STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601488	A. BUILDING: _____ B. WING _____	11/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESIDENTIAL ADOLESCENT COMMUNITY SERVICES	443 NORTH SUMMITT AVENUE CHARLOTTE, NC 28216

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 11-7-22. One complaint was substantiated (Intake #NC00193968) and one was unsubstantiated (Intake #NC00193264). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children and Adolescents. This facility is licensed for four and currently has a census of four. The survey sample consisted of three current clients.	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and	V 108		

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V 108	Continued From page 1 trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure that all staff were trained to meet the needs of the clients served, effecting six of six audited staff (Staff #1, #2,, #3, #4, AP (Associate Professional) and the Qualified Professional/Chief Executive Officer/Director (QP/CEO/D). The findings are: Review on 9-22-22 of Client #1's record revealed: -Admitted 11-1-21. -14 years old. -Diagnoses included Post Traumatic Stress Disorder and Major Depressive Disorder. -Assessment dated 7-12-21 revealed: "DSS (Department of Social Services) involvement: due to inappropriate sexual behaviors ...younger brother said [Client #1] was caressing his bottom and pleasuring himself while watching porn ...other involvement when [Client #1] was 10, he and his brother were inappropriately touching each other." -Admission assessment dated 11-1-21 revealed: criminal history of sexual battery pending.	V 108		

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V 108	Continued From page 2	V 108		

-"Sexual Offense Specific Evaluation" dated 5-2-22 revealed: "...stated to have forcibly touch manually, orally and it is unclear if genitally...would watch pornography and would then undress them (two younger siblings) and touch them, have them touch him manually or orally on his penis...."

Review on 9-22-22 of Staff #1's record revealed:
-Hire date 2-6-22.
-No documentation of training for inapropriate sexualized behaviors.

Review on 9-22-22 of Staff #2's record revealed:
-Hire date 8-22-22.
-No documentation of training for inapropriate sexualized behaviors.

Review on 9-22-22 of Staff #3's record revealed:
-Hire date 2-14-22.
-No documentation of training for inapropriate sexualized behaviors.

Review on 9-22-22 of Staff #4's record revealed:
-Hire date of 2-9-21.
-No documentation of training for inapropriate sexualized behaviors.

Review on 9-22-22 of the AP's record revealed:
-Hire date of 2-9-21.
-No documentation of training for inapropriate sexualized behaviors.

Review on 9-22-22 of the QP/CEO/Director's record revealed:
-Hire date 2-9-21.
-No documentation of training for inapropriate sexualized behaviors.

Interview on 9-21-22 and 10-12-22 with Staff #1

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V 108	Continued From page 3 revealed: -She remembered having had medication training, power struggles, and accountability. -"There are so many." (trainings) -She had read Client #1's Person Centered Plan when she first started working at the facility but had not had any training in inapropriate sexualized behaviors. Interview on 9-22-22 with the AP revealed: -She had read the Person Centered Plan for Client #1 but had not had any formal training in inapropriate sexualized behaviors. Interview on 10-10-22 with the QP/CEO/D revealed: -She should have ensured everyone had training in inapropriate sexualized behaviors. -The therapist was going to get everyone trained as soon as possible. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (293) for a Type A2 rule violation and must be corrected within 23 days.	V 108		
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	V 112		

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V 112	Continued From page 4 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: Based on record reviews and interviews the facility failed to develop goals and strategies to address the needs of the client, effecting one of three audited clients (Client #1). The findings are: Review on 9-22-22 of Client #1's record revealed: -Admitted 11-1-21. -14 years old. -Diagnoses included Post Traumatic Stress Disorder and Major Depressive Disorder. On 5-2-22 a diagnosis of Unspecified Paraphilic Disorder was added after the "Sexual Offense Specific Evaluation" was completed. -Assessment dated 7-12-21 revealed: "DSS (Department of Social Services) involvement: due to inappropriate sexual behaviors ...younger brother said [Client #1] was caressing his bottom	V 112		

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V 112	Continued From page 5	V 112		

and pleasuring himself while watching porn ...other involvement when [Client #1] was 10, he and his brother inappropriately touching each other."

