STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-379	A. BUILDING: _____ B. WING _____	R 03/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMPBELL HOME	201 TACOMA CIRCLE ASHEVILLE, NC 28801

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 3/7/22. The complaint was substantiated (intake #NC00184979). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living. This facility is licensed for 3 beds and currently has a census of 2. The survey sample consisted of audits of 2 current clients and 1 former client.	V 000		
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 1	V 112		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to develop and implement, goals and strategies to meet the treatment needs for 1 of 1 former clients (Former Client #3). The findings are:

Cross Reference: 10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers (V366). Based on record reviews and interviews, the facility failed to attend to the health and safety needs of individuals, determine the cause of the incident and develop and implement corrective measures affecting 1 of 1 former clients (Former Client #3).

Cross Reference: 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367). Based on record reviews and interviews, the facility failed to ensure all Level II incidents were reported to the Local Management Organization (LME) responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident affecting 1 of 1 former clients (Former Client #3).

Review on 2/22/22 of Former Client (FC) #3's record revealed:
-admitted on 7/18/14
-discharged on 12/20/21
-notice of discharge to guardian on 10/22/21

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V 112	Continued From page 2 -diagnoses of Moderate Intellectual/Developmental Disability (IDD), Attention Deficit Hyperactivity Disorder (d/o), combined type; Unspecified Cerebral Palsy, Autistic d/o, Oppositional Defiant d/o, Epilepsy, unspecified, not retractable -monthly notes written by the QP for FC #3 included: --6/15/21- "inappropriate behavior has been sporadic at times" even with medication change but medication change has been helpful --7/14/21-this was a duplicate of the 6/15/21 note --8/13/21-FC #3 "continues to act out at school and assaulting people"; most of the assaults occur at school --9/15/21-FC #3 was discharged from the day program, "reportedly consumer did 30,000 worth of damage to the property"; Local Management Entity/Managed Care Organization (LME/MCO) and "provider are working diligently to find new placement"; FC #3 "demonstrating 4 nights of OCD (Obsessive Compulsive Disorder) putting on layers of clothes, took sheets off bed and taking bed apart and screaming he needs help." --10/12/21- "consumer was beating and kicking on door when QP arrived ....provider states that client has been that way since she got home"; "provider reports she is documenting all consumer's incidents in the placement" --11/14/21- FC #3 continues to demonstrate behaviors in the placement, "damages property in the home, tore the toilet seats off commode, steals food out of the kitchen" FC #3's last day is 12/22/21. Review on 2/22/22 and 2/28/22 of FC #3's treatment plan goals effective 7/1/21 revealed: 1. "[FC #3] will practice his coping skills daily when he becomes stressed, upset, anxious, or agitated with 2 or fewer verbal/gestural or	V 112		

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V 112	Continued From page 3 modeling prompts per event for 10 of 30 days per month for the duration of the plan year" Support/intervention: "AFL (Alternative Family Living) staff will provide needed assistance for client to be able to practice his coping skills when there are unexpected changes to his schedule or situation or he becomes upset or agitated. Coping skills that have been effective for [FC #3] include but are not limited to -closing eyes and taking ten deep breaths, counting out loud, playing with his number cards, taking a walk with staff, reading his map book, and playing with his tablet (Kindle)" 2. "[FC #3] will exhibit appropriate behavior and social skills daily while in the home and in the community with 3 or fewer verbal prompts per event for 15 of 30 days per month for the duration of the plan year" Support/Intervention: "AFL staff will provide training and instruction for [FC #3] to learn and exhibit appropriate behavior and social skills while at home and in the community. Training will be provided through role playing, anticipatory guidance, modeling and gentle counseling. Appropriate behaviors and social skills to be taught and encouraged include but are not limited to: keeping hands and feet to self, respecting the property of others, giving eye contact when interacting with others, refraining from cursing, refraining from inappropriate teasing and practical jokes. AFL staff will provide praise and encouragement for [FC #3's] efforts to exhibit social skills and behavior." -new goals and strategies were not developed to address ongoing behaviors of verbal and physical aggression, agitation, and property destruction despite the increased intensity and frequency since the 7/1/21 treatment plan effective date.	V 112		

