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
	MHL090-218	A. BUILDING: _____ B. WING _____	02/03/2023

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LENDON COTTAGE	1915 HASTY ROAD, SUITE D MARSHVILLE, NC 28103

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 2-3-23. The complaints were substantiated (#NC00197297 and #NC00197190). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 1300 Residential Treatment for Children or Adolescents. This facility is licensed for twelve and currently has a census of eight. The survey sample consisted of audits of three current clients.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility	V 105	Received by MHL & C 3/1/23	

Tim Hull 2/27/23

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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V 105	Continued From page 1 can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to implement a written policy, effecting standard of care. The findings are: Review on 2-2-23 of the Behavior Management Policy effective 3-1-20 and reviewed 5-1-22 revealed: -"The Registered Nurse trained in the use of TCI (Therapeutic Crisis Intervention) techniques must assess the physical and psychological well-being of the consumer within 1 hour of the initiation of the restrictive intervention. This assessment must be face-to-face... -The Restrictive Intervention Report form is completed on all incidents requiring physical restraints of a client. Always document specific date and time the restraint occurred. Print name of the staff reporting the incident (should be someone who witnessed or was part of the incident). Other staff involved must also be listed on the form. When completing the report form staff are required to document if there were injuries to client and/or staff and the nature/severity of injury and if, medical attention was required, what action was taken. An injury report for clients or workman ' s compensation form for staff is completed if there were injuries that require medical attention. -The staff member reporting the physical restraint shall notify all appropriate [Licensee] staff (Cottage Supervisor, Therapist, etc.) within 24 hours of the restraint. The legal guardian, mental health case manager/DSS (Department of Social Services) social worker and any member	V 105	AHS will revise the Behavior Management Policy to reflect the regulation of a Level 2 facility that a nurse does not have to order a restraint and a nurse must order a restraint for PRTF facilities, but a client must receive a physical assessment rather they are residing in a level 2 or PRTF 1 hour after a restraint is performed. AHS will provide a refresher to Direct Care and Nursing staff the procedure with notifying nurse within 5 minutes after a restraint is performed and nursing performing a physical assessment within 1 hours of a performed restraint. AHS will provide a refresher training to all staff regarding the incident reporting process to ensure compliance with under reporting and following the reporting system with required documents and notifying appropriate parties. AHS Shift Managers and Program Manager will receive a refresher training on responsibilities when it comes to completing IRIS reports within 72 hours. AHS Shift Managers will be responsible for reviewing all shift notes daily to ensure compliance with incident reporting and notifying legal guardians of any incident within 24 hours of the incident and notifying the appropriate administrative staff to email the client's LG and Care Coordinator the appropriate incident documents within 24 hours of the incident. Shift Managers will track their shift note review daily on a tracking tool and will provide a copy to the Program Manager weekly to review. Case Manager will continue providing weekly updates to the client's legal guardian and Care Coordinator. The Case Manger will also email a monthly incident update to the client's legal guardian and care coordinator at the end of each month with incident reports and restrictive intervention form. The Clinical Director will track each email being sent weekly and monthly with date, time, and to whom on a tracking tool. Quality	

			Director will collect the tracking tool monthly to ensure compliance.	

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V 105	Continued From page 3 of the child and family team legally or clinically responsible to ensure the child ' s safety shall be notified by phone within 24 hours of the physical restraint by the program director or designee. Documentation of each notification must be recorded on the Restrictive Intervention form and the Incident form. The program director or designee will send a copy of the Restrictive Intervention form within 24 hours or one business day to the child ' s case manager. In addition, Administrative Assistant sends a copy of each Restrictive Intervention form to the child ' s legally responsible person at the end of each month." Review on 1-31-23 of Incident Report completed 12-27-22 of the incident the happened 12-26-22 revealed: -"After staff sent clients to their room from one altercation [Client #1] decided he wanted to still sit in the day room and turn the tv. Staff told [Client #1] that they all had to go to their rooms, [Client #1] stated he wasn't going to f******g bed it want time. [Client #1] then throws remote, and staff proceeds to take [Client #1] items and he continued to curse and disrespect staff. Staff then restrained client." Interview on 2-2-23 with Staff #1 revealed: -They had restrained Client #1 on 12-26-22. -The nurse had been there watching. -The nurse came down later to check on Client #1. Interview on 2-2-23 with Staff #2 revealed: -She had helped restraint Client #1 on 12-2622. -No nurse had been there to see the restraint. -The nurse had been at the cottage, but she was leaving and going off duty.	V 105		

