3 weeks - the cameras worked by WiFi and the O/D/QP turned the WiFi off due to the clients' behaviors - the clients played games that used the	V 112		

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V 112	Continued From page 7 facility's WiFi During interview on 1/20/22 client #1 reported: - staff were supposed to do 15 minute checks at night - he does not sleep much at night - staff did not come into his bedroom at night During interview on 1/20/22 client #2 reported: - admitted June 2021 - he used to be in FC#3's bedroom prior to FC#3's admission - the window alarm did not work when he was in that bedroom During interview on 1/27/22 staff #1 reported: - been at the facility since 2009 - work 3rd shift (12am-8am) - job duties: ensured clients were in bed, documented notes, prepped the next day meal, reviewed treatment plans, ensured house was clean & 15 minute checks of the clients - FC#3 had eloped on her shift - she worked during the September 2021 & November 2021 incidents - it happened so long ago, she may mix up the incidents - recalled she worked with staff #3 on one of the shifts. The clients were asleep when they arrived on third shift. Staff #3 was new & she reviewed the clients' books & their job duties. They were in the kitchen area. FC#3 said he needed to go to the bathroom. She heard him return to his bedroom. A few minutes later she went to check on him. He was there and she returned to review the clients' books with staff #3. Fifteen minutes later she looked through his door and assumed he was in bed. Something told her to go back & enter the bedroom. He made up his bed like he was in it. She called the police. She	V 112		

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V 112	Continued From page 8 was not sure if that was the same night or during another incident he went to a local restaurant 2 miles away to get a sandwich. The police returned him to the facility both times. - not sure how long the sensors on FC#3's window did not work - she does not check the windows to test the sensors - unsure of how long the cameras in the facility didn't work - after FC#3's elopements, management instructed staff to continue the 15 minute checks & look for movement when clients were in bed During interview on 1/27/22 staff #2 reported: - began May 2021 - job duties: monitor clients, cook & document notes - worked third shift - during the July 2021 incident, she came in and completed room checks. She sat in the den area and FS#5 was in the hall area - 3:30am she prepped food for the next day - next shift came in at 8am & they exchanged notes - FS#5 was not aware nor was she aware FC#3 eloped from the facility on their shift - within 30 minutes - hour after she left the facility, she was informed FC#3 had eloped - was not aware of a time he could have eloped from the facility - was told he eloped through a window, she assumed his bedroom window - there were alarms on the bedroom windows, so not sure what happened - the AP & O/D/QP tested windows and the bedroom alarms & the alarm could be heard throughout the facility - the cameras in the facility did not work - never saw a bicycle at the facility, FS#5	V 112		

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V 112	Continued From page 9	V 112		

mentioned something about she saw a bicycle in the woods near the facility.
- FS#5 quit after the July 2021 incident. $80.00 was stolen from her vehicle the same night as the 7/27/21 incident
- after the incident the AP & O/D/QP requested the clients' bedroom doors be left opened & look for a body part. Staff "basically" already did that
- not aware of any other strategies to address FC#3's elopements

During interview on 1/27/22 staff #3 reported:
- been at the facility 2 1/2 months
- worked third shift
- job duties: checked clients every 15 minutes, documented notes & cleaned the facility
- FC#3 eloped one time on his shift
- he and staff #1 were on shift together
- eloped during the November 2021 incident
- the night he left, staff #1 had reviewed the clients' records with him
- staff #1 thought she saw FC#3 in his bed
- FC#3 went out his bedroom window
- the police were called & FC#3 was located at a local restaurant about a mile from the facility
- he was unsure of how he got to the local restaurant
- 15 minute checks were completed during the November 2021 incident
- his 15 minute checks consisted of: a knock on the clients' bedroom door, call their name, shine a light & look for a hand or foot
- the AP instructed him to keep the bedroom door cracked, look for a body part & check on clients every 15 minutes or more to ensure clients were in bed
- was not sure if alarms were on the clients' bedroom windows
- the cameras did not work when he started at the facility

