STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL059-086	A. BUILDING: _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD LINVILLE GROUP HOME	145 OLD LINVILLE ROAD MARION, NC 28752

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V 000	INITIAL COMMENTS An annual survey was completed on October 27, 2022. Deficiencies were cited. The facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents. The facility is licensed for four and currently has a census of 4. The survey sample consisted of audits of three current clients.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall	V 109		

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V 109	Continued From page 1 develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record review and interviews, 1 of 2 Qualified Professionals, Behavioral Health Director/Qualified Professional #1 (BHD/QP #1) failed to demonstrate the knowledge, skills, and abilities required by the population served. Review on 10/18/22 of BHD/QP #1's record revealed: -Date of Hire 9/25/17; -Position: Behavioral Health Director/QP. Review on 10/20/22 of BHD/QP #1's job description dated 1/24/20 revealed: "Behavioral Health Director (QP) will coordinate and monitor all aspects of the consumer case. This includes monitoring the progress of the person-centered plans ... responding to deficiencies in services and managing the consumer caseload/documentation. The QP will provide administrative support ... and advises the Associate Professional and direct care team members of all consumer support plans/goals and interventions" "Duties and Responsibilities: -Conduct initial assessments and intake of new	V 109		

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V 109	Continued From page 2 clients; -Be knowledgeable in the challenges and care of adolescent clients with mental illness; -Lead the initial and ongoing revisions of the Person Centered Plan (PCP); -Consult with community agencies and families to maintain coordination of care; -Provide oversight to the direct care team and ensure staff are completing their duties ..." "Skills, Knowledge and Abilities: -have thorough knowledge of rules, regulations, policies and procedures." Interview on 10/13/22 and 10/27/22 with the BHD/QP #1 revealed: -he did not complete an updated admission assessment when clients moved to another one of their facilities; -he supervised QP #2; QP #2 was responsible for Health and Comfort inspections; -he learned of the foul odor at the facility two nights ago; the work order was completed yesterday for it; -the Associate Professional (AP) had been helping him with incident reports for "roughly two months;" -"I guess you could say there have been some delays" in submitting incident reports in a timely manner; -for incident reports, "we could do a more formal training, probably be good to do that." The BHD/QP #1 failed to demonstrate competency by the following: -failed to complete an admission assessment when Client #2 was re-admitted to the facility; -failed to submit a Level II incident report to the NC Incident Response Improvement System (IRIS); -failed to submit other incident reports to NC IRIS	V 109	Health ands Comfort Inspections are completed in the facility at least once per month and sometimes twice. These are conducted at random dates and times to ensure they are done without notice given. Staff has been notified of the process to corrected facilities needing repair without waiting on a QP to identify a problem. Vaya is conducting IRIS and Incident Report training with both [redacted] (QP) during the first week of December. This has been scheduled and will be welcomed by our staff.	12/1/2022 12/10/2022

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V 109	Continued From page 3 within 72 hours; -failed to ensure the facility was maintained in a safe, clean, attractive, and orderly manner.	V 109		
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 (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.	V 111	Assessment of residents moving from facility to facility internally will have a completed intake assessment completed as of this survey. It was the position of Clear Sky Behavioral that our staff clinician is completing the CCA or Addendum for the transfer to take place and this would satisfy our obligation for assessment purposes. We have devised a form titled Internal Transfer Assessment Tool that will be utilized to begin the process of the transfer along with notify the staff clinician of a need for evaluation of this transfer. This form is similar to the form used by Clear Sky Behavioral for initial intake but simplified to leveled concerns. This was condensed to eliminate medical and physical attributes of an assessment due to these already being in the file and the client being served in a Clear Sky Behavioral facility up to the point of internal transfer taking place. This practice is currently in place and will be utilized in any future movement from facility to facility.	11/22/2022

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V 111	Continued From page 4 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to have an assessment completed prior to delivery of services for 1 of 3 clients (client #2). The findings are: Review on 10/25/22 of Client #2's record revealed: -Re-Admission to this facility: 10/5/22 -Age: 16 -Diagnoses: Attention Deficit Disorder with Hyperactivity, Unspecified Trauma and Stressor Related Disorder (D/O), and Autism Spectrum D/O. -Comprehensive Clinical Addendum Completed on 6/23/22 revealed Department of Social Services (DSS) Involvement, homelessness, truancy, depression, a need for educational testing, and inappropriate online behavior; -Admission Screening completed on 7/12/22; -Discharge summary on 9/30/22: ... "Client lived at [sister facility] and went on therapeutic leave on 9/30/22..when group home was shut down;" -"he was moved back into a sister facility, Level II group home, on 10/5/22." -no evidence of an updated assessment completed prior to admission at the current facility. Interview on 10/13/22 with Behavioral Health Director/Qualified Professional #1 (BHD/QP#1) revealed: -he does not do updated admission assessments when clients are moved to another one of their facilities.	V 111		