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V 105	Continued From page 4 Interview on 1-31-23 with one of the facilities Registered Nurse revealed: -She had been working the night on 12-2622. -She got to the cottage approximately 8:30 to give out medications, and the incident had already happened. -She reported that Client #1 had asked for his as needed medication because he "needed something to calm him down." Interview on 2-2-23 with the Quality Director revealed: -She would ensure the all staff understood they needed to call a nurse before initiating a restraint. Interview on 1-31-23 with the Qualified Professional revealed: -The staff are supposed to notify nursing before they start a restraint. Interview on 1-31-23 with the Nurse Administrator revealed: -She had not been notified of the restraint until 12-30-22. -She then went through the nursing notes for 12-26-22 and there was nothing about a restraint for Client #1.	V 105		
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	V 112		

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V 112	Continued From page 5 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 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 review and interview the facility failed to ensure that a Person Centered Plan shall be developed within 30 days of admission, effecting three of three clients (Clients #1, #2, and #3). The findings are: Review on 1-31-23 of Client #1's record revealed: -Admitted 11-29-22. -Person Centered Plan dated 11-17-21 and last updated 8-17-22, -All goals reflected his last facility placement as being responsible for his goals.	V 112	Clinical Director will implement a treatment plan schedule for all case mangers to follow to ensure compliance that all clients are receiving a treatment plan update within 30 days of admissions. Clinical Director will provide all Case Managers a re-training on how to complete a PCP and crisis plan to ensure compliance.	

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V 112	Continued From page 6 -Crisis Plan reflects his last placement as his clinical home, his service provider and his therapist. Review on 1-31-23 of Client #2's record revealed: - Admitted 12-19-22. -Person Centered Plan dated 9-2-22 with no updates documented. -Goals reflect that his Therapeutic Foster care is responsible for his goals. -Crisis Plan reflects his Foster family and last provider as who to call in case of a crisis. Review on 1-31-23 of Client #3's record revealed: -Admitted 11-2-22. -Person Centered Plan dated 9-19-22 and last updated 12-29-22. -Crisis Plan dated 9-19-22 with the last placement listed as the clinical home, first responder and therapist. Interview on 2-3-23 with the Quality Director revealed: -Client #1 was scheduled for a Person Centered Plan update on 2-3-23, Client #2 had bee admitted in December and they would be scheduling an update for him. -The facility would ensure that all Person Centered Plans and Crisis Plans would be updated in a timely manner in the future.	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.	V 114		

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V 114	Continued From page 7 (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 accessible for use. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure that and fire drills and a disaster drills was completed at least quarterly on each shift. The findings are: Review on 1-31-23 of documentation of fire drills for 2022 revealed: -No third shift fire drill documented the for the first quarter of 2022. -No second or third shift fire drill documented for the third quarter of 2022. -No first shift fire drill documented the fourth quarter of 2022. Review on 1-31-23 of documentation of disaster drills for 2022 revealed: -No 1st shift, second shift, or third shift disaster drills documented for the first quarter of 2022. -No 1st shift, second shift, or third shift disaster drills documented for the second quarter of 2022. -No 1st shift, second shift, or third shift disaster drills documented for the third quarter of 2022.	V 114	Quality Director will create a yearly, quarterly scheduled for all fire and disaster drills to be conducted by AHS, Facility Manager. The Facility Manager will email the completed drills monthly to the Quality Director to ensure compliance.	

