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CARE HEALTH SERVICES 1	111 RAINEY AVENUE HILLSBOROUGH, NC 27278

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V 000	INITIAL COMMENTS An annual survey was completed on July 27, 2022. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and currently has a census of 5. The survey sample consisted of audits of 3 current clients.	V 000		
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. (f) The governing body for each facility shall	V 110		

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V 110	Continued From page 1 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 one of four audited staff (Executive Director) failed to demonstrate the knowledge, skills and abilities required for the population served. The findings are: Cross Reference: 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (V112) Based on record reviews and interviews, the facility failed to develop and implement strategies to meet the needs and behaviors affecting two of three audited current clients (#1 and #2). 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 implement a policy governing their response to Level II incidents as required. 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 incidents were reported to the LME for the catchment area where services are provided within 72 hours of becoming aware	V 110		

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V 110	Continued From page 2 of the incident. Review on 7/27/22 of a Plan of Protection (POP) written by the Assistant Director and Executive Director dated 7/27/22 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care?: Will discuss with [Client #1] not to use non-prescribed drugs at all times. Will discuss with staff to monitor [Client #1] at all times with smoking. Paraprofession will monitor [Client #2] closer at all time. To make sure he doesn't walk off. Will have a training with staff in 5 days on Incident Reporting. Describe your plans to make sure the above happens. Will have a treatment plan meeting for [Client #1] within 5 day to develop a plan for non-prescribed drug use. Will have a treatment plan meeting with [Client #2] and his guardian and develop a plan about him leaving the home or not on his own. [The Assistant Director] will monitor the staff closer on reporting incidents." The facility served clients whose diagnoses included Schizophrenia and History of Substance Abuse. Staff #2 caught client #1 smoking marijuana in May 2022 at the facility twice in one day. Staff #2 called the police department in order to report those incidents. A police officer searched client #1 and found the end of the marijuana joint on him. Client #1 had no strategies to address his substance abuse issues. Client #2 walked away from the facility twice in May 2022 in order to purchase cigarettes from the store. Staff #2 called the police department each time to report those incidents. According to staff #2 the road near the facility was not safe because there was no shoulder and it could be dangerous for anyone walking. Client #2 had no strategies to address his walking away	V 110		

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V 110	Continued From page 3 from the facility. The Qualified Professional (QP) was responsible for revising the clients treatment plans. The Executive Director (ED) failed to inform the QP about the above incidents that occurred in May 2022 with clients #1 and #2. Staff failed to complete incident reports for the May 2022 incidents that occurred with clients #1 and #2. The May 2022 incidents were not put into the Incident Reporting Improvement System by the QP because the ED failed to inform him of those incidents. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 110		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and	V 111		

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V 111	Continued From page 4 (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure an assessment was completed prior to the delivery of services affecting one of three audited current clients (#2). The findings are: Review on 7/19/22 of client #2's record revealed: -Admission date of 8/13/21. -Diagnosis of Schizophrenia. -No evidence of an admission assessment completed for client #2 prior to the delivery of services. Interview on 7/20/22 with the Qualified Professional (QP) revealed: -He completed an admission assessment for client #2 at admission. He thought the admission assessment was in client #2's record at the facility. He wasn't sure why the admission	V 111		

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V 111	Continued From page 5 assessment for client #2 was no longer in his client record. -He confirmed the facility failed to provide documentation of an admission assessment for client #2. Interview on 7/20/22 with the Executive Director revealed: -The QP was responsible for completing the admission assessment for clients. He wasn't sure why client #2 had no admission assessment in his chart. -He confirmed the facility failed to provide documentation of an admission assessment for client #2.	V 111		
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	V 112		

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V 112	Continued From page 6 responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement strategies to meet the needs and behaviors affecting two of three audited current clients (#1 and #2). The findings are: a. Review on 7/19/22 of client #1's record revealed: -Admission date of 10/3/08. -Diagnoses of Schizophrenia, History of Substance Abuse, Gastroesophageal Reflux Disease, Constipation, Tardive Dyskinesia, Tinea Pedis and Urinary Incontinence. -Psychosocial Assessment dated 3/11/13-"[Client #1] stated he started going down the wrong path at age 16 by drinking, smoking marijuana and cigarettes, crack cocaine, and fighting. He had a history of depression, anxiety, drug abuse, alcohol abuse, lying, stealing and problems with the police." -Client #1's Person Centered Plan (PCP) dated 3/16/22 had no strategies to address his substance abuse treatment needs. Review on 7/19/22 of facility records revealed: -Log note dated 5/28/22-"Around 6pm [Staff #2] observed [Client #1] smoking marijuana on the	V 112		

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property. Spoke to [Client #1] and he said he was smoking a cigarette, but you could smell the marijuana, [Staff #2] stated she was going to call [Executive Director] and [Client #2] asked staff did she want his phone number. [Staff #2] called the police they serch him and found burnt paper in his cigarette pack they throwed on the ground and mashed it up. [Client #2] told the police yes he was smoking on the property."

