STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601400	A. BUILDING: _____ B. WING _____	C 12/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH COTTAGE	6725 SAINT PETER'S LANE MATTHEWS, NC 28105

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on December 22, 2022. Two complaints were substantiated (Intake #NC00196148, #NC00196252). One complaint was unsubstantiated (Intake #NC00196158). Deficiencies were cited. The facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents. This facility is licensed for 9 and currently has a census of 7. 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;	V 110		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE [redacted] [redacted]
[redacted]/2023 Hannah Dunham
[redacted] [redacted] [redacted]

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V 110	Continued From page 1 (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall 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 interviews and record reviews 1 of 3 audited paraprofessionals (#2) failed to demonstrate the knowledge, skills, and abilities required by the population served. The findings are: Review on 12/20/22 of staff # 2's record revealed: - Hire date 3/4/19; - Job Title Shift Lead; -Trained in population served on 3/15/19. Review on 12/20/22 of client #2's record revealed: -Date of admission: 10/5/22. -Age: 17. -Diagnoses: Oppositional Defiant Disorder; Major Depressive Disorder, Moderate, Recurrent; Generalized Anxiety Disorder; Attention Deficit Hyperactivity Disorder, Predominantly Inattentive Type; Cannabis Use Disorder, Moderate, In Early Remission; Tobacco Use Disorder, Moderate, In Early Remission. Review on 12/20/22 of client #5's record	V 110		

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V 110	Continued From page 2	V 110		

revealed:
-Date of admission: 10/7/22.
-Age: 17.
-Diagnoses: Post-traumatic Stress Disorder, Unspecified; Major Depressive Disorder, Single Episode, Moderate.

Review on 12/20/22 of North Carolina Incident Response Improvement System (IRIS) report for client #5 dated 12/17/22 revealed:
-"Client was at the playground while on campus with her peers and staff. Staff was in close proximity to clients and monitoring them while they were playing. Client did not say anything regarding AWOL (absence without leave) attempts or inappropriate conversation. They were engaging in conversations regarding feelings about being at Thompson (Licensee), and how they are bored. Staff therapeutically engaged with clients, let them talk, and attempted to problem solve with them. Client engaged with staff. Staff then prompted client's to return to the unit for dinner. [Client #5] and peer walked toward staff, then immediately turned the other direction and ran toward the woods. Staff followed them, but quickly lost eyesight due to being in a heavily wooded area. Staff immediately informed [local police department], as well as program supervisor, and client's guardian (mother). Police received information on client, and provided staff with casenumber...and police contact information."

Review on 12/20/22 of NC IRIS report for client #2 dated 12/17/22 revealed:
-She eloped on 12/17/22 with client #5.

Interview on 12/20/22 with staff #4 revealed:
- Staff #2 took more than 3 clients outside by herself;

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V 110	Continued From page 3 - Staff #2 instructed the clients to come back into the cottage; - Client #2 and client #5 took off running after instructed to come back into cottage. Interview on 12/21/22 with staff # 2 revealed: - Took 5 clients outside to play; - This was not protocol to take 5 clients outside alone; - Did not receive permission to take 5 clients outside by herself ; - Client #2 and #5 were on the swings talking for about 15 minutes, then were told to come inside; - Client #2 and #5 "walked towards me and then just ran towards the woods and kept running." - Immediately notified the supervisor and called 911; - Was out of ratio when she took the 5 clients outside to play; - Received no additional training due to elopement incident with client #2 and client #5. Interview on 12/21/22 with the Residential Program Director revealed: - Aware the staff to client ratio on 12/17/22 was out of compliance; - Provided verbal coaching to staff #2 about her decision to take 5 clients outside alone; - Explained to staff #2 it's impossible to provide line of sight to 5 clients outside; - The documentation of the verbal coaching on 12/20/22 will be in staff's file on 12/21/22. Interview 12/21/22 with the Quality Improvement Specialist revealed: - "[Client #5] was located at some time yesterday. Her mother got her and took her to the hospital. Team trying to make a determination if she is coming back. Still no information about [Client #2]."	V 110		

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V 110	Continued From page 4 Review on 12/21/22 of the first Plan of Protection written by Quality Improvement Specialist dated 12/21/22 revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care? Residential Director met with [staff #1] on 12/20/22 to review judgement and provided coaching on expectations regarding ratio and safety provisions and documented the coaching in Insperity (feedback on job performance). Supervisor will review with Smith RCS (Residential Care Specialist) staff the AWOL(absent without leave) operating guideline to ensure that all staff know the policies and procedures in the event a client leaves without permission on 12/22/2022. Describe your plans to make sure the above happens. Supervisor will provide documentation of training to residential director and PQI (Performance Quality Improvement) of completed training to include agenda and staff attendance." Review on 12/22/22 of the second Plan of Protection written by Residential Program Director dated 12/22/22 revealed: - "Additionally, the program supervisor will review the 'Residential Client Supervision' policy and require staff to sign to ensure understanding and receipt of expectations." The facility served clients with diagnoses of Post Traumatic Stress Disorder, Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, Major Depressive Disorder, Generalized Anxiety Disorder and Cannabis Use Disorder. Staff #2 failed to demonstrate knowledge by not following the facility protocol of two staff to six clients. She took 5 clients outside by herself on 12/17/22.	V 110		