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V 112	Continued From page 4 Review on 2/25/22 and 2/28/22 of the summary of incidents documented on a spreadsheet by Staff #1 and Staff #2 revealed: -FC #3's behavior from 10/6/21 through 12/14/21 was recorded on this spreadsheet -there were 41 entries between 10/6/21-12/14/21 documenting FC #3's behavior under the column heading "description of situation" which included: -29 incidents of verbal aggression -27 incidents of "physical aggression towards self" described as "dropping to knees, scratching/hitting self"; FC #3 scratched his arm, nose, or chest, and scratched his arm on a window blind panel -20 incidents of property damage which included breaking a light cover, smacking the walls and kicking the door for 1.75 hours, kicked bedroom door consistently for hours/pictures fell off the wall, slamming doors, smacking the car door and windows, knocked pictures off the wall, throwing things, hitting bathroom window/broke bathroom window blinds, hitting bedroom window and door/broke the bottom panel of bedroom door, scratching walls in hall and bedroom, hitting the car window and pulling at seat while in moving car, beating on bedroom door, pushed out the bathroom screen and threw things out of the window, jumping on bed on and off for 5 hours, broke the box spring and bed again, broke toilet seat off toilet, kicked foot board off his bed -14 incidents of physical aggression which were described as "hitting/kicking others" -6 incidents occurred in one day on 10/11/21 -7 incidents occurred in one day on 10/12/21 -the strategies under the column heading "action of staff during incident" utilized to address FC #3's behavior included verbal prompts, remove breakable items, redirection, remove the audience, breathing techniques, safe space to calm down and time	V 112		

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V 112	Continued From page 5 -follow-up response by staff included: reviewed expectations, discussed expectations/consequences, processed behaviors, discussed replacement behaviors, reviewed goals and choices, and planned ignoring/1 prompt directive -there were 8 incidents that included a time frame for FC #3's behavior which ranged from 2 hours to "majority of the day" -the QP initialed, dated and reviewed the spreadsheet on 10/19/21, 11/21/21, and 1/6/22; the QP made notes on each entry which included "incident handled appropriately, appropriate action taken, processed and handle incident appropriately, or occurrence handled appropriately." Interviews on 2/23/22 and 2/28/22 with the QP revealed: -she completed monthly QP notes and submitted the notes to the Licensee -she participated in goal plan meetings; the last annual treatment plan meeting was June 2021 -she met with Staff #1 and Staff #2 monthly; Staff #1 called her outside of their monthly meeting if she had questions or needed assistance with FC #3 -she did impromptu visits to the facility; she noticed holes in the walls due to FC #3's behavior -FC #3's behaviors escalated and he was hitting walls, doors and was assaultive to workers; behaviors occurred at the facility and the day program -Staff #1 called the Licensee office to alert them of behaviors or if Staff #1 needed guidance in addressing FC #3's behaviors -she thinks FC #3 had the same 1:1 worker after he was discharged from the day program and she is not sure if the worker tried to come up with new strategies to address FC #3's behavior	V 112		

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V 112	Continued From page 6 -"never knew what was getting him (FC #3) escalated"; no one needed first aid that she knew of when FC #3 was aggressive towards himself or others -she reviewed the spreadsheet documenting behaviors when Staff #1 sent it to her and then she forwarded it to the Program Director -FC #3's "behavior was every hour on the hour" -she thought FC #3 needed a higher level of care -she did not change the goals and strategies on FC #3's treatment plan after the June 2021 meeting despite the ongoing behaviors. Review on 3/4/22 of an email written on 3/3/22 by the President of the Company in response to the Division of Health Service Regulation (DHSR) surveyor's question to clarify who was responsible for updating the goal plan revealed: -"The Team meets annually and during the year if there is an update to the ISP (Individual Support Plan). The QP, Guardian, Complex Care Manager, any other providers that need to also meet with the Team. Needs are discussed at the meeting and the QP writes the short term goals to address the needs. If the QP assigned to the particular member is not available at the time of this meeting, [Program Director] will make herself available to meet during this time." Interview on 3/1/22 and 3/2/22 with the Local Management Entity/Managed Care Organization (LME/MCO) Care Manager (CM) revealed: -FC #3's behavior was "cyclical" and Staff #1 and Staff #2 "knew what worked and what didn't work" -there was an annual treatment team meeting in June 2021 to update the treatment plan -there were additional meetings to address FC #3's behavior but new goal and strategies were not added to the the treatment plan to address the ongoing escalating behaviors.	V 112		