Interview on 7/20/22 with client #1 revealed:
-In May 2022 staff #2 caught him smoking "weed" at the facility twice in one day.
-He was sitting outside of the facility in the parking lot area smoking his "weed."
-He had that "weed" on him for several months and decided to smoke it that day.
-Staff #2 called the police department and reported that incident.
-A police officer did search him and only found burned paper on him. The police officer did not arrest him for smoking the "weed." The police officer gave him a verbal warning.

Interviews on 7/19/22 and 7/20/22 with staff #2 revealed:
-There was an incident with client #1 in May 2022. She caught client #1 smoking marijuana at the facility twice in one day.
-One morning after breakfast around 9:30 am she thought she smelled marijuana in the facility. She went outside a few minutes later to smoke a cigarette and started smelling marijuana again. Client #1 was sitting in a chair in the parking lot area. She saw a bunch of white smoke surrounding client #1. She told client #1 "I know you are not sitting out here smoking marijuana." Client #1 said, "no I'm smoking my cigarette." Client #1 said he was not smoking marijuana. She asked again if he was smoking marijuana

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and client #1 said he was smoking a cigarette.
-Client #1 also had a cigarette in the opposite hand. It looked like he had a cigarette in each hand. "I just left it alone, I know I smelled marijuana. I know how marijuana smells."
-After dinner around 5:45 pm she smelled marijuana again in the facility. She went out into the parking lot area and saw client #1 sitting under the tree smoking again. She smelled marijuana and asked him if he was smoking marijuana. Client #1 said he was smoking a cigarette and not marijuana. This time she called the Executive Director and the police department. The Police Officers came out and client #1 admitted he was smoking marijuana. The Police Officers found a "roach" on client #1 when they searched him. "A roach is the end of the marijuana joint." The Police Officers told him he could not smoke at the facility. The Police Officers basically gave client #1 a warning, client #1 was not arrested.
-The Assertive Community Treatment Team (ACTT) was also contacted and his Case Manager came out later that evening. Client #1 told his ACTT Case Manager he got the marijuana from his brother when he visited him at the facility.
-She confirmed client #1 had no strategies to address his substance abuse treatment needs.

b. Review on 7/19/22 of client #2's record revealed:
-Admission date of 8/13/21.
-Diagnosis of Schizophrenia.
-Client #2's PCP dated 8/13/21 had no strategies to address his walking away from the facility.

Review on 7/19/22 of facility records revealed:
-Log note dated 5/21/22-"[Staff #2] was in the kitchen. Clients outside smoking. When another

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V 112	Continued From page 9 client came into the home and said [Client #2] walked away. [Staff #2] looked for [Client #2] he was not in sight. Call the police. [Client #2] return from the store with a pack of cigarette. Stated to the police he just walked to the store for cigarettes without permission." Interview on 7/20/22 with client #2 revealed: -They are not supposed to go into the community without staff supervision. -He walked away from the facility twice in May 2022. He walked to the store both times in order to buy cigarettes. He thought he walked to the store and returned to the facility within 30 minutes each time. -He knew staff called the police department when he walked away because when he returned from the store an officer was at the facility. Interviews on 7/19/22 and 7/20/22 with staff #2 revealed: -Client #2 walked away from the facility twice in May 2022. -The first time client #2 walked off she thought the clients were outside smoking. She was in the facility cleaning the bathroom and client #1 told her client #2 walked off. She searched and was not able to find client #2. She then called the police department to report client #2 left the facility. The Police Officers came to the facility and client #2 returned on his own. Client #2 said he walked to a store in the area to buy cigarettes. -About 2-3 days later client #2 left the facility again without permission. She was in the kitchen preparing dinner for the clients. Client #1 came in the kitchen and said he saw client #2 walk away from the facility. She went outside and could not find client #2 anywhere. She called the police department to report client #2 walking off from the facility. Client #2 returned before the Police	V 112		