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V 112	Continued From page 10 During interview on 1/28/22 staff #4 reported: - Worked varying hours at the facility - been there since 2012 - FC#3 walked down the road one time on his shift - couldn't recall when - the clients played football on the side of the facility near a wooded area. He & another staff were nearby in the yard. He went over to check on the clients and observed FC#3 down the road. FC#3 returned to the facility after his request - FC#3 left so long ago he could not recall all his goals - after he was reminded FC#3 left this month (January 2022), he did not recall any goals about elopement or stealing behaviors - management informed them during 15 minute checks to go in the clients' bedrooms and look for a head - all clients' bedrooms had window alarms - during the deep cleaning of the facility he tested the window alarms - the cameras worked at the facility During interview on 1/25/22 the Health Care Personnel Registry representative reported: - she visited the facility in October 2021: - was informed the cameras were offline - FC#3 had a history of elopements - nothing in the treatment plan to address his elopements - the O/D/QP could not explain why there were no strategies to address FC#3's elopements During interview on 1/28/22 the Local Management Entity/Managed Care Coordinator (LME/MCO) for FC#3 reported: - was not involved in the completion of FC#3's treatment plan	V 112		

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V 112	Continued From page 11 - the O/D/QP completed FC#3's treatment plan - was aware of FC#3's elopement behaviors while at the facility - prior to his admission, she mentioned multiple times to the O/D/QP about his elopement behaviors - "elopements are a huge safety issue" - does not recall any goals or strategies being put in place to address elopements - the facility does not have to contact the Care Coordinator to revise the treatment plan - an emergency child & family team meeting (CFT) could be called by the O/D/QP During interview on 1/28/22 FC#3's guardian with the Department of Social Services reported: - was aware of FC#3's elopements from the facility - eloped at least 3 times - aware he stole a cash card and used it at a local store - management informed her the sensors on FC#3's window did not work properly - did not recall if FC#3's elopements or stealing behaviors were included in the CFT meetings - a meeting was held October 2021 but it was a discharge meeting for FC#3 - no concerns about his care while at the facility During interview on 2/1/22 the AP reported: - been at the facility for 13 years - worked first shift Monday - Friday or as needed - job duties: reviewed plans with the clients & staff, planned activities and ensured clients attended physician appointments - there were no goals in the treatment plan for FC#3's elopement & stealing behaviors - the O/D/QP incorporated goals into the	V 112		

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V 112	Continued From page 12 treatment plans - he & staff worked with FC#3 in regards to aggression and disruptive behaviors - on third shift, one staff was to sit in the hallway & the other in the kitchen area to monitor the clients - during the 15 minute checks, staff were to look for hair or skin of the clients - there was no excuse for a client to elope from his bedroom window and return without staff knowledge - the 15 minute checks were not completed due to the number of elopements - the sensors on all the clients' bedroom windows worked because he tested them monthly - FC#3 must have tampered with his prior to discharge - the DSS social worker went on vacation after FC#3's admission & when he returned, he was moved to another department. - a CFT was not held until several months later. During interview on 2/1/22 the O/D/QP reported: - was at the facility 10 hours a week and visited during the weekend - spoke with the AP daily about any concerns at the facility - spoke with the clients about any behaviors, school & if there were any transitions to a new facility - FC#3 would deceive third shift by placing items in his bed to resemble him - sensors were placed on the windows after the July 2021 incident - FC#3 would break the sensors off the window - staff were required to complete 15 minute checks & check for the clients' skin and breathing - apparently staff did not check for skin or breathing due to FC#3's elopements	V 112		

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V 112	Continued From page 13 - prior to admission, he was not aware of FC#3's elopement & criminal history - the DSS social worker informed him about the elopements & stealing history after the July 2021 incident - he thought with the sensors on the bedroom window and staff at his bedroom door would prevent the elopements - he (O/D/QP) checked the window sensors but was not sure how often - the cameras worked by WiFi and he removed the WiFi because the clients played unhealthy games - could not recall when the WiFi was removed which caused the cameras to be inoperable - he emailed the DSS social worker several times about FC#3's elopements from the facility - was not able to locate the emails - spoke often with FC#3's Care Coordinator about his behaviors - she recommenced the 1:1, but the paperwork was difficult to understand - was not sure if he followed back up with the Care Coordinator about the 1:1 referral - he (O/D/QP) was responsible for updating the treatment plans - the September 2021 treatment plan update was to discuss FC#3's discharge Attempted telephone calls were made to FS#5 on 1/25/22 & 1/27/22...no return phone calls This deficiency constitutes a re-cited deficiency. This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 112		

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V 118	Continued From page 14	V 118		
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. (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:	V 118	The following measures will be put in place to correct the deficient areas: Medications will not be administered without a doctor's order; The Intake packet will be revised and completed prior to acceptance and all forms including doctor's orders will be received prior to the consumer physically coming to the facility. The following measures will be put in place to prevent the problem from happening again: Amani will implement a systematic approach by the CCO designing an intake check off list of all forms required for the QP to complete during the intake, screening and admission process. This checkoff list will include the checkoff for signed doctor's orders. This will be verified and signed off by the LP and/or CCO prior to physically accepting the consumer.	3/15/22

