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
	MHL065-269	A. BUILDING: ______ B. WING ______	R 07/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROJECT TRANSITION-WILMINGTON	**1514 DOCTOR'S CIRCLE WILMINGTON, NC 28401**

(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 and follow up survey was completed on July 7, 2023. The complaint was unsubstantiated (intake #NC00203446). Deficiencies were cited. This facility is licensed for the following service category: 10 A NCAC 27 G .1100 Partial Hospitalization for Individuals Who Are Acutely Mentally Ill. This facility has a current census of 30. The survey sample consisted of audits of 2 current clients and 1 former client.	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug;	V 118		

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V 118	Continued From page 1 (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review, interview, and observation, the facility failed to administer medications as ordered by the physician and maintain an accurate MAR affecting 2 of 2 current clients (clients #2 and #3) and 1 of 1 former client (FC #1) audited. The findings are: Finding #1: Review on 7/5/23 and 7/6/23 of FC #1's record revealed: -20 year old male admitted 12/9/22 and discharged 6/19/23. -Diagnoses included disruptive mood dysregulation disorder (DMDD); autism spectrum disorder; attention deficit hyperactive disorder (ADHD), combined type; and borderline intellectual developmental disorder. Review on 7/5/23 and 7/6/23 of FC #1's medication orders revealed: -Orders dated 11/3/22 included the following: -Anafranil 50 mg (milligrams) at HS (bedtime). (antidepressant) -Benztropine 1 mg daily. (treat side effects of certain psychiatric medications)	V 118		

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V 118	Continued From page 2 -Clonidine 0.2 mg at bedtime. (ADHD) -Desmopressin (DDAVP) 0.2 mg at bedtime. (antidiuretic, bed wetting). -Depakote 500 mg DR (delayed release) twice daily. -Levetiracetam 750 mg BID (twice daily). (antiseizure) -Melatonin 5 mg at bedtime PRN (as needed) for sleep. -Olanzapine 10 mg BID. -No orders on hand for the following medications: 1. Depakote 250 mg DR. (antiseizure) 2. Dextroamphetamine Saccharate, Amphetamine Aspartate, Dextroamphetamine Sulfate, Amphetamine Sulfate Extended Release. (ADHD) 3. Famotidine 20 mg. (acid indigestion, reflux). Review on 7/5/23 and 7/6/23 of FC #1's 4/1/23 - 5/31/23 MARs revealed: -Anafranil 50 mg and Clonidine 0.2 mg was transcribed and scheduled on the MAR to be administered every morning. -The following medications without an order on hand had been transcribed to the May 2023 MAR and documented daily as given, refused, or out of facility: 1. Depakote 250 mg DR, twice daily in addition to Depakote 500 mg. Medication 2. Dextroamphetamine Saccharate, Amphetamine Aspartate, Dextroamphetamine Sulfate, Amphetamine Sulfate 15 mg Extended Release (ER) every morning. MAR was blank from 5/1/23 - 5/10/23 and documented as "not provided" from 5/11/23 - 5/22/23. 3. Famotidine 20 mg twice daily. MAR was blank until 5/30/23 when it was documented as "not provided." -Melatonin 5 mg was transcribed as a routine	V 118		

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medication to be given every night.
-5/20/23: The night scheduled doses of the following medications were documented as "not provided:"
-DDAVP 0.2 mg.
-Depakote 250 mg DR.
-Depakote 500 mg DR.
-Levetiracetam 750 mg.
-Olanzapine 10 mg.
-Melatonin 5 mg.
-5/22/23: The morning scheduled doses of the following medications were documented as "not provided:"
-Anafranil 50 mg.
-Benztropine 1 mg.
-Clonidine 0.2 mg.
-Depakote 250 mg DR.
-Depakote 500 mg DR.
-Levetiracetam 750 mg.
-Olanzapine 10 mg.

Finding #2:
Review on 7/5/23 and 7/6/23 of client #2's record revealed:
-48 year old male admitted 1/17/23.
-Diagnoses included schizoaffective disorder, depressive type; post traumatic stress disorder (PTSD); epilepsy; and, hypothyroidism.