-Admission assessment dated 11-1-21 revealed: criminal history of sexual battery pending.

-"Sexual Offense Specific Evaluation" dated 5-2-22 revealed: "...stated to have forcibly touch manually, orally and it is unclear if genitally at least two younger children...would watch pornography and would then undress them and touch them, have them touch him manually or orally on his penis...he represents a persistent danger to himself and the community in this current state."

-Person Centered Plan dated 11-22-21 and last updated 9-6-22 revealed: "5-11-22 Team discussed the results of the psychosexual assessment completed by [counseling office]...6-6-22 [Client #1] expressed he is still having sexual thoughts...DSS and DJJ (Department of Juvenile Justice) said they notify the courts that they are not in agreement with the [Counseling office] recommendations...."

-Client #1's goals in the Person Centered Plan (PCP) dated 11-22-21 and last updated 9-6-22 revealed: follow the level III group home rules, increase anger management skills as evidenced by reducing angry outburst, eliminating any physical aggression and/or property damage, utilize coping skills to manage episode of anger and frustration.

-No goals or strategies in place to address Client #1's inapropriate sexualized behaviors.

Interview on 10-12-22 with Staff #1 revealed:

-She had read Client #1's PCP when she first started working at the facility and that was how she learned about Client #1.

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V 112	Continued From page 6 Interview on 10-10-22 with the Qualified Professional/Chief Executive Officer/Director (QP/CEO/D) revealed: -The facility should have a goal with strategies in Client #1's PCP. -She would make sure one was added as soon as possible. Interview on 10-10-22 with the Therapist revealed: -She specialized in working with adolescents with inapropriate sexualized behavior. -She would work with the QP/CEO/D to make sure a goal, including strategies to address Client #1's inapropriate sexualized behaviors was added. This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (293) for a Type A2 rule violation and must be corrected within 23 days.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies	V 114		

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V 114	Continued From page 7 accessible for use. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure fire and disaster drills were completed on each shift at least quarterly. The findings are: Interview on 9-22-22 with the Qualified Professional/Chief Operating officer/Director revealed: -Facility shifts are 8am-4pm, 4pm-11pm,11pm-7 or 8 and a 12 shift. Review on 9-22-22 of facility fibre and disaster drill documentation revealed: - No third shift fire drills and no disaster drills completed for the first three quarters of 2022 Interview on 10-10-22 with the QP/CEO/D: -She would ensure that both fire and disaster drills were completed on each shift in the future,	V 114		
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	V 118		

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V 118	Continued From page 8 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 review and interview the facility failed to ensure MAR's were kept current, effecting one of three audited clients (Client #2). The findings are: Review on 9-22-22 of Client #1's Physicians' orders revealed: Resperidone .25mg (milligrams) two times daily (am and pm) for behavior, signed 7-28-22. -Divalproex 25mg three tablets one time daily (am) for behavior, signed 7-28-22. -Guanfacine HCL (Hydrochloride) 3 mg one tablet twice daily (am and pm) for Attention	V 118		

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V 118	Continued From page 9 Deficit/Hyperactivity Disorder, signed 7-28-22. -Trazadone 50mg once daily for sleep, signed 7-28-22. Record review on 9-22-22 of Client #2's medications revealed: -Resperidone .25mg (milligrams) two times daily (am and pm) for behavior, -Divalproex 25mg three tablets one time daily (am) for behavior, -Guanfacine HCL (Hydrochloride) 3 mg one tablet twice daily (am and pm) for Attention Deficit/Hyperactivity Disorder, -Trazadone 50mg once daily for sleep. Review on 9-22-22 of Client #2's August and September MAR's revealed missing signatures for: -9-1-22 for risperidone .25 mg and divalproex 25 mg am doses. -9-6-22 for risperidone .25 mg and divalproex 25 mg am doses, trazadone 50mg and guanfacine 3mg pm doses. -9-8-22, 9-15-22, 9-19-22 and 9-20-22 divalproex pm doses. Interview on 9-20-22 with Client #2 revealed: -He always got all of his medications and staff never forgot to give them to him. Interview on 9-22-22 with the Qualified Professional/CEO (Chief Executive Operator) /Director revealed: -She would have a talk with the staff that didn't sign the MAR's and let her know that would not be accepted in the future.	V 118		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection	V 132		

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V 132	Continued From page 10 G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.	V 132		

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V 132	Continued From page 11	V 132		

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to report allegations of abuse to the Health Care Personnel Registry (HPCR) within 5 working days. The findings are:

Finding #1.