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V 110	Continued From page 5 When it was time to return to the cottage client #2 and client #5 eloped from the facility. Client #5 was not located until 12/20/22. Client #2 had not been found at the time the survey ended. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $1,500.00 is imposed. If the violation is not corrected with 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 110	V110 Correction: 1. Supervisor will review AWOL Policy,Supervison Policy, And Client Safety Prevention and Intervention Guideline with Residential Care Staff. 2. Director coached staff #2 on 12/20/22 understanding ratio and importance of assessing client safety and being proactive in efforts to ensure safety at all times. Prevention: 1. Supervisor will train staff about importance of ratio in monthly meetings. 2. Supervisor will meet with Para Professional staff monthly in individual and group supervision. 3. Supervisor will ensure Residential Care Staff have client specific training monthly. Monitor: 1. Supervisor will complete random monthly checks in the cottage to ensure ratio is being met. 2. Director will complete checks of monthly supervisions in 1:1 meetings.	12/28/2022 Ongoing Ongoing Ongoing Ongoing Ongoing
V 315	27G .1902 Psych. Res. Tx. Facility - Staff 10A NCAC 27G .1902 STAFF (a) Each facility shall be under the direction a physician board-eligible or certified in child psychiatry or a general psychiatrist with experience in the treatment of children and adolescents with mental illness. (b) At all times, at least two direct care staff members shall be present with every six children or adolescents in each residential unit. (c) If the PRTF is hospital based, staff shall be specifically assigned to this facility, with responsibilities separate from those performed on an acute medical unit or other residential units. (d) A psychiatrist shall provide weekly consultation to review medications with each child or adolescent admitted to the facility. (e) The PRTF shall provide 24 hour on-site coverage by a registered nurse.	V 315		

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V 315	Continued From page 6 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure at least 2 direct care staff were present with every 6 children or adolescents at all times. The findings are: Review on 12/20/22 of client #2's record revealed: - Admission date 10/5/22; - Age 17; - Diagnoses- Oppositional Defiant Disorder; Major Depressive Disorder, Moderate, Recurrent; Generalized Anxiety Disorder; Attention Deficit Hyperactivity Disorder, Predominantly Inattentive Type; Cannabis Use Disorder, Moderate, In Early Remission; Tobacco Use Disorder, Moderate, In Early Remission. Review on 12/20/22 of client #5's record revealed: - Admission date 10/7/22; - Age 17; - Diagnoses- Post Traumatic Stress Disorder, Unspecified; Major Depressive Disorder, Single Episode, Moderate. Review on 12/20/22 of client #7's record revealed: - Admission date 11/4/22; - Age 16; - Diagnoses- Post Traumatic Stress Disorder, Unspecified; Major Depressive Disorder, with Congruent Psychotic Features, in Partial Remission; Generalized Anxiety Disorder. Review on 12/20/22 of the facility's internal incident reports revealed: - On 12/16/22 at 5:59 pm Client #7 called 911 about her feelings and was transported to the	V 315		

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V 315	Continued From page 7 hospital for evaluation. Review on 12/22/22 of the facility's 1:1 Safety Monitoring Tool dated 12/17/22 revealed: - Client #7 was on 1:1. Interview on 12/21/22 with staff #2 revealed: -She and one other staff (staff #10) were working in the cottage 12/17/22. -Staff #10 was providing 1:1 safety monitoring for client #7. -"I took a total of 5 clients outside. I was outside with the girls. Some girls were riding bikes and other clients sitting by the swings." - She was aware this violated staffing ratio protocol. Interview on 12/21/22 and 12/22/22 with the Quality Improvement Specialist revealed: - There were 3 staff working together on 12/17/22 during the shift when client #2 and client #5 eloped; - Would provide documentation to show three staff were on shift; - Unable to provide documentation to show three staff were on shift when client #2, #5 eloped.	V 315	V315 Correction: 1. Supervisor will review AWOL Policy,Supervison Policy, And Client Safety Prevention and Intervention Guideline with Residential Care Staff. Prevention: 1. Supervisor will train staff about importance of ratio in monthly meetings. 2. Supervisor will meet with Para Professional staff monthly in individual and group supervision. 3. Supervisor will ensure Residential Care Staff have client specific training monthly. 4. Director updated AWOL policy to add an AWOL assessment to use. Monitor: 1. Supervisor will complete random monthly checks in the cottage to ensure ratio is being met. 2. Director will complete checks of monthly supervisions in 1:1 meetings.	12/28/2022 Ongoing Ongoing onging 12/20/2022 ongoing ongoing
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;	V 366		