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V 112	Continued From page 7 -she was not getting written documentation of FC #3's behavior which impacted her ability to ask for additional services -there was a lot of phone discussion with Staff #1 and #2 and FC #3's mother but there was not a written update to the goal plan -Staff #1 and Staff #2 completed monthly notes and sent the notes to the QP but she wasn't getting any written documentation. Review on 3/4/22 of the Plan of Protection dated 3/4/22 by the Program Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? 1. The Treatment Team will identify the unsafe behaviors that are happening, included in this meeting will be the QP, Staff, Behavior Plan Specialist, Complex Care Manager and the Guardian. 2. The Treatment Team will hold an emergency meeting to address the urgency of the individual's needs. 3. Discuss what the strategies that are not working and try to implement new strategies to try to reduce behavioral episodes. 4. The Treatment Team will update the short team goals in the treatment plan and develop strategies and interventions to lessen and/or respond to an unsafe/crisis situation. 5. The Treatment Team will also discuss the setting or situations where the behaviors are likely to occur. 6. The Team will develop a safety plan to insure the safety of the individual served and other individuals. 7. Make sure the treatment plan includes access to North Carolina Start or a local respite facility to change the scene of inappropriate behaviors for a	V 112		

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V 112	Continued From page 8 de-escalation period. Describe your plans to make sure the above happens. The QP and facility staff will follow their training to report incident reports in a timely manner using the appropriate forms. Summerland Homes (Licensee) will be responsible for contacting all individuals above with time of meeting, place of meeting (virtual or in person) to put the above plan into action to provide the plan of protection for the individual served and others involved." Review on 3/4/22 of the revised Plan of Protection dated 3/4/22 written by the Program Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? I. The Treatment Team will identify the unsafe behaviors that are happening, included in this meeting will be the QP, Staff, Behavior Plan Specialist, Complex Care Manager and the Guardian. 2. The Treatment Team will hold an emergency meeting to address the urgency of the individual's needs. The timeframe for this meeting will be within 3-7 days based on urgency of the client's needs. 3. Discuss what the strategies that are not working and try to implement new strategies to try to reduce behavioral episodes. 4. The agency's QP on the Treatment Team will update the short team goals in the treatment plan and develop strategies and interventions to lessen and/or respond to an unsafe/crisis situation.	V 112		

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V 112	Continued From page 9 5. The Treatment Team will also discuss the setting or situations where the behaviors are likely to occur. 6. The Team will develop a safety plan to insure the safety of the individual served and other individuals. The team will review the safety plan in 30 days or what the team would consider necessary based on the client's needs. 7. Make sure the treatment plan includes access to North Carolina Start or a local respite facility to change the scene of inappropriate behaviors for a de-escalation period. Describe your plans to make sure the above happens. The QP and facility staff will follow their training to report incident reports in a timely manner using the appropriate forms. Summerland Homes will be responsible for contacting all individuals above with time of meeting, place of meeting (virtual or in person) to put the above plan into action to provide the plan of protection for the individual served and others involved." The Campbell Home is an Alternative Family Living in a Private Residence facility. Former Client (FC) #3's diagnoses included Moderate Intellectual/Developmental Disability (IDD), Attention Deficit Hyperactivity Disorder (d/o), combined type; Unspecified Cerebral Palsy, Autistic d/o, Oppositional Defiant d/o, Epilepsy, unspecified, not retractable. There were a total of 41 incidents documented by Staff #1 and Staff #2 that occurred between 10/6/21 and 12/14/21 which included 29 verbal and 14 physical aggression (hitting /kicking others), 20 property damage, and 27 aggression to self. These behaviors ranged from 2 hours to the majority of	V 112		