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V 112	Continued From page 10 Officers arrived and said he walked to a store in the area to buy cigarettes. -She was not sure how long client #2 was gone because she never saw him leave during either incident. She thought the store in the area client #2 was walking to was less than one half mile from the facility. -The clients had not been walking anywhere unsupervised since moving to that facility. The road near the facility was not safe. The road had no shoulder and could be "very dangerous" for someone walking. Vehicles drive really fast up and down the road near that facility. -She confirmed client #2 had no strategies to address his walking away from the facility. Interview on 7/20/22 with the Qualified Professional (QP) revealed: -He was not aware of the incidents in May 2022 with client #1 smoking marijuana at the facility. He knew client #1 had a history of substance abuse. -Client #1 had a goal and strategies to address his substance abuse in the past. They decided to discontinue that goal because he had been making progress and had not used any substances. He thought they discontinued that goal last year, not sure of the specific date. -He was not aware of client #2 walking away from the facility without staff supervision. -He normally did supervision with staff on a monthly basis and no one mentioned those incidents with clients #1 and #2. -He confirmed client #1 had no strategies to address his substance abuse treatment needs. -He confirmed client #2 had no strategies to address his walking away from the facility. Interviews on 7/19/22 and 7/20/22 with the Executive Director revealed:	V 112		

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V 112	Continued From page 11 -He was aware of incident with client #1 using marijuana in May 2022. That was the first time client #1 smoked marijuana at facility as far as he knew. He thought client #1 had a history of substance abuse from years ago. -He was also aware that client #2 walked away from the facility twice in May 2022. He thought he walked away from another facility prior to his admission to this facility in August 2021 when he lived in another city. -The QP was responsible for updating the treatment plans for clients as needed. The QP didn't know about the incidents with client #1 smoking marijuana at the facility. The QP also was not aware of the incidents with client #2 walking to the store twice without staff supervision. He did not say anything to the QP because they had no incidents at that facility in several months. "I really didn't think about reporting those incidents to the QP." -He confirmed client #1 had no strategies to address his substance abuse treatment needs. -He confirmed client #2 had no strategies to address his walking away from the facility. This deficiency is cross referenced into 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS(V110) for a Type B rule violation and must be corrected within 45 days.	V 112		
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	V 118		

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V 118	Continued From page 12 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: Based on record reviews and interviews, the facility failed to keep the MAR current affecting one of three audited current clients (#1) and the facility failed to ensure physician's orders were available affecting one of three audited current clients (#3). The findings are: The following is evidence the facility failed to	V 118		

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V 118	Continued From page 13 ensure the MAR was kept current. Review on 7/19/22 of client #1's record revealed: -Admission date of 10/3/08. -Diagnoses of Schizophrenia, History of Substance Abuse, Gastroesophageal Reflux Disease (GERD), Constipation, Tardive Dyskinesia, Tinea Pedis and Urinary Incontinence. Review on 7/19/22 and 7/20/22 of physician's orders for client #1 revealed: -Order dated 6/10/22 for Multivitamin with Iron (Vitamin Deficiency), one tablet once daily. -Order dated 5/3/22 for Omeprazole DR 20 milligrams (mg) (GERD), one capsule daily; Movantik 25 mg (Constipation), one tablet daily and Metoprolol Succinate ER 25 mg (High Blood Pressure) (HBP), one half tablet daily. -Order dated 8/26/21 for Oxybutynin CL ER 10 mg (Overactive Bladder), one tablet daily; Docusate Sodium 100 mg (Stool Softener), one caplet twice daily and Lithium Carbonate 150 mg (Mood Stabilizer), one caplet twice daily. Review on 7/19/22 of the July 2022 MAR for client #1 revealed: -There were blank boxes for the following medications: -Multivitamin with Iron on 7/16 thru 7/19 -Omeprazole DR 20 mg on 7/16 thru 7/19 -Movantik 25 mg on 7/16 thru 7/19 -Metoprolol Succinate ER 25 mg on 7/16 thru 7/19 -Oxybutynin CL ER 10 mg on 7/16 thru 7/19 -Docusate Sodium 100 mg on 7/16 thru 7/19 -Lithium Carbonate 150 mg on 7/16 thru 7/19 am doses and 7/15 thru 7/18 pm doses. "Due to the failure to accurately document	V 118		

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V 118	Continued From page 14	V 118		

medication administration it could not be determined if clients received their medications as ordered by the physician"

Interview on 7/19/22 with staff #1 revealed:
-"When you'll came this morning, I was in the process of filling out the MAR for [Client#1]".
-She forgot to sign off on the July 2022 MAR for client #1. She normally don't forget to fill out the MAR.
-There were no issues with client #1 not getting his medication daily.
-She confirmed staff failed to keep the MAR current for client #1.