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V 366	Continued From page 8 (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; (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	V 366		

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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:
(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

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V 366	Continued From page 10 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 document their response to a level II incident for 1 of 3 audited clients (client #7). The findings are: Review on 12/20/22 of client #7's record revealed: - Admission date 11/4/22; - Age 16; - Diagnoses- Post Traumatic Stress Disorder, Unspecified; Major Depressive Disorder, with Congruent Psychotic Features, in Partial Remission; Generalized Anxiety Disorder. Review on 12/20/22 of the facility's internal incident reports revealed: -On 12/16/22 at 5:59 pm Client #7 called 911 about her feelings and was transported to the hospital for evaluation. Review on 12/20/22 of the North Carolina Incident Repsonse Improvement System (IRIS) from 11/25/22-12/20/22 revealed: -No IRIS report submitted for client #7 contacting the local police and being transported to the local hospital on 12/16/22.	V 366		

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V 366	Continued From page 11 Review on 12/20/22 of the facility's records revealed: -Documentation of an internal incident report with a risk/cause/analysis for the 12/16/22 incident involving client #7. Interview on 12/20/22 with the Program Supervisor revealed: - Responsible for submitting IRIS reports for the cottage; - She submitted an incident report in IRIS on 12/18/22 from the incident with client #7 on 12/16/22.	V 366	V366 Correction: 1. Quality Improvement Specialist reviewed incident reporting procedures and protocols with program supervisor on 12/20/2022 to ensure compliance with reporting timelines. 2. Incident Reporting Policy will be reviewed by Supervisor at the next staff meeting. Prevention: 1. Program Supervisor will facilitate Incident reporting refreshers will be completed quarterly to ensure staff are aware of incident reporting procedures and expectations are met. 2. Incident Reporting Policy will be placed in resource binder in staff office. Monitoring: 1. Program Supervisors will review all incidents to ensure that all components of the report have been completed to include prevention/mitigation and notification of legal guardians, LME, and other authorities required by law. 2. Program Director will monitor adherence to the Incident Reporting Guidelines. 3. Performance and Quality Improvement Department will conduct regular internal reviews of incidents to ensure compliance.	12/20/2022 2/10/2023 Ongoing Ongoing Ongoing ongoing
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;	V 367		

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V 367	Continued From page 12 (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 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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601400	A. BUILDING: _____ B. WING _____	C 12/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
SMITH COTTAGE	6725 SAINT PETER'S LANE MATTHEWS, NC 28105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 367	Continued From page 13 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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all level I, II and III incidents in the Incident Response Improvement System (IRIS) and notify the Local Management Entity /Management Care Organization (LME/MCO) responsible for the catchment area where services were provided with 72 hours of becoming aware of the incident for 1 of 3 audited clients (#7). The findings are: Review on 12/20/22 of client #7's record revealed: - Admission date 11/4/22; - Age 16;	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SMITH COTTAGE	6725 SAINT PETER'S LANE MATTHEWS, NC 28105

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V 367	Continued From page 14 - Diagnoses- Post Traumatic Stress Disorder, Unspecified; Major Depressive Disorder, with Congruent Psychotic Features, in Partial Remission; Generalized Anxiety Disorder. Review on 12/20/22 of the facility's internal incident reports revealed: -On 12/16/22 at 5:59 pm Client #7 called 911 about her feelings and was transported to the hospital for evaluation Review on 12/20/22 of the IRIS from 11/25/22-12/20/22 revealed: -No IRIS report submitted for client #7 contacting the local police and being transported to the local hospital on 12/16/22. Review on 12/20/22 of the facility's records revealed: -No documentation of the LME/MCO notification. Interview on 12/20/22 with the Program Supervisor revealed: - Responsible for submitting IRIS reports for the cottage; - She submitted an incident report in IRIS on 12/18/22 from the incident with client #7 on 12/16/22. Interview on 12/21/22 with Residential Program Director revealed: - Program Supervisor was responsible for completing IRIS reports; - IRIS reports were randomly reviewed by herself and Performance Quality Improvement.	V 367	V367 Correction: 1. Quality Improvement Specialist reviewed incident reporting procedures and protocols with program supervisor on 12/20/2022 to ensure compliance with reporting timelines. 2. Incident Reporting Policy will be reviewed by Supervisor at the next staff meeting. Prevention: 1. Program Supervisor will facilitate Incident reporting refreshers will be completed quarterly to ensure staff are aware of incident reporting procedures and expectations are met. 2. Incident Reporting Policy will be placed in resource binder in staff office. Monitoring: 1. Program Supervisors will review all incidents to ensure that all components of the report have been completed to include prevention/mitigation and notification of legal guardians, LME, and other authorities required by law. 2. Program Director will monitor adherence to the Incident Reporting Guidelines. 3. Performance and Quality Improvement Department will conduct regular internal reviews of incidents to ensure compliance.	12/20/2022 2/10/2023 Ongoing 2/10/2023 ongoing Ongoing Ongoing