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V 114	Continued From page 8 -No second shift, or third shift disaster drills documented for the fourth quarter of 2022. Interview on 2-2-23 with Client #1 revealed: -He knows they have had fire drills, but no disaster drills since he has been at the facility. Interview on 2-2-23 with Client #3 revealed: -They have had fire drills, but no disaster drills at the facility. Interview on 2-2-23 with Client #3 revealed: -They have had fire drills and one disaster drill since she had been at the facility. Interview on 1-31-23 with the Quality Director revealed: -The shifts are; first shift is 7am-3pm, second shift is 3pm-11pm, and third shift is 11pm-7am. -She would talk with the maintence person, since he was in charge of running the fire drills, to ensure the drills were run correctly in the future.	V 114		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.	V 131		

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V 131	Continued From page 9 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to hire for 1 of 3 audited current staff (Staff #2) and 1 of 1 audited former staff (FS #1). The findings are: Review on 2-2-23 of Staff #2's personnel record revealed: -Date of Hire: 11-29-22. -Job Title: Residential Care Worker. - No HCPR check. Review on 2-2-23 of FS #1's personnel record revealed: -Date of Hire: 5-16-22. -Job Title: Residential Care Worker. - No HCPR check. Interview on 2-2-23 with Staff #2 revealed: - Employed since November 2022. Attempted interviews on 1-31-23, 2-2-23 and 2-3-23 with FS #1 were unsuccessful due to no response to phone calls. Interview on 2-2-23 with the Chief Operation Officer (COO) revealed: -The facility utilized a third party vendor for HCPR checks. -The 3rd party vendor accessed HCPR when performing criminal background checks. -The facility had received approval to use the 3rd party vendor for HCPR checks. Review on 2-2-23 of a Request for Waiver of Licensing Rules revealed: -Name of Agency: Anderson Health Services. -Title of Individual Requesting Waiver: COO.	V 131	AHS HR Director will perform all HCPR checks manually instead of using Shield Screening to ensure compliance with performing checks prior to hire and ensuring the sate seal is on all checks.	

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V 131	Continued From page 10 -The request was to the "Division of Social Services (DSS)" for waiver of rule 10A NCAC 70F .0206 (7b (6)) Personnel Policies. -DSS approved the waiver through 8-31-2024. Review on 2-3-23 of DHSR facility files for the licensee revealed: -No waiver of rule approval.	V 131		
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	V 366		

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V 366	Continued From page 11 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 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	V 366		

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V 366	Continued From page 12 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 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 written policies governing their response to level I, II, and III incidents. The findings are: Refer to V367 for specific incident details	V 366	AHS will provide a refresher training to all staff regarding the incident reporting process to ensure compliance with under reporting and following the reporting system with required documents and notifying appropriate parties. AHS Shift Managers and Program Manager will receive a refresher training on responsibilities when it comes to completing IRIS reports within 72 hours. AHS Shift Managers will be responsible for reviewing all shift notes daily to ensure compliance with incident reporting and notifying legal guardians of any incident within 24 hours of the incident and notifying the appropriate administrative staff to email the client's LG and Care Coordinator the appropriate incident documents within 24 hours of the incident.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENDON COTTAGE	1915 HASTY ROAD, SUITE D MARSHVILLE, NC 28103

(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 366	Continued From page 13 Review on 2-3-23 of the North Carolina Incident Response Improvement System (IRIS) from 11-1-22 through 1-31-23 revealed: -No incident report, or risk/cause analysis was submitted into IRIS for incidents which occurred on 11-14-22, 11-27-22, 12-4-22, 12-11-22, 12-20-22, 12-26-22, 1-1-23, 1-2-23, 1-12-23, 1-13-23 and 1-24-23. Interview on 2-2-23 with the Cottage Supervisor revealed: -Direct care staff were required to complete incident reports by the end of each shift. -Incident reports were reviewed by supervisors. -Staff had access to a reference manual to help determine the level of each incident. Interview on 2-3-23 with the Quality Director revealed: -Incident reports were completed by direct care staff. -Cottage Supervisors completed one section of the level II and level III incident reports. -Cottage Supervisors forwarded the level II and level III incident reports to the Residential Director. -The Residential Director completed the rest of the level II and level III incident reports and submitted them into IRIS. -Cottage Supervisors were supposed to read and review incidents from each shift by the next day. -Cottage Supervisors had been trained on the levels that need to be entered into IRIS. Interview on 2-3-23 with the Residential Director revealed: -Direct care staff complete an incident report. -The Cottage Supervisors completed a section of each IRIS report.	V 366		