Review on 7/5/23 and 7/6/23 of client #2's medication orders revealed:
-12/7/22: Quetiapine 250 mg TID (3 times daily). (schizoaffective disorder)
-12/7/22: Lorazepam 0.5 mg tab every night. (anxiety)
-Omega-3 Acid Ethyl Esters, 2 gm (grams) BID. (lower triglyceride level)
-No orders on hand for the following:
1. Metoprolol 25 mg daily (QD). (lower blood pressure)

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2. Lorazepam 0.5 mg tab QD PRN for anxiety.

Review on 7/5/23 and 7/6/23 of client #2's 4/1/23 - 7/5/23 MARs revealed:
-Quetiapine 250 mg morning doses were documented as "not provided" for 4/23/23 - 5/26/23.
-Quetiapine 250 mg noon doses were documented as "not provided" for 4/9/23, 4/12/23, 4/13/23, 4/15/23, 4/23/23 - 5/31/23, 6/5/23, 6/8/23, 6/9/23, 6/12/23, 6/13/23, 6/15/23, 6/16/23, 6/18/23, 6/20/23 - 6/24/23, 6/26/23 - 6/30/23.
-Quetiapine 250 mg noon doses were documented as given at 8 am on 4/11/23 ; 8 pm on 5/29/23, 5 pm on 6/2/23, 8 am on 6/4/23
-Quetiapine 250 mg night doses were documented as "not provided" for 4/23/23 - 5/25/23.
-Lorazepam 0.5 mg night dose was not printed on the April 2023 MAR.
-Lorazepam 0.5 mg night dose was blank from 5/1/23 - 5/25/23; and documented as given at 5 pm on 6/24/23.
-2 entries for Lorazepam 0.5 mg at night were entered on the June and July 2023 MARs.
-Omega-3 Acid Ethyl Esters, take 2, 1 gm (gram) capsules was documented as "not provided" BID 4/28/23 - 5/26/23; 6/28/23 - 7/5/23.
-Entry on May - July MARs for Metoprolol, 1 tablet daily. No dosage documented. Medication documented as given 5/27/23 - 7/5/23.

Observation on 7/6/23 at approximately 3:20 pm of client #2's medications on hand revealed the label on Metoprolol read the dosage was 25 mg and it was to be administered daily in the morning.

Interview on client #2 stated:

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-He would pick up his medications from the facility and self administer at home.
-He started administering his medications 2-3 months into the program.
-The facility provider an his primary care physician wrote his medication orders.
-There had never been times he was not supplied with his medications as ordered.

Finding #3:
Review on 7/5/23 and 7/6/23 of client #3's record revealed:
-20 year old male admitted 5/4/23.
-Diagnoses included schizophrenia, unspecified; major depressive disorder, recurrent episode with anxious distress; alcohol use disorder, moderate, in sustained remission; cocaine use disorder, severe, in sustained remission; cannabis use disorder, moderate in sustained remission; tobacco use disorder, moderate.

Review on 7/5/23 and 7/6/23 of client #3's medication orders dated 5/2/23 revealed:
-Clozapine 150 mg BID. (schizophrenia)
-Invega Sustenna 234 mg injection monthly. (schizophrenia)
-Risperidone 1 mg daily. (schizophrenia)
-No order to increase Risperidone to BID.
-Rosuvastatin 20 mg at bedtime. (hyperlipemia)
-Senna 8.6 mg daily. (constipation)
-No order to increase Senna 8.6 mg to 2 tablets daily.
-Vitamin D 50,000 units weekly. (vitamin deficiency)
-No order to increase Vitamin D to daily dosing.
-Vivitrol 380 mg injection (frequency not documented). (history of alcohol use disorder)
-No order for Hydroxyzine 50 mg BID
-No order for Depakote ER 500 mg ER nightly.

