PRINTED: 01/09/2023
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL014-067	A. BUILDING: _____ B. WING _____	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDING	2419 MORGANTON BOULEVARD LENOIR, NC 28645

(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
V 000	INITIAL COMMENTS An annual survey was completed on January 6, 2023. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 4 and currently had a census of 4 clients. The survey sample consisted of audits of 3 current clients and 1 former client.	V 000		
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		

[redacted] ER/SUPPLIER REPRESENTATIVE'S SIGNATURE BSQP TITLE Quality Improvement Director (X6) DATE 1/19/2023

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V 367	Continued From page 1 (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 2 (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 interview, the facility failed to report all level II incidents in the Incident Response Improvement System (IRIS) and notify the Local Management Entity (LME) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident affecting 1 of 3 current clients audited (Client #3) and 1 of 1 audited Former Client (FC #4). The findings are: Review on 1/6/23 of Client #3's record revealed: -Admitted 7/20/22. -Diagnoses of Attention-Deficit Hyperactivity Disorder (ADHD), Unspecified Disruptive Disorder, and Impulse Control and Conduct Disorder.	V 367	Responsible Party: [redacted] QI Director Implementation Date: 1/11/2023 Projected Completion Date: 3/6/2023 Mandatory trainings are being put in place for all residential staff. The training that occurred for the Landing location was held on January 11th, 2023. This training encompassed level 1 and level 2/3 requirements per company and DHSR standards. Timelines and requirements were discussed in depth with examples to assist staff with completing these. In order to prevent this occurrence from happening again, staff have been trained (also at training on the 11th) that when an IRIS report is needed that they must inform the QI director immediately- via phone or email- so that this can be completed within the 72 hour time frame. If it is a weekend then the staff must notify the On-call who will then notify the QI director via email immediately. Staffs have been provided with an IRIS report form to send to the QI director as well so that the director may fill out the IRIS thoroughly. The QI director will monitor the need for an IRIS completion daily via a specialized email, QI@focusbhs.com, to ensure that all IRIS reports are completed when they occur.	

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V 367	Continued From page 3 Review on 1/6/23 of FC #4's record revealed: -Admitted 10/4/22. -Discharged 12/28/22. -Diagnoses of Post-Traumatic Stress Disorder, Trauma and Stressor-Related Disorder, Borderline Intellectual Functioning, ADHD, Conduct Disorder and Other Circumstances related to Child Sexual Abuse, Encounter for Mental Health Services for Perpetrator of Nonparental Child Sexual Abuse. Interview on 1/5/23 with Client #3 revealed: -He ran from the facility either last week or the week before. -He went to a local store and the police had to bring him back to the facility. Interview on 1/5/23 with Staff #1 revealed: -She was on shift during an incident with FC #4 that happened in the "beginning of December." -FC #4 had a blanket wrapped about his neck and at first was acting like it was a cape. -When she said it wasn't safe for him to do this and to stop FC #4 started tightening it around his neck. -He continued to tighten the blanket more and more as she tried to re-direct him. -She called her supervisor who said to put him on a safety watch and check him every 15 minutes. -Then FC #4 said he wanted to kill himself so she did not let him out of her sight. -He continued to escalate and attempted to get out of his room by opening the window or going out the door. -She would block the door so he couldn't leave. -When he went toward the window she tried to grab his waist and he stopped. -As they were standing in front of the window she held his arms and crossed them in front of him.	V 367		