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V 366	Continued From page 14 -She completed the remaining section and submitted it into IRIS. -There was "lapse in staff knowledge" of the different levels of severity. -Staff would be re-trained.	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 (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	V 367		

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V 367	Continued From page 15 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: (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	V 367		

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V 367	Continued From page 16 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 II and III incidents in the Incident Response Improvement System (IRIS) and failed to notify the Local Management Entity /Management Care Organization (LME/MCO) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident. The findings are: Review on 2-3-23 of the facility's internal incident reports dated 11-1-22 through 1-31-23 revealed: -11-14-22 an unaudited client went to the emergency room (ER) to get stitches under his left eye after a physical altercation with a peer. Documented as a level 1 incident. -11-27-22 the same unaudited client as above destroyed property and had self-inflicted scratches to his right forearm. Documented as a level II incident. -12-4-22 Two unaudited clients were involved in a physical altercation. Documented as a level II incident.	V 367	AHS will provide a refresher training to all staff regarding the incident reporting process to ensure compliance with under reporting and following the reporting system with required documents and notifying appropriate parties. AHS Shift Managers and Program Manager will receive a refresher training on responsibilities when it comes to completing IRIS reports within 72 hours. AHS Shift Managers will be responsible for reviewing all shift notes daily to ensure compliance with incident reporting and notifying legal guardians of any incident within 24 hours of the incident and notifying the appropriate administrative staff to email the client's LG and Care Coordinator the appropriate incident documents within 24 hours of the incident. Quality Director will provide AHS Shift Manager, Program Manager, and Residential Service Director a retraining on how to complete an IRIS report and when to notify all parties to ensure compliance that all reports are submitted within 72 hours. The Quality Director will maintain a tracking form to ensure compliance with the 72-hour submission requirement.	

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V 367		V 367		

Continued From page 17

-12-11-22 An unaudited client was taken to the ER after an injury related to a fall. Documented as a level I incident.
-12-20-22 An unaudited client was seen by the nurse and transferred to urgent care for an injured knee. Documented as a level II incident. -12-26-22 Client#2 and Client#3 involved in physical altercation. Client#2 punched Client#3 in the face. Documented as a level I incident. -12-26-22 Client#1 allegation of abuse and restraint. Documented as a level I incident. -1-1-23 Client#2 dislocated his shoulder and was taken to the ER. Documented as a level I incident.
-1-2-23 An unaudited client assaulted Client#3. Unaudited client was removed from the cottage by local law enforcement. Documented as a level I incident.
-1-12-23 An unaudited client was taken to urgent care for an injury. Documented as a level I incident.
-1-13-23 Client#3 eloped from the facility. Documented as a level II incident.
-1-24-23 Client#2, Client#3 and an unaudited client eloped from the facility. Law enforcement was called to locate the clients. The type of incident level was not documented.

Review on 2-3-23 of IRIS from 11-1-22 through 1-31-23 revealed:
-No incident report, or risk/cause analysis was submitted into IRIS for incidents which occurred on 11-14-22, 11-27-22, 12-4-22, 12-11-22, 12-20-22, 12-26-22, 1-1-23, 1-2-23, 1-12-23, 1-13-23 and 1-24-23.

Interview on 2-2-23 with the Cottage Supervisor revealed:
-Direct care staff were required to complete incident reports by the end of each shift.