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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 or while the client is on the provider's premises. The policies shall require the provider to respond by:	V 366		

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V 366	Continued From page 6 (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 minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the	V 366		

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V 366	Continued From page 7 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 interviews the facility failed to implement policies governing their reporting and response to level I and II incidents as required. The findings are: Review on 10/25/22 of facility incident reports revealed: -Level I incidents on 10/16/22 and 10/19/22 with former client #5 eloping and making homemade alcohol; -9/5/22 Level II incident, former client #10 threatened to kill self, staff, and clients; -law enforcement responded and client was taken for involuntary commitment. -no documentation of measures used to prevent similar incidents from occurring or corrective	V 366		

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V 366	Continued From page 8 measures needed. Review on 10/25/22 of North Carolina Incident Response Improvement System (IRIS) revealed: -9/5/22 incident had not been entered within the IRIS system. Interview on 10/27/22 with BHD/QP #1 revealed: -there had been a delay in getting some of the reports in timely. -this was an area that needed to be improved.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and	V 367		

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V 367	Continued From page 9 (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:	V 367		

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V 367	Continued From page 10 (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to submit Level II incidents within 72 hours to the local management entity/managed care organization (LME/MCO) as required. Review on 10/25/22 of facility incidents reports revealed: -9/5/22 Level II incident, former client #10 threatened to kill self, staff, and clients; -law enforcement responded and the client was taken for involuntary commitment. Review on 10/25/22 of North Carolina Incident Response Improvement System (IRIS) revealed: -9/5/22 incident had not been entered within the IRIS system.	V 367	This concern has developed on several occasions regarding reporting incidents to the IRIS system. It has been noted that the IRIS system is very cumbersome to navigate and very little training opportunities exist to ensure proper utilization of this platform. We have reached out to Vaya and they are working with us to ensure our QPs responsible for submission to IRIS are properly trained in utilization. I have also began requiring screen shots of the "THUMBS UP" icon to ensure that the submission was successfully transmitted in the first place. The IRIS system provides a confirmation number at some point but this still doesn't constitute that the submission went through completely. This was an issue that was overlooked by administration because of reviewing the case file revealed a screenshot of the confirmation but not the "thumbs up" icon. This expectation and submission of the IRIS within 72 hours of the incident is currently in place.	12/10/2022

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V 367	Continued From page 11 Interview on 10/27/22 with BHD/QP #1 revealed: -he reviews incident reports; -there was a staff helping him complete incident reports that took over in September 2022; -there had been a delay in getting some of the reports in timely.	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to be maintained in a safe, clean, attractive, and orderly manner that was free from offensive odor. The findings are: Observation on 10/25/22 at 2:45PM revealed: - a foul odor of decayed/dead animal inside the facility that surveyors could smell through their masks. -a visible broken window on the exterior of the facility, on the basement level; -the window was broken through one pane on the right side; -a basketball sized piece of glass was missing from the window with jagged pieces remaining; -there were gnats coming out of the shower drain in the client bathroom;	V 736		

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V 736	Continued From page 12 -there were two tiles/piece of flooring in front of the shower that was sunk into the floor; -there was an electric outlet wall plate that was damaged, and partially missing in the living room. Interview on 10/25/22 with Staff #1 revealed: -the facility had a bad smell to it, "like something had died;" -he reported the issue to Qualified Professional #2; -he believed that the landlord used sticky mousetraps in the basement and "something was dead." Interview on 10/25/22 with QP #2 revealed: -he was at the facility this morning and noted the smell; -he did not see the broken window; -he would get someone out to the facility. Interview on 10/27/22 with BHD/Qualified Professional #1 revealed: -supervised QP #2; -the maintenance man went to the facility yesterday to address the smell and put plexi-glass over the window; -he became aware of the issue on 10/25/22.	V 736	Repairs to the facility are completed by work order to our maintenance personnel. The foul odor was a dead rodent in the basement that had been captured in a trap. It was removed and alleviated the smell. The basement area is locked and unaccessible to the residents from inside the facility. The staff also doesn't have a key to access this part of the house. Staff has received remedial training in ensuring the appropriate personnel are notified when things need attention. The window pane has been covered prior to the exit of this survey. All action relative to these findings will be corrected no later than 12/1/2022.	12/1/2022