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V 367	Continued From page 4 -He was trying to slide down and get out of the restraint. -He was eventually able to push by her and get out of the room and ended up running outside of the facility. -The police were called as he ran laps around the house and refused to come inside. -Once the police arrived and they spoke with him he walked in the facility and went to bed. -The entire incident lasted from approximately 5:00 p.m. to 8:00 p.m. Review on 1/5/23 of facility level II and level III incidents submitted in IRIS revealed; -No incident reports regarding Client #3 or FC #4. Interview and record review on 1/6/23 with the House Manager revealed: -She remembered last month, "sometime before Christmas" Client #3 ran from the facility and the police were called. -She believed there was an incident report regarding this and printed it from her computer. -The licensee's "IRIS Incident Reporting Form" reflected the incident regarding Client #3 running and the police returned him to the facility, however no date was provided. -The times indicated Client #3 was gone from approximately 3:45 p.m. to 7:15 p.m. -She also remembered the incident when FC #4 wrapped a blanket around his neck; She was not aware he was restrained during this incident. -She believed an incident report was completed on this as well, however she could not locate one. Interview and record review on 1/6/23 with the Quality Improvement/Residential Treatment Director revealed: -She provided three incident reports in addition to the previous reports received on 1/5/23; two for	V 367		

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V 367	Continued From page 5 Client #3 and 1 for FC #4. -12/3/22 - a level I for FC #4 when he tied a blanket around his neck and "...was placed on health and safety watch..." -The incident did not reflect FC #4 was restrained or that the police were called. -She was not aware of the restraint or the police being called. -12/27/22 - level II - IRIS report when Client #3 ran to a local store and was returned by police, last submitted 1/6/23. -12/28/22 - level II - IRIS report - Client #3 was placed on suicide watch; facility called police to seek involuntary commitment and he was transported to the hospital; last submitted 1/5/23. -The staff on call at the time of the incident was responsible to do an IRIS report. -She went ahead and completed the IRIS reports for Client #3 and would be discussing this with staff who did not complete the report. -She called Staff #1 to inquire about the restraint of FC #4 and requested a written statement regarding the incident. -She would complete an IRIS report once this information was received.	V 367	Responsible Party [redacted] QI Director Implementation Date: 1/11/2023 Projected Completion Date: 3/6/2023 Maintenance was contacted and a work order was put in place for the hot water heater to be evaluated and checked. Once the maintenance department comes to look at the heater and evaluate- then necessary steps will be taken according to the findings. If a technician is needed to evaluate the hot water heater then one will be identified and called. If anything needs to be replaced or serviced in a different manner then this will occur in order to meet DHSR guidelines. The landing's house manager will take random temperature checks when they are at the landing on shift (2-3 times weekly), at random times throughout the shift, and document these to identify any fluctuations in the water temperature. If any fluctuations are noticed then QI will be notified immediately and they will contact maintenance.	
V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit.	V 752		

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V 752	Continued From page 6 This Rule is not met as evidenced by: Based on observation and interview the facility failed to maintain the facility water temperature between 100-116 degrees Fahrenheit. The findings are: Observation on 1/6/23 at approximately 11:35 a.m. of the facility revealed : -The kitchen sink water temperature was 90 degrees Fahrenheit. -The client bathroom sink water was 90 degrees Fahrenheit. Interview on 1/6/23 with the House Manager revealed: -She called maintenance in the past and they adjusted the water temperature and at one point it was hotter. -She checked the water temperatures monthly and it did still fluctuate. -She would call maintenance again.	V 752		

FOCUS
BEHAVIORAL HEALTH SERVICES, LLC
PO Box 3624 Morganton, NC 28680
Phone: (828) 439-8191 • Fax: (828) 439-2500

January 19, 2023

Attention: Mental Health Licensure and Certification Section-NC Division of Health Service Regulation

Re: Statement of Deficiencies and Plan of Correction

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center, Raleigh, NC 27699-2718

Re: Annual Survey completed January 5/6, 2023
Burkwell, 3476 Morganton Boulevard, Lenoir, NC, 28645
MHL #014-006
The Landing, 2419 Morganton Boulevard, Lenoir, NC, 28645
MHL #014-087
E-mail Address: [redacted]

Dear NCDHHS Survey Team,

Attached are the plans of corrections for *The Landing* and *Burkwell* locations for Focus Behavioral Health Services. I hope you will find these corrections to your standards. Thank you for your time and attention to this matter. If you have any questions please do not hesitate to reach out to me at kwilson@focusbhs.com or at 8285448351.

[redacted] BSQP 1/19/2023
QI Director