Review on 9-22-22 of facility's internal investigation dated 8-16-22 and completed by the Qualified Professional/ Chief Executive Operator/Director (QP/CEO/D) revealed:
-Client #2 made an allegation that Staff #4 had hit him on the arm, but when asked what happened, he demonstrated being led by the arm. Client #2 then alleged that Staff #4 had thrown him on the bed.
-An internal investigation was completed, with staff being suspended during the investigation.
-The internal investigation concluded on 8-16-22 that no abuse took place.
-No allegation was reported to HPCR.

Finding #2

Review on 10-12-22 of internal investigation dated 10-4-22 revealed:
-Client #1 made an allegation that Staff #3 had called him names and had tried to make him stay in his room all day.
-Staff #3 was suspended while an internal investigation was completed.

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V 132	Continued From page 12 -Staff #3 was terminated for verbal abuse. -No allegation was reported to HPCR. Interview on 9-22-22 and 10-12-22 with the QP/CEO/D revealed: -She didn't realize she had to report the first incident because they had investigated and unsubstantiated it. -She didn't realize the second incident needed to be reported. -She would go over the Incident Response Improvement System Manual again to fully familiarize herself with the rules.	V 132		
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 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	V 293		

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V 293	Continued From page 13 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. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to provide services designed to minimize the occurrence of behaviors related to functional deficits, effecting one of three audited clients (Client #1). The findings are: CROSS REFERENCE: 10A NCAC 27G .0202	V 293		

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RESIDENTIAL ADOLESCENT COMMUNITY SERVICES	443 NORTH SUMMITT AVENUE CHARLOTTE, NC 28216

(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
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Personnel Requirements (V 108)
Based on interviews and record reviews the facility failed to ensure that all staff were trained to meet the needs of the clients served, effecting six of six audited staff (Staff #1, #2,, #3, #4, AP (Associate Professional) and the Qualified Professional/Chief Executive Officer/Director (QP/CEO/D).

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 goals and strategies to address the needs of the client, effecting one of three audited clients (Client #1).

CROSS REFERENCE: 10A NCAC 27G .0304
Facility Design and Equipment (V784)
Based on interviews and record reviews the facility failed to ensure that the area in which therapeutic and habilitation activities are routinely conducted shall be separate from sleeping areas.

Review on 9-22-22 of Client #2's record revealed:
-Admitted 8-1-22.
-Assessment dated 8-15-22 revealed: He has destroyed property, lied, demonstrated aggression towards others, disobedience. Presenting problems include: explosive anger, separation anxiety, lying, and aggressive behavior.

Review on 9-22-22 of statements written by Client #1 and signed on 9-10-22- and 9-11-22 revealed:
-9-11-22: He and Client #2 had oral sex weekly for three weeks and then on the fourth week, Client #2 refused so he masturbated while Client #2 was sleeping.
-9-10-22: "I am so sorry that I lied to you

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about what I did, I was just trying to see yall's (staff) reaction...you believed me...but it NEVER happened! Thanks for not putting me out! LOL (laugh out loud) (heart shape) drama."

Review on 9-22-22 of statement dated 9-11-22 and signed by Client #2 revealed:

-"For the past 21-22 out of 30 days [Client #1] has been asking to see or touch my penis. It has made me feel VERY uncomfortable. I wasn't going to say anything until he told me the reason he was here. Then [Director/Owner] brought it up so I thought is was a perfect time to bring it up."

Review on 9-22-22 of progress notes for Client #1 dated 9-12-22 and signed by the therapist revealed:

-Client #1 reported he regrets lying to staff and will comply with the staff's requirements that have been put in place regarding safety plans and restrictions.

