STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-145	A. BUILDING: ______ B. WING ______	01/19/2023

DHSR - Mental Health
FEB 09 2023
Lic. & Cert. Section

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GETTING READY INC	510 CHURCH STREET BLACK CREEK, NC 27813

(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 A complaint survey was completed on January 18, 2023. The complaints were unsubstantiated (Intake #NC00194314 and NC00194328). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1400 Day Treatment for Children and Adolescents with Emotional or Behavioral Disturbances and .4400 Substance Abuse Intensive Outpatient Program. This facility has a current census of 22. The survey sample consisted of audits of 2 former clients.	V 000	In response to the failure to report the alleged abuse to HCPR, MCO, and DSS and in response to the failure to complete an in-house incident report on the alleged abuse, Getting Ready will implement the following plan of correction: -A mandatory training for all staff, to include QPs, LPs, Program Directors, and QA/QI Director, will be provided by our Clinical Training Director, [redacted] to ensure all staff members understand the policies of deficiency here. Specifically that whenever there is any alleged abuse, they must report to the 3 entities mentioned above within 72 hours from the incident AND complete an in-house incident report within 24 hours. That in-house incident report and copies of all external reports will be provided to QA/QI Director [redacted] for filing in QA records. This training will be provided and completed by all applicable/direct care staff members by March 30, 2023. -QA/QI Director, [redacted] will create a checklist for incidents reporting by 2/14/2023 for her own use and to provide to staff, indicating the requirements whenever there is an allegation of abuse. Specifically the checklist will include (1) reporting to HCPR	
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection 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	V 132		

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V 132	Continued From page 1 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. 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 (HCPR). The findings are: Review on 01/18/23 of facility records from September 2022 thru December 2022 revealed no allegations of abuse had been reported to the HCPR. Review on 01/19/22 of Former Client (FC) #9's record revealed: -9 year old male. -Admission date of 03/09/22.	V 132	withing 72 hours of the incident; (2) reporting to DSS within 72 hours of the incident; (3) reporting to the MCO within 72 hours of the incident and (4) completing an in-house incident report within 24 hours. The in-house incident report will be required within 24 hours to ensure the other reports will be made in a timely manner, if applicable. All staff members will receive a copy of this checklist for their keeping and use. When QA/QI Director [redacted] receives an in-house incident report, she will cross reference the incident report checklist to ensure the proper external entities receive reports from the appropriate staff member. -Chief Operating Officer, [redacted] will add a stationary agenda item for "Recent Incident Reports" to the bi-weekly Operations Director Meeting, with Clinical Training Director [redacted] and QA/QI Director [redacted] to review any recent incidents and to verify they were reported consistent with the rules outlined here. Additionally, Clinical Training Director [redacted] will add a stationary agenda item to the monthly agency-wide Director/LP meeting to review any recent incidents and to verify they were reported consistent with the rules outlined here. These stationary agenda items will be added by February 3, 2023.	

Division of Health Service Regulation

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V 132	Continued From page 2 -Discharge date of 10/06/22. -Diagnoses of Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, and Autistic Disorder. Review on 01/18/23 of the facility incident reports revealed: -No Level 3 incident reports had been completed for Former Client (FC) #23 accusing staff #3 of "snatching" him up in the van. During interview on 01/19/23 staff #3 revealed: -The incident occurred several months ago (did not know specific date). -Staff #3 was driving the van back to the facility. -FC #23 was out of his seat and not in a seat belt. -Staff #3 pulled the van over and asked FC #3 to sit down and put his seat belt on. -FC #23 finally sat down and they arrived back to the facility. -Staff #3 never put his hands on FC #3. -Staff #3 was bothered by the incident because he had worked with children for years and had never had a complaint against him until that incident. During interview on 01/19/23 the Quality Assurance/Human Resource Director (QA/HRD) revealed: -QA/HRD had several problems with FC #23 with his behaviors and with the mother. -QA/HRD did not complete a Level 2 and was not aware an incident report had to be completed for all allegations. -QA/HRD interviewed all the clients in the van the day of the incident and no one saw staff #3 touch FC #23.	V 132	-Since the time of this alleged incident, Getting Ready has hired a new, more experienced Day Treatment Director, [redacted] LCHMC. [redacted] is highly knowledgeable and it is unanimously agreed within Getting Ready that had [redacted] been the Day Tx Director at the time of this alleged incident, all proper reporting procedures would have been followed. She, and all Directors and Team Leads for all services, will add a stationary agenda item to their weekly team meetings to verify they were reported consistent with the rules outlined here. These stationary agenda items will be added by February 3, 2023.	