Interview on 7/20/22 with the Executive Director revealed:
-Staff #1 showed him client #1's MAR for July 2022. Staff #1 said client #1 got his medications. She said she forgot to sign off on the July 2022 MAR to indicate the medication was administered. She said "it was an honest mistake."
-He confirmed staff failed to keep the MAR current for client #1.

The following is evidence the facility failed to ensure physician's orders were available.

Review on 7/19/22 of client #3's record revealed:
-Admission date of 3/20/10.
-Diagnoses of Paranoid Schizophrenia-Chronic, Cervical Stenosis, Hypertension, Obesity and Chronic low back pain.

Review on 7/19/22 and 7/20/22 of the MAR's for client #3 revealed:
July 2022 had the following:
-Vitamin D 400 IU (international unit) with Iron (Vitamin Deficiency), one tablet daily. Medication

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V 118	Continued From page 15 was listed and administered by staff. -Spiriva Respimat 2.5 mcg (micrograms) (Lung Diseases), inhale two puffs once daily. Medication was listed and administered by staff. -Benztropine Mesylate 0.5 mg (Involuntary Movements), three tablets by mouth in the morning and four at bedtime. Medication was listed and administered by staff. -Tamsulosin HCL 0.4 mg (Enlarged Prostate), one capsule daily after the same meal daily. Medication was listed and administered by staff. -Gabapentin 300 mg (Pain Relief), one capsule every eight hours. Medication was listed and administered by staff. -Fluphenazine Deconate 125 mg/5 ml (milliliters) (Schizophrenia), inject 50 mg intramuscularly once every two weeks. Medication was listed and shot administered by medical staff. -Bisacodyl 10 mg (Laxative), insert 1 suppository in rectum once daily as needed. Medication was listed, however it was not administered between July 1-20. May 2022 had the following: -Lisinopril 20 mg (HBP), one half tablet daily. Medication was listed. -Pantoprazole Sodium DR 40 mg (GERD), one tablet daily 30 minutes before a meal. Medication was listed. -Therems Multivitamin (Vitamin Deficiency), one tablet daily. Medication was listed. -Metoprolol Succinate ER 25 mg (HBP), one half tablet twice daily. Medication was listed. -Tramadol HCL 50 mg (Pain relief), two tablets twice daily. Medication was listed. -Benztropine Mesylate 2 mg, one tablet by mouth twice daily. Medication was listed. -Ammonium Lactate 12% cream (Dry skin), apply as directed to affected area as needed. Medication was listed.	V 118		

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V 118	Continued From page 16 Review on 7/19/22 and 7/20/22 of client #3's record revealed: -There were no physician's orders for any of the above medications. Interview on 7/20/22 with staff #1 revealed: -They had issues getting physician's orders for client #3 because he got his medications filled through the Veteran Affairs (VA) hospital. The VA will not give them an order whenever the medications were filled. She talked to the physician about signing the agency health care note document, however he refused to sign it. -There were changes with client #3's medications when he was in the hospital for several months. Client #3's physician would not provide them with a discontinuation order to indicate the changes for those medications. -She confirmed the facility failed to ensure physician's orders were available for client #3. Interview on 7/20/22 with the Executive Director revealed: -Staff had issues in the past getting physician's orders for client #3. Client #3 medications were filled at the VA hospital. Staff at the VA hospital would not provide facility staff with an order once the medication was filled. Staff talked to client #3's physician about signing the agency health care note document and the physician refused to sign it. -He confirmed the facility failed to ensure physician's orders were available for client #3.	V 118		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR	V 366		

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V 366	Continued From page 17 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; (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;	V 366		

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(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;
(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:

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V 366	Continued From page 19 (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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement a policy governing their response to Level II incidents as required. The findings are: a. Review on 7/19/22 of client #1's record revealed: -Admission date of 10/3/08. -Diagnoses of Schizophrenia, History of Substance Abuse, Gastroesophageal Reflux Disease, Constipation, Tardive Dyskinesia, Tinea Pedis and Urinary Incontinence. Review on 7/19/22 of facility records revealed: -Log note dated 5/28/22-"Around 6pm [Staff #2] observed [Client #1] smoking marijuana on the property. Spoke to [Client #1] and he said he was smoking a cigarette, but you could smell the marijuana, [Staff #2] stated she was going to call	V 366		

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V 366	Continued From page 20 [Executive Director] and [Client #2] asked staff did she want his phone number. [Staff #2] called the police they serch him and found burnt paper in his cigarette pack they throwed on the ground and mashed it up. [Client #2] told the police yes he was smoking on the property." Interviews on 7/19/22 and 7/20/22 with staff #2 revealed: -There was an incident with client #1 in May 2022. She caught client #1 smoking marijuana at the facility twice in one day. -One morning after breakfast around 9:30 am she thought she smelled marijuana in the facility. She told client #1 "I know you are not sitting out here smoking marijuana." Client #1 said, "no I'm smoking my cigarette." -After dinner around 5:45 pm she smelled marijuana again in the facility. She asked client #1 if he was smoking marijuana and he said he was smoking a cigarette. This time she called the Executive Director and the police department. b. Review on 7/19/22 of client #2's record revealed: -Admission date of 8/13/21. -Diagnosis of Schizophrenia. Review on 7/19/22 of facility records revealed: -Log note dated 5/21/22-"[Staff #2] was in the kitchen. Clients outside smoking. When another client came into the home and said [Client #2] walked away. [Staff #2] looked for [Client #2] he was not in sight. Call the police. [Client #2] return from the store with a pack of cigarette. Stated to the police he just walked to the store for cigarettes without permission." Interviews on 7/19/22 and 7/20/22 with staff #2 revealed:	V 366		

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V 366	Continued From page 21 -Client #2 walked away from the facility twice in May 2022. -The first time client #2 walked off she thought the clients were outside smoking. Client #1 told her client #2 walked off. She searched and was not able to find client #2. She then called the police department to report client #2 left the facility. -About 2-3 days later client #2 left the facility again without permission. Client #1 said he saw client #1 walk away from the facility. She went outside and could not find client #2 anywhere. She called the police department to report client #2 walking off from the facility. Review of the Incident Reporting Improvement System (IRIS) on 7/19/22 revealed: -There was no documentation of incident reports completed by group home staff for any of the above issues. -There was no documentation to determine the cause of the incident; developing and implementing corrective measures according to the provider specified timeframes not to exceed 45 days; developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days and assigning person(s) to be responsible for implementation of the corrections and preventive measures. Interview on 7/20/22 with the Qualified Professional (QP) revealed: -He was responsible for ensuring incidents are put into IRIS. He had not done any IRIS reports for that facility in several months. -If there was an incident staff were supposed to call him to report that incident. Staff were supposed to document the incident on an incident reporting form and submit the form to him. He	V 366		

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V 366	Continued From page 22 would then put the incident into IRIS. -He visited the facility once a month. No one reported any incidents to him or gave him any documentation of an incident. -He confirmed the facility failed to develop and implement a policy governing their response to Level II incidents as required. Interview on 7/20/22 with the Executive Director revealed: -He talked with staff about the reason they were not doing incident reports, they really offered no excuse. -He felt like staff failed to complete incident reports because they went several months without having an incident with those clients. He thought staff just forgot to complete the incident report. -The QP was responsible for putting incidents into IRIS whenever it came to his attention. -He confirmed the facility failed to develop and implement a policy governing their response to Level II incidents as required. This deficiency is cross referenced into 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS(V110) for a Type B rule violation and must be corrected within 45 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	V 367		

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V 367	Continued From page 23 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: (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	V 367		

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V 367	Continued From page 24 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 25 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure incidents were reported to the LME for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are: Refer to V-366 regarding implementing a policy governing their response to Level II incidents. -Client #1 smoked marijuana twice in one day on 5/28/22. The police was called due to that incident. Review of the Incident Reporting Improvement System (IRIS) revealed staff failed to submit an incident report for client #1. -Client #2 walked away from the facility twice in May 2022. The police was called due to those incidents. Review of IRIS revealed staff failed to submit incident reports for client #2. This deficiency is cross referenced into 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (V110) for a Type B rule violation and must be corrected within 45 days.	V 367		