Review on 9-22-22 of progress notes for Client #2 dated 9-12-22 and signed by the therapist revealed:

-Discussed the situation with Client #1. Client #2 reported he was not touched in any capacity. Client #1 asked Client #2 to perform oral sex, but respected Client #2's statement that he would not. Client #1 then later informed Client #2 that he is in treatment for sexually inapropriate behavior.

Review on 9-22-22 of safety plan dated 9-12-22 and signed by Client #1, the QP/CEO/Director, and the therapist revealed:

-"[Client #1] cannot be alone with any other housemate in any of the bedrooms/rooms without staff present."

-"Will sleep in the den area at night."

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Interview on 9-26-22 with Client #1 revealed:
-He had never asked Client #2 for oral sex, he had been lying.
-He is in therapy three times a week for sexualized behavior.

Interview on 9-26-22 with Client #2 revealed:
-Client #1 had been asking him to perform oral sex "25-30 days, 1-2 times a night."
-He did finally tell staff about it.
-He did not report to the surveyor during the first interview because Client #1 was now sleeping in a different room and the surveyor didn't ask about sexual behavior.

Interview on 10-10-22 with the Therapist revealed:
-She has been working with Client #1 and feels that it might have triggered some of his behaviors.

Interview on 10-10-22 with the QP/CEO/Director revealed:
-She realized that she should have trained all staff in sexualized behaviors.
-They will be adding a goal for Client #1 to address his sexualized behaviors as soon as possible.
-Client #1 will be moving back into his room with increased supervision.

Review on 10-10-22 of the Plan of Protection dated 10-10-22 and signed by the QP/CEO/Director on 10-10-22 revealed:

What immediate action will the facility take to ensure the safety of the consumers in your care?

"1) On October 10, 2022, [Client #1's] Person Centered Plan (PCP) will be updated to include

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goals to prevent and control sexual offending as well as strategies to limit and prevent sexual offending. These goals will be comprehensive and formulated based upon the seven phase curriculum that is approved for juvenile sex offender programs. The updated PCP will be printed for all staff members to be reviewed at the beginning of their shift beginning today, October 10, 2022. Primarily, this program is going to be implemented by the Lead Clinician, [Therapist], PhD., LCMHC, CA, who is a juvenile sex offender therapist and adult sex offender therapist. [Therapist] will also be providing staff training in core aspects of the curriculum to RACS (Residential Adolescent Community Service) staff members beginning October 10, 2022 to ensure that [Client #1] is complying with the curriculum and that staff is aware of safety plan protocol.

2) On October 10, 2022, [Therapist] will begin providing staff training to RACS direct care staff members who interface with [Client #1] in the area of sexual offending/sexual reactive behavior. This training will occur on Monday mornings at 11 am. This training will take place for sixteen weeks.

3) [Client #1's] safety plan will continue to be discussed, reviewed and updated per session. [Client #1] will meet with [Therapist] three times a week to maintain continuity and stability. He will complete a seven phase curriculum that is approved for juvenile sex offender treatment that addresses areas of responsibility taking, behavior control, emotional regulation, anger management, victim empathy, healthy sexuality, and relapse prevention.

4) [Client #1] is not permitted to be in any room with the door closed with the exception of the

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V 293	Continued From page 18 bathroom. He is also not permitted to be in any room with any other roommates with the door closed. This includes common areas, bedrooms, or offices. Staff members will be conducting routine and mandatory room checks every five minutes to ensure that [Client #1] is complying with all rules. He will not be permitted to be in his bedroom with the door closed. He will not be permitted to be in the therapy room with any other roommate with the door closed unless staff is present." Describe your plans to make sure the above happens. "Please see above the specifics associated with the plans." Client #1 was admitted on 11-21-21 with diagnoses of Post Traumatic Stress Disorder and major Depressive Disorder. He had a history of inappropriate sexualized behavior with legal charges for assaulting a minor. No staff had any training in inapropriate sexualized behaviors and there was no goal in his Person Centered Plan to address this behavior. Client #1 had a Sexual Offense Specific Evaluation on 5-2-22 where he received a diagnosis of unspecified Paraphilic Disorder. He still did not receive a goal in his Person Centered Plan and staff did not receive training. On 9-10-22 Client #2 (roommate) made an accusation that Client #1 had asked him to perform oral sex. This allegation could not be substantiated, but a safety plan had been put in place. This deficiency constitutes a Type A2 for serious risk of harm and must be corrected within 23 days. An administrative penalty of 500.00 is imposed. If the violation is not corrected within 23 days, an additional penalty on 500.00 per day will be imposed for each day the facility is out of	V 293		