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V 118	Continued From page 15 Based on record review and interview the facility failed to administer medications on the written order of a physician for 2 of 2 audited clients (#1 & #2). The findings are: A. Review on 1/20/22 of client #1's record revealed: - admitted 6/9/21 - age 14 - diagnoses of Post Traumatic Stress Disorder and Attention Deficit Hyperactivity Disorder (ADHD) - physician's orders dated 7/9/21: - Buspar 10mg (milligrams) twice a day (anxiety) - Trazodone 100mg bedtime (depression) - Abilify 5 mg daily (depression) Review on 1/26/22 of client #1's June 2021 & July 2021 MARs revealed: - staff signatures were documented from 6/10/21 - 7/8/21 to indicate medications were given B. Review on 1/20/22 of client #2's record revealed: - admitted: 6/29/21 - age 13 - Disruptive Mood Disorder, Intermittent Explosive Disorder & ADHD - physician's orders dated 7/29/21: - Depakote 500mg morning (bipolar) - Seroquel 4mg morning (bipolar) - Seroquel 100mg as needed Review on 1/26/22 of client #2's June & July 2021 MARs revealed: - staff signatures were documented from 6/30/21 - 7/28/21 to indicate medications were given	V 118		

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V 118	Continued From page 16 During interview on 1/26/22 the Owner/Director/Professional reported: - both clients came with only their medications - no reasons for physician orders not being obtained - he was responsible for ensuring there were physician orders for medications This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 118		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 6 month drug regimen reviews were completed for 2 of 2 audited clients (#1 &	V 121	The following measures will be put in place to correct the deficient areas: The Pharmacy Reviews will be completed by the AP and then the QP will verified who is the supervisor every 6 months per the standard. A pharmacy review form has been adopted and will be implemented in Amani Policy & Procedures by the CCO. The following measures will be put in place to precent the problem from happening again: This form will be placed at the front of the MAR by the AP so that it can be accessible when it's due. This form will be checked on Monday of the last week of the 5th month by the AP-to be reminded of this date thru google calendar, taken to the Pharmacist for completion, signed, and put back into the MAR book for review by the AP and verified by the QP who will be implementing this	3/15/22

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V 121	Continued From page 17 #2). The findings are: A. Review on 1/20/22 of client #1's record revealed: - admitted 6/9/21 - age 14 - diagnoses of Post Traumatic Stress Disorder and Attention Deficit Hyperactivity Disorder (ADHD) - physician's orders dated 7/9/21: - Buspar 10mg (milligrams) twice a day (anxiety) - Trazodone 100mg bedtime (depression) - Abilify 5 mg daily (depression) - no documentation of a 6 month drug regimen review Review on 1/26/21 of client #1's June 2021 & July 2021 MARs revealed: - staff signatures were documented from 6/10/21 - 7/8/21 to indicate medications were given B. Review on 1/20/22 of client #2's record revealed: - admitted: 6/29/21 - age 13 - Disruptive Mood Disorder, Intermittent Explosive Disorder & ADHD - physician orders dated 7/29/21: - Depakote 500mg morning (bipolar) - Seroquel 4mg morning (bipolar) - Seroquel 100mg as needed - no documentation of a 6 month drug regimen review Review on 1/26/22 of client #2's June & July 2021 MARs revealed: - staff signatures were documented from 6/30/21 - 7/28/21 to indicate medications were	V 121		

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V 121	Continued From page 18 given During interview on 1/20/22 the Associate Professional (AP) reported: - there were no drug regimen reviews completed - were not able to print their drug regimen review form for the pharmacy to complete - spoke with the facility's corporate compliance representative and she will print the form During interview on 1/26/22 the Director/Owner/Qualified Professional reported: - was not able to obtain drug regimen reviews due to the pandemic - he ensured the AP had drug regimen reviews completed Review on 1/26/22 of a drug regimen review dated 1/26/22 revealed: - a pharmacist completed 6 month drug regimen reviews for client #1 & #2 This deficiency constitutes a re-cited deficiency. This deficiency is cross referenced into 10A NCAC 27G .1701 SCOPE (V293) for a Type A1 rule violation and must be corrected within 23 days.	V 121		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual	V 293		