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V 367	Continued From page 3	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 4	V 367		

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

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V 367	Continued From page 5	V 367		

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 ensure critical incident reports were submitted to the Local Management Entity/Managed Care Organization (LME/MCO) as required. The findings are:

Review on 01/18/23 of the North Carolina Incident Response Improvement System (IRIS) for September 2022-December 2022 revealed no level III reports submitted by the facility for an allegation of abuse.

Review on 01/18/23 of the facility incident reports revealed:
-No Level 3 incident reports had been completed for Former Client (FC) #23 accusing staff #3 of "snatching" him up in the van.

During interview on 01/19/23 the Quality Assurance/Human Resource Director (QA/HRD) revealed:
-QA/HRD had several problems with FC #23 with his behaviors and with the mother.
-QA/HRD did not complete a Level 2 and was not aware an incident report had to be completed for all allegations.
-QA/HRD interviewed all the clients in the van the day of the incident and no one saw staff #3 touch

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V 367	Continued From page 6 FC #23.	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing	V 500		

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V 500	Continued From page 7 the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to report to the Department of Social Services (DSS) in the county where services are provided all allegations of resident abuse by health care personnel. The findings are: Review on 01/19/23 of facility records from September 2022 thru December 2022 revealed no reports of allegations of abuse to the local DSS. Review on 01/19/22 of Former Client (FC) #9's	V 500		

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V 500	Continued From page 8 record revealed: -9 year old male. -Admission date of 03/09/22. -Discharge date of 10/06/22. -Diagnoses of Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, and Autistic Disorder. Review on 01/18/23 of the facility incident reports revealed: -No Level 3 incident reports had been completed for Former Client (FC) #23 accusing staff #3 of "snatching" him up in the van. During interview on 01/19/23 the Quality Assurance/Human Resource Director (QA/HRD) revealed: -QA/HRD had several problems with FC #23 with his behaviors and with the mother. -QA/HRD did not complete a Level 2 and was not aware an incident report had to be completed for all allegations. -QA/HRD interviewed all the clients in the van the day of the incident and no one saw staff #3 touch FC #23.	V 500		

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

January 25, 2023

Laura Atkinson
Getting Ready, Inc.
P.O. Box 355
Black Creek, NC 27813

Re: Complaint Survey completed 01/19/23
Getting Ready, Inc., 510 Church Street, Black Creek, NC 27813
MHL # 098-145
E-mail Address: Latkinson@gettingreadywilson.net
Intake #NC00194314 and NC00194328

Dear Ms. Atkinson:

Thank you for the cooperation and courtesy extended during the complaint survey completed 01/19/23. The complaints were unsubstantiated.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- All tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is 03/20/23.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

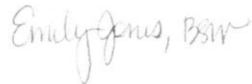
Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

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

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Gloria Locklear at 910-214-0350.

Sincerely,



Emily Jones, BSW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: DHSR@Alliancebhc.org
DHSRreports@eastpointe.net
Joy Futrell, CEO, Trillium Health Resources LME/MCO
Fonda Gonzales, Director of Quality Management, Trillium Health Resources LME/MCO
Pam Pridgen, Administrative Supervisor