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V 293	Continued From page 19 compliance beyond the 23rd day.	V 293		
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; (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	V 366		

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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;
(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

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V 366	Continued From page 21 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. This Rule is not met as evidenced by: Based on record review and interview the facility failed to develop and implement written policy for the response to Level I, Level II, and Level III incidents. The findings are: Review on 9-22-22 and 10-12-22 of incident reports revealed: -Review on 9-22-22 of statements written by Client #1 and signed on 9-10-22- and 9-11-22 revealed: -9-11-22: He and Client #2 had oral sex weekly for three weeks and then on the fourth week, Client #2 refused so he masturbated while	V 366		

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V 366	Continued From page 22 Client #2 was sleeping. -9-10-22: "I am so sorry that I lied to you about what I did, I was just trying to see yall's (staff) reaction...you believed me...but it NEVER happened! Thanks for not putting me out! LOL (laugh out loud) (heart shape) drama." Review on 9-22-22 of statement dated 9-11-22 and signed by Client #2 revealed: -"For the past 21-22 out of 30 days [Client #1] has been asking to see or touch my penis. It has made me feel VERY uncomfortable. I wasn't going to say anything until he told me the reason he was here. Then [Director/Owner] brought it up so I thought is was a perfect time to bring it up." Statements about alleged sexual encounters did not result in any incident report being completed. -Internal investigation completed by the Qualified Professional/CEO (Chief Executive Officer)/Director an accusation of abuse on 8-14-22, no incident report completed. -Internal investigation completed by the Qualified Professional/CEO (Chief Executive Officer)/Director on an accusation of abuse on 10-1-22, with statements from the clients on an incident report form. Interview on 10-12-22 with the Qualified Professional/CEO (Chief Executive Officer)/Director revealed: -She knew that she had to do better with the incident reports and was looking for an appropriate form to use. -The facility would make sure that incident reports were filled out correctly in the future.	V 366		

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V 367	Continued From page 23	V 367		
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 (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	V 367		

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V 367	Continued From page 24 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: (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	V 367		

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V 367	Continued From page 25 meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that all level II incident reports were reported to the Local Management entity within 72 hours in the Incident Response Improvement System (IRIS). The findings are: Review on 9-22-22 and 10-12-22 of the facility incident reports revealed: -Two internal investigations regarding allegations of staff abuse completed by the Qualified Professional/CEO (Chief Executive Officer)/Director One on 8-14-22 the did not substantiate an allegation of abuse and one on 10-4-22 which did substantiate an allegation of abuse. -No reports entered into the IRIS system documenting the allegations. Interview on 9-22-22 and 10-12-22 with the Qualified Professional/CEO (Chief Executive Officer) /Director revealed: -The facility had done an investigation completed 8-14-22 on an allegation that a staff member had hit Client #2 but it had been false. -She didn't know she had to enter it into IRIS since that allegation had been disproven. -She didn't know that the allegation on 10-1-22 rose to a level II so she didn't enter that one	V 367		

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V 367	Continued From page 26 either, but they had fired the staff and substantiated the allegation.	V 367		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int. 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the	V 536		

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V 536	Continued From page 27 following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior; (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program	V 536		

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	MHL0601488	A. BUILDING: _____ B. WING _____	11/07/2022