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V 367	Continued From page 18 -Incident reports were reviewed by supervisors. - Staff had access to a reference manual to help determine the level of each incident. Interview on 2-3-23 with the Quality Director revealed: -Incident reports were completed by direct care staff. -Cottage Supervisors completed one section of the level II and level III incident reports. -Cottage Supervisors forwarded the level II and level III incident reports to the Residential Director. -The Residential Director completed the rest of the level II and level III incident reports and submitted them into IRIS. -Cottage Supervisors were supposed to read and review incidents from each shift by the next day. - Cottage Supervisors had been trained on the levels that need to be entered into IRIS. Interview on 2-3-23 with the Residential Director revealed: -Direct care staff complete an incident report. - The Cottage Supervisors completed a section of each IRIS report. -She completed the remaining section and submitted it into IRIS. -There was "lapse in staff knowledge" of the different levels of severity. -Staff would be re-trained.	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	V 536		

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V 536	Continued From page 19 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 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;	V 536		

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V 536	Continued From page 20 (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 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	V 536		

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V 536	Continued From page 21 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 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.	V 536		

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V 536	Continued From page 22 (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 1 of 4 audited staff (Registered Nurse (RN) #1) demonstrated competency prior to providing services by completing training on alternatives to restrictive interventions. The findings are: Review on 2-3-23 of RN #1's personnel record revealed: -Date of Hire: 11-7-22. -No documentation of approved training on alternatives to restrictive interventions. Interview on 1-31-23 with RN #1 revealed: -She had not received training on alternatives to restrictive interventions. -She was scheduled to have training in Therapeutic Crisis Intervention (TCI) next month.	V 536	AHS HR Director will create a tracking form to ensure all nursing and AHS staff receive TCI training prior to being in ratio with clients. AHS training specialist will maintain a tracking of all staff's training and ensure compliance with training requirements.	
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT	V 537		

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V 537	Continued From page 23 (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 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	V 537		

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V 537	Continued From page 24 (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); (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	V 537		

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V 537	Continued From page 25 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 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.	V 537		

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V 537	Continued From page 26 (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 review and interview, the facility failed to ensure 1 of 4 audited staff (Registered Nurse (RN) #1) completed training in seclusion, physical restraint and isolation time out prior to providing services. The findings are: Review on 2-3-23 of RN #1's personnel record revealed: -Date of Hire: 11-7-22. -No documentation of approved training in seclusion, physical restraint and isolation time out. Interview on 1-31-23 with RN #1 revealed: - She had not received training in seclusion, physical restraint and isolation time out. - She had not monitored any restrictive	V 537	AHS HR Director will create a tracking form to ensure all nursing and AHS staff receive TCI training prior to being in ratio with clients. AHS training specialist will maintain a tracking of all staff's training and ensure compliance with training requirements.	

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	MHL090-218	A. BUILDING: _____ B. WING _____	02/03/2023

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V 537	Continued From page 27 interventions since being hired by the facility. -She was scheduled to have training in Therapeutic Crisis Intervention (TCI) next month.	V 537		
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 interviews, observation, and record reviews the facility failed to be maintained in a clean, safe, attractive manner. The findings are: Observation on 1-31-23 at approximately 9:15 am revealed: Client #4's bedroom: - Burgundy colored cloth tacked over the window; - sunflower seeds shells on the night stand; - bedroom door had a black stain on the back; - baseboard in the bedroom near the bathroom entrance extends approximately 2 inches past the door frame causing a trip hazard; - bathroom shower has black colored stains smeared along the wall and floor of the tub; - baseboard is missing along the right side of the shower.	V 736	Quality Director will create a Facility walk through checklist to ensure compliance with facility appearance and maintenance request. AHS Facility Manager will be responsible for completing the walk through checklist weekly and emailing the weekly checklist on the 1st of every month to the Quality Direct.	