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V 112	Continued From page 10 the day and were increasing in intensity and frequency. Despite the Qualified Professional and Summerland Homes being aware of the ongoing behaviors no new strategies were added to the treatment plan to address these behaviors. Additionally, the facility did not address the behaviors as incidents that are required to be reported and didn't submit reports to the NC Incident Response Improvement System as required. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 112		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;	V 366		

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V 366	Continued From page 11 (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;	V 366		

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V 366	Continued From page 12 (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.	V 366		

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V 366	Continued From page 13 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to attend to the health and safety needs of individuals, determine the cause of the incident and develop and implement corrective measures affecting 1 of 1 former clients (Former Client #3). The findings are: Refer to tag V112 for a summary of incidents for Former Client (FC) #3. Review of the Incident Response Improvement System (IRIS) on 2/22/22 revealed: -there were no Level II incident reports for FC #3 from 6/1/21 to 12/20/21. Interviews on 2/23/22 and 2/28/22 with the Qualified Professional (QP) revealed: -she met with Staff #1 and Staff #2 monthly -she reminded Staff #1 and Staff #2 complete and submit incident reports (IR) within 24 hours -she didn't enter incidents in IRIS; she signed off on it and forwarded it to the Licensee to enter in IRIS -Former Client (FC) #3's behaviors escalated and he was hitting walls, doors and assaultive to workers; behaviors occurred at the facility and the day program -FC #3's behaviors were ongoing and Staff #1 didn't distinguish his behavior as incidents that needed reporting -she instructed Staff #1 and Staff #2 to record behaviors; she encouraged them to document every time there was an incident -she wasn't sure about incidents rising to a level II; she suggested talking to the Program Director or the President.	V 366		

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V 366	Continued From page 14 Interview on 2/23/22 with Staff #1 revealed: -she did a monthly report and FC #3's behavior was documented in her notes -she created a spreadsheet so anyone could access it; she started using this form in October 2021 -we "kind of normalized behavior because we are a skilled family" -FC #3's behavior escalated over 6-7 months -sometimes FC #3's behaviors would go on for hours -she was told to complete incident reports, "was hard to stop in the middle of dinner, clear the room for safety" and complete a report -she acknowledged she wasn't completing reports -she completed a daily tracking log in Therap (electronic health record) of FC #3's progress towards goals. Interview on 2/23/22 with Staff #2 revealed: -FC #3's behaviors were "challenging, frequent ...multiple times a day" -Staff #1 did most of the documentation but he completed the daily tracking grid in Therap for FC #3. Interviews on 2/25/22 and 3/1/22 with the President of the Company revealed: -all incident reports need to be submitted on the Licensee's "Incident/Accident Report for Level I" form -Staff #1 and Staff #2 were responsible for completing the incident report, forwarding it to the QP for review and the QP forwarded it to the office -there were no written incident reports for FC #3 from 6/1/21-12/20/21 -either she or the Program Director were	V 366		

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V 366	Continued From page 15	V 366		

responsible for entering the information in IRIS, not the QP or Staff #1 or #2
-if the time is short, Staff #1 or Staff #2 could forward it directly to the office, prior to the QP reviewing it
-FC #3 did not physically harm anyone, "may bump you" but not serious physical harm
-FC #3 did property damage at the facility
-the QP, Staff #1 and Staff #2 completed training on 2/19/22 on Summerland's (Licensee) "Incident Accident Report Policy" and "Incident Accident Report Form"
-Staff #1 was handwriting monthly notes through 10/1/21 documenting FC #3's behavior; beginning in October, Staff #1 and Staff #2 began using a spreadsheet to document FC #3's behavior
-the QP did monthly supervision with Staff #1 and Staff #2 in addition to her own monthly notes about each client at the facility.