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V 293	Continued From page 19 who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.	V 293	The following measures will be put in place to correct the deficient areas: Amani's LP, QP, AP and CCO met on Feb. 1st to discuss a more detailed review of this citation and how we can become more effective and correct these issues. Amani's CCO conducted an in-service training on Thursday, February 3, 2022 which included the Scope, Service Definition, Role of Supervision as it pertains to staff and consumers, the Plan of Protection, protocol, interventions, documentation, elopement prevention, reporting and the changes that will be implemented moving forward. Next training for updates will be 3/10/2022. The following measures will be put in place to prevent the problem from happening again: Supervision of staff and consumers will be monitored more closely, especially on 3rd shift, by conducting random, unannounced visits/checks by AP/QP and documenting properly in supervision plans/progress notes. Amani will become more compliant and more engaged with the MCO on trainings and coordination of monthly meetings. This will be monitored by the LP, new QP, and CCO. Amani is resetting its organization, staffing, and systems to be able to provide better care to its consumers. All changes made to become compliant to these deficiencies will be updated in Amani's policy and procedures manual for a systematic change. Staff will continue to be trained bi-monthly on relevant topics to continue professional development and supervised accordingly. The management team-Director, LP, QP, AP, CFO and CCO will monitor and conduct QA/QI meetings with minute meeting notes on 2/1/22, 2/6/22, 2/9/22, 3/1/22 and weekly thereafter until April 1, 2022, then quarterly unless otherwise necessary.	3/15/22

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This Rule is not met as evidenced by:
Based on observation, record review and interview the facility failed to provide supervision, structure of daily living and failed to coordinate with other agencies within the adolescent's system of care for 2 of 2 audited current clients (#1 & #2) and 1 of 1 former client (FC#3). The findings are:

A. Cross-reference: 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (V109). Based on record review and interview the facility failed to ensure 1 of 1 Owner/Director/Qualified Professional (O/D/QP) demonstrated knowledge, skills and abilities required by the population served.

B. Cross-reference: 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (V112). Based on observation, record review and interview the facility failed to develop and implement goals & strategies to meet the needs for 1 of 1 former client (FC#3).

C. Cross-reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (V118). Based on record review and interview the facility failed to administer medications on the written order of a physician for 2 of 2 audited clients (#1 & #2).

D. Cross-reference: 10A NCAC 27G .0209

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V 293	Continued From page 21 MEDICATION REQUIREMENTS (V121). Based on record review and interview the facility failed to ensure 6 month drug regimen reviews were completed for 2 of 2 audited clients (#1 & #2). The following are examples of how staff failed to provide supervision: E. Review on 1/26/22 of the facility's governing body policy revealed: "...staff are awake during sleep hours and supervision is continuous..." During interview on 1/26/22 client #1 reported: - got up 3 - 4 times during the night to use the bathroom - witnessed staff asleep - will see one staff asleep in a chair in the hallway & the other asleep in a chair in the den area - did not attempt to wake the staff but returned to his bedroom - couldn't recall how often this happened During interview on 1/27/22 client #2 reported: - one time he saw a staff asleep in the chair that was in the hallway and one time a staff was asleep in the chair in the den area - does not wake the staff but return to bed During interview on 1/27/22 staff #1 reported: - worked third shift (12am - 8am) - 2 staff on duty - staff monitored clients by one staff in a chair in the hallway & the other in the den area near another client's bedroom - to be honest "I doze off a few minutes not hours...get plenty of sleep at home" During interview on 1/27/22 staff #2 reported: - worked third shift at the facility	V 293		

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V 293	Continued From page 22 - 2 awake staff sat at 2 different locations in the facility - her eyes may close "a time or two" but does not fall asleep - she completed puzzles, would draw in a tablet or played games on her phone to keep awake During interview on 1/28/22 staff #4 reported: - his work hours varied but does not work third shift - third shift was not supposed to sleep on duty - the clients had to be monitored 24 hours During interview on 2/1/22 the Associate Professional (AP) reported: - "does not encourage staff to sleep on duty" - "the two staff on duty needed to work it out if one felt sleepy" - "they could switch chairs if they were sleepy" - he was not aware of any staff that dozed off or felt sleepy on third shift During interview on 2/1/22 the O/D/QP reported: - the State rule allowed one staff to sleep and the other to remain awake - as a precaution, he request his staff to remain awake to avoid elopements The following is an example of how the O/D/QP failed to coordinate with the Local Management Entity/Managed Care Organization (LME/MCO): F. During interview on 1/28/22 the Care Coordinator for FC#3 reported: - the O/D/QP was a difficult provider to schedule meetings with - she would reach out to the O/D/QP to inquire about a monthly meeting for FC#3 & he would agree to schedule the meeting but it would not	V 293		