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aimed at preventing, reducing and eliminating the need for restrictive interventions.
(2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.
(3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.
(5) Acceptable instructor training programs shall include but are not limited to presentation of:
(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) methods for evaluating trainee performance; and
(D) documentation procedures.
(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.
(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.
(8) Trainers shall complete a refresher instructor training at least every two years.
(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the

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V 536	Continued From page 29 outcomes (pass/fail); (B) when and where attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may request and review this documentation any time. (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that all staff had training in alternatives to restrictive interventions before providing services effecting one of four audited staff (Staff #2), The findings are: Review on 9-23-22 of Staff #2's record revealed: -Hire date 8-22-22. -No training in alternative to restrictive interventions documented. Interview on 9-21-22 with Staff #2 revealed: -He had not had any training in alternative to restrictive interventions yet. Interview on 9-22-22 with the Qualified	V 536		

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V 536	Continued From page 30 Professional/CEO (Chief Executive Officer) /Director revealed: -She had not had a chance to provide training for Staff #2. -She did not know he had to have training before he started working. -She would make sure he got training as soon as possible.	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of	V 537		

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behavior) on those objectives and measurable methods to determine passing or failing the course.
(e) Formal refresher training must be completed by each service provider periodically (minimum annually).
(f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule.
(g) Acceptable training programs shall include, but are not limited to, presentation of:
(1) refresher information on alternatives to the use of restrictive interventions;
(2) guidelines on when to intervene (understanding imminent danger to self and others);
(3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention);
(4) strategies for the safe implementation of restrictive interventions;
(5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention;
(6) prohibited procedures;
(7) debriefing strategies, including their importance and purpose; and
(8) documentation methods/procedures.
(h) Service providers shall maintain documentation of initial and refresher training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcomes (pass/fail);

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V 537	Continued From page 32 (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this	V 537		

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V 537	Continued From page 33 Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure that all staff had been	V 537		

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V 537	Continued From page 34 trained in seclusion, physical restraint and isolation time out before providing services effecting one of four audited staff (Staff #2). The findings are: Review on 9-23-22 of Staff #2's record revealed: -Hire date 8-22-22. -No training in seclusion, physical restraint and isolation time-out. Interview on 9-21-22 with Staff #2 revealed: -He had not had any training in seclusion, physical restraint and isolation time-out. Interview on 9-23-22 with the Qualified Professional/CEO (Chief Executive Officer)/Director revealed: -She had not had a chance to provide training for Staff #2. -She did not know he had to have training before he started working. -She would make sure he got training as soon as possible.	V 537		
V 784	27G .0304(d)(12) Therapeutic and Habilitative Areas 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (d) Indoor space requirements: Facilities licensed prior to October 1, 1988 shall satisfy the minimum square footage requirements in effect at that time. Unless otherwise provided in these Rules, residential facilities licensed after October 1, 1988 shall meet the following indoor space requirements: (12) The area in which therapeutic and habilitative activities are routinely conducted shall	V 784		

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V 784	Continued From page 35 be separate from sleeping area(s). This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure that the area in which therapeutic and habilitation activities are routinely conducted shall be separate from sleeping areas. The findings are: Observation on 9-21-22 at approximately 4:00pm revealed: -The den is connected to bedroom #1 and the kitchen. Review on 9-26-22 of a Safety Plan for Client #1 dated 9-12-22 and signed by Client #1, the Qualified Professional/CEO/Director, the Associate Professional and the Therapist revealed: -"[Client #1] will sleep in the den at night." Interview on 9-26-22 with Client #1 revealed: -He currently sleeps on a pull out sofa in the den. -He sleeps with the doors open. Interview on 9-26-22 with Client #2 revealed: -Client #2 sleeps in bedroom #1. -Client #1 now "sleeps in a different room." Interview on 9-22-22 with the Qualified Professional/CEO/Director revealed: -"He couldn't share a room. He is sleeping in the den. We created a safety plan that's still in place." -The den is normally used to watch television, play board games, and sometimes the Therapist has met with clients there.	V 784		

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V 784	Continued From page 36 This deficiency is cross referenced into 10A NCAC 27G .1701 Scope (293) for a Type A2 rule violation and must be corrected within 23 days.	V 784		