Interview on 2/24/22 with FC #3's guardian revealed:
-she spoke frequently with Staff #1
-her only complaint was that the "provider" was not doing paperwork but she addressed that with Staff #1
-she didn't know about some incidents except when someone else mentioned it
-she thought Staff #1 and Staff #2 normalized FC #3's behavior versus seeing it as an incident that needed more documentation.

Review on 3/1/22 of "Monthly Alternative Family Living (AFL) Report" for July, August and September 2021 signed by Staff #2 revealed:
-July 2021- FC #3 "continues to have sporadic outburst and explosive episodes ...able to pull it together within an hour or so ...suspended from day program for throwing chairs, hitting staff, and pushed client ...behaviors not so well since the

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suspension ...has shown increase agitation, on edge and will act out at any given time ...one of his outbursts he kicked holes in his bathroom wall, tore off the towel holder from the wall ...slammed door so hard the knob went threw the wall"
-August 2021- FC #3 "was doing well at beginning of month. He was immediately discharged from day program due to aggressive behaviors towards staff/clients ...since then , he has been on an emotional rollercoaster ...some behaviors are happening more frequently. They seem to be more intense ...[psychiatrist] and the team have discussed a plan-looking for a new day program and other options ..."
-September 2021- FC #3 "no longer in day program ...majority of his time is in the home ...becomes upset about not going to program. Which usually results in a behavior meltdown, outburst and sometimes aggression to self/others ...behaviors have not changed however are more frequent ....we continue to review goals, get creative with incentives and accommodate him anyway we can. [Psychiatrist] has recommended a higher level of care due to nature of his aggressive behaviors ...seems that he's more compulsive obsessive behaviors triggered by his anxiety/anxiousness and not adjusting to schedule change- these behaviors at times can be safety issues."
-the monthly notes were signed and dated by Staff #2 and the Program Director.

Interview on 2/25/22 and 3/1/22 with the Program Director revealed:
-FC #3's behavior of hitting and kicking others was "nothing that lays you out or bruises you"
-Staff #1 and Staff #2 were very competent but FC #3 was becoming unsafe in the community
-FC #3's behavior escalated in the last 6 months

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V 366	Continued From page 17 -there were a lot of meetings, calls, and discussions between the QP, Staff #1 and Staff #2 that FC #3 needed a higher level of care -incidents were not processed ... "would be debriefing all day long." This deficiency is cross referenced into 10A NCAC 27G .0205 Assessment and Treatment/ Habilitation or Service Plan (V112) for a Type A1 rule violation and must be corrected within 23 days.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and	V 367		

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

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V 367	Continued From page 19 (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure all Level II incidents were reported to the Local Management Organization (LME) responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident affecting 1 of 1 former clients (Former Client #3). The findings are: Refer to V112 for summary of incidents for Former Client (FC) #3. Review of the Incident Response Improvement System (IRIS) on 2/22/22 revealed: -there were no Level II incident reports for FC #3 from 6/1/21 to 12/20/21.	V 367		

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V 367	Continued From page 20 Interview on 2/25/22 with the Local Management Entity/Managed Care Organization (LME/MCO) representative revealed: -the facility was not completing Level II incident reports in IRIS -FC #3's behavior was "frequent and regular"; Staff #1 said it was just his typical behavior and it didn't feel like it needed to be documented -the treatment team was unable to request additional services because they didn't have the documentation to justify it -the treatment team needed behavioral documentation to request a higher level of care -she thinks Staff #1 "came around and realized she needed to do it" (documentation). Interviews on 2/25/22 and 3/1/22 with the President of the Company revealed: -all incident reports need to be submitted on the Licensee's "Incident/Accident Report for Level I" form -Staff #1 and Staff #2 were responsible for completing the incident report, forwarding it to the QP for review and the QP forwarded it to the office -there were no written incident reports for FC #3 from 6/1/21-12/20/21. This deficiency is cross referenced into 10A NCAC 27G .0205 Assessment and Treatment/ Habilitation or Service Plan (V112) for a Type A1 rule violation and must be corrected within 23 days.	V 367		