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V 736		V 736		
	Continued From page 28 Clients #5 and #6's bedroom: - Bedroom door had a crack approximately three inches long; - several gray/ cream colored stains that appeared to be paint were dried onto the floor; - no window coverings on the only window; -on the nightstand were 2 half empty jars of cheese and salsa, empty Dr. Pepper bottle, open can of root beer; - empty bottle of water on the floor; - two of two drawers broken on nightstand; - empty Wendy's cup on the floor, food wrappers, masks, dirty Kleenex with brown substance on them, used paper towels, plastic cups on the floor; -only one cabinet in the room that served as a closet, and it was missing both of the doors; - shelf full of empty chip bags, and a damp towel rolled into a ball; - tissues, bandages, and papers piled in the bathroom approximately 1 foot high next to the toilet; - hole in the wall behind the door approximately 2 inches wide; - toilet and sink had dirt, hair, and toothpaste residue on them both. Client #1 and #2's bedroom revealed: - cabinets that were being used as closets had no doors; - large amount of dirt and bits of paper on the floor; - empty bed was attached to the floor but had two of the legs detached from the floor with the screws hanging out that were approximately two inches long; - spindle missing from the toilet paper holder in the bathroom; - floor and the bottom of the toilet stained with black colored substance;			

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V 736	Continued From page 29 - brown colored patches of dirt on the floor in the bathroom; - light switch in the bathroom had tan colored substance around it. Client #3's bedroom revealed: -No window covering on the window; - one of two cabinets had a door which was broken with wooden splinters sticking out; - no toilet paper spindle in the bathroom; - numerous smears of brown thick colored substance on all the bathroom walls, shower walls, bedroom walls and cabinet wall and cabinet door handle appearing to be fecal matter and/or nasal mucus; - shower curtain torn from three rings at the top. Common area revealed: -Door frame missing from the inside of the front entrance; -fine chips of broken ground glass in the outside window frame. Bedroom #2 was not observed, due to client having Covid. Interview on 2-3-23 with Client #1 revealed: -He cleaned his own room and staff checked behind him. Interview on 2-2-23 with Client #3 revealed: -She was in charge of keeping her room clean, and she did keep it clean. Interview on 2-2-23 with Staff #2 revealed: -It was the staff's responsibility to keep the rooms clean, but they did encourage the clients to clean their own rooms.	V 736		

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V 736		V 736		
	Continued From page 30 Interview on 2-2-23 with Staff #3 revealed: -It was all of the staff's responsibility to ensure the cottage was kept clean. Interview on 1-31-23 with the Program Manager revealed: -It was the clients' job to ensure their rooms were kept clean. -The blinds had been torn down by the clients. Interview on 1-31-23 with the Qualified Professional revealed: -It was the staff responsibility to ensure the cottage was clean. Review on 2-3-23 of the Plan of Protection dated 2-3-23 and signed by the Quality Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Anderson Health services (licensee) will ensure that all residential facilities are kept safe, clean, attractive, orderly mannered, and free from offensive odor. AHS (Anderson Health Services) will have maintenance or designee clean all areas of the facility of glass, fixing base board, bolting bedframe to the floor, and locating blinds to replace the missing blinds in Lendon Cottage by close of business on 2/3/2023. Describe your plans to make sure the above happens. -AHS will conduct a thorough cleaning within 48 hours of submitting this plan of protection. The Program Director or designee will conduct a check to ensure all areas are back in compliance			

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V 736	Continued From page 31 of cleanliness. -AHS will provide a weekly cleaning schedule to ensure that Direct Care Staff are supporting clients with room and bathroom cleanings. -By next Friday, 2/10/2023, Quality Director will facilitate an emergency meeting with Direct Care staff and leadership to explain the importance of regulation around cleanliness of facility, cottages, and safety hazards. -AHS Program Manager or designee will provide oversite by conducting a physical check of client rooms and bathrooms weekly. Rooms checks will be formally documented and saved. -AHS Residential Service Director or Designee will provide oversite of facility grounds by checking each facility and client's rooms weekly to ensure that each facility is free of safety hazards such as nails, glass, missing blinds or broken furniture. This weekly check will be formally documented and saved." Facility had trash piled up in the rooms and unknown substances smeared on the walls in Client #3's bedroom, floorboard extending past the walls creating a trip hazard, fine chips of broken glass in the window frames, and screws exposed on a bedframe. The presence of potentially dangerous items, and the substance on the walls represent a health and safety hazard. This deficiency constitutes a Type B rule violation which is detrimental to health, safety and welfare of the clients. If the violation is not corrected within 45 days, an administrative penalty of 200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 736		