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happen
- sent him an application to apply for additional funding for a 1:1 for FC#3
- the 1:1 could have helped prevent the elopements
- the paperwork was difficult to complete but providers could reach out to the LME/MCO network for assistance
- she did not hear back from the O/D/QP in regards to the 1:1

During interview on 2/1/22 the O/D/QP reported:
- attended the monthly Child & Family Team meetings
- spoke often with FC#3's Care Coordinator about his elopement behaviors
- recommended a 1:1 for FC#3
- he did not understand the paperwork and was not sure if he followed back up with the Care Coordinator

Review on 2/1/22 of the Plan of Protection completed by the Corporate Compliance Officer (CCO) & Licensed Professional (LP) dated 2/1/22 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Starting today, Amani and its staff will immediately start working on correcting V293-Scope of Practice. Amani's LP, QP, AP, and CCO will meet today to discuss a more detailed review of this citation and how we can become more effective and correct these issues. Amani will begin this process by scheduling and conducting an inservice training on Thursday, February 3, 2022 which will include the Scope, Service Definition, Role of Supervision as it pertains to staff and consumers. Supervision of staff and consumers will be monitored more closely, especially on third shift, by the AP/QP and documented properly. Amani will become

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more compliant and more engaged with the MCO on trainings and coordination of monthly meetings. This will be monitored by the LP, new QP and CCO.

V121 - Drug Regimen - the pharmacy reviews will be completed every 6 months per the standard. A pharmacy review form has been adopted and will be implemented in Amani Policy & Procedures. This form will also be attached to the MAR so that it can be accessible when it's due. This form will be checked on Monday of the last week of the 5th (fifth) month, taken to the Pharmacist for completion, signed and put back in the MAR book for review.

V118 - Medications will not be administered without a doctor's order; intake packet will be completed prior to acceptance and all forms including doctor's orders will be received prior to the consumer physically coming to the facility. Proof of this will be evident by completing a checkoff list of all the paperwork required including the signed doctor's orders. This will be verified by the LP and/or CCO prior to physically accepting the consumer.

V112 - Treatment planning - Amani will initiate hiring another competent QP asap (as soon as possible) to help with the treatment planning process. The treatment plan will be updated monthly and changes will be made as necessary as well as anytime a client is having consistent behaviors. Amani will integrate an electronic health record system to assist with ongoing monitoring to ensure treatment planning is updated and appropriate to address consumers issues and behaviors.

V109 - QP Competency - A new competent QP

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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 293	Continued From page 25	V 293		

will be hired asap. The LP will monitor the hiring process and supervise the new QP as required to ensure compliance and effective delivery of service."

FC#3 was admitted to the facility in July 2021 with a diagnosis of Post Traumatic Stress Disorder & an extensive history of elopements and criminal behaviors. He eloped from his bedroom window in July 2021, September 2021 and November 2021 during third shift. During the July 2021 incident, FC#3 went to a local store a half a mile from the facility and stole a person's cash app card & made purchases at the local store. Staff were not aware he had eloped from the facility until a police officer showed camera footage of FC#3 making purchases at the local store. Charges were pressed against FC#3 and he was responsible for $500.00 in restitution. During the tour of the facility, each clients' bedroom windows had alarms that sounded when lifted with the exception of FC#3's bedroom window. The facility had cameras, however, staff were unsure of how long they had been inoperable. A treatment plan dated 5/3/21, with updates on 6/30/21 & 9/10/21 had no goals or strategies to address FC#3's elopements and criminal behaviors. Even though the facility's policy required staff to remain awake, clients had witnessed staff asleep on third shift. Staff admitted at times they would doze off. The Care Coordinator said monthly meetings for FC#3 were supposed to be held but the O/D/QP failed to schedule them. She also attempted to get FC#3 a 1:1 but the O/D/QP did not follow through with the paperwork. Client #1 & #2 were admitted to the facility in June 2021 with diagnoses of Disruptive Mood Disorder, Intermittent Explosive Disorder & Attention Deficit Hyperactivity Disorder. Medications were given to client #1 &

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL058-022	A. BUILDING: _____ B. WING _____	R-C 02/02/2022

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V 293	Continued From page 26 #2 in June & July without a physician's order. Both were on psychotropic medications, however, 6 month drug regimen reviews were not completed until 1/26/22. Due to the systemic failures of the facility, this deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 293		