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V 118	Continued From page 6 Review on 7/5/23 and 7/6/23 of client #3's 5/1/23 - 7/5/23 MARs revealed: -There were no medications documented as given or refused from admission until 5/30/23. -Entries for Hydroxyzine 50 mg BID, first dose on 5/30/23. -Entries for Depakote ER 500 mg nightly, first dose on began 5/30/23. -Entries for Risperidone 1 mg BID, first dose on 5/30/23. -Entries for Senna 8.6 mg, 2 tablets every night, first dose on 5/30/23. -Entries for Vitamin D 50,000 units daily, first dose on 5/30/23 and continued through 7/5/23 with the exception of 3 client refusals (6/9/23, 7/4/23, 7/5/23). -The night scheduled doses of the following medications were documented as "not provided" on 5/31/23: 1. Clozapine 150 mg. 2. Depakote ER 500 mg. 3. Hydroxyzine 50 mg. 4. Risperidone 1 mg. 5. Rosuvastatin 20 mg. 6. Senna 8.6 mg, 2 tablets. -Invega Sustenna 234 mg injection was documented as given on 6/13/23 - 6/16/23, 6/19/23 - 6/20/23. Other days "client refused" was documented. -Vivitrol 380 mg injection was documented as given on 6/14/23 - 6/16/23. Other days "client refused" was documented. -No documentation when client #3 received Vivitrol and Invega injections by an outside provider. Observation on 7/5/23 at 3:17 pm of client #3's medications on hand revealed Vitamin D3 125 mcg (microgram) was packaged and labeled to be administered daily in the morning.	V 118		

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V 118	Continued From page 7 Interviews on 7/5/23 and 7/6/23 the Lead Residential Advisor (LRA) stated: -There were not orders on site for all medications being administered. -Orders were sent electronically to the pharmacy. -Client #2 had received his medications, but due to a computer issue, had been documented as "not provided." -Client #3 was admitted on 5/4/23 and received his medications in May. The reason the medications were not documented on the May MAR was because orders had to be entered by off site staff, and there was a delay in that process. -There was no back up documentation system in place for staff to document client #3 received his medications. Interviews on 7/5/23 and 7/6/23 the Program Director (PD) stated: -Some missed doses of medications could be due to some systems issues that had recently been corrected. -This recent electronic record system change allowed the local LRA or PD to enter orders for the electronic MAR. -Prior to this change, a MAR entry could "fall off" when the number of days/doses between the order date and the calendar date equaled/exceeded the number of doses ordered, even if the client still had medications on hand. -If the client continued to have medications on hand, the staff would give the medication, but could not enter the administration into the MAR. -This could happen if the provider wrote an order to continue a current medication for a certain quantity, i.e. 30 day supply, but the client currently had that medication on hand. The entry on the MAR would "fall off" 30 days after the order was	V 118		

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V 118	Continued From page 8 written, but there would still be medications on hand and that the staff continued to administer. However, staff could not document the medications on the MAR. -There was no "back up" documentation system for medication administration if the electronic record became unavailable. -The printed MAR did not print the exact time medications were administered, but a detail report for each medication could be accessed to identify that time. -They would instruct staff to use the MAR comment field to document why a medication was not administered. -The injections for client #3 were not administered by the staff. Each of these were given monthly by an outside provider. The documentation on client #3's MAR for these medications was a documentation error. -When a client is first admitted staff administered all medications. -As clients progressed, they were allowed to receive a weeks supply of their medications to self administer. -The printed MAR did not differentiate if the medication was administered by staff or client. Due to the failure to accurately document medication administration, it could not be determined if clients received medications as ordered by the physician.	V 118		
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	V 366		

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V 366	Continued From page 9 response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (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	V 366		

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V 366	Continued From page 10 review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the 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;	V 366		

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V 366	Continued From page 11 (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 interview, the facility failed to implement written policies meeting regulatory requirements for their response to Level I and Level II incidents. The findings are: Review of incident reports on 7/5/23 and 7/6/23 revealed: -No level 1 incident reports for medication omissions. -No incident reports for restrictive interventions. Finding #1: Review on 7/5/23 and 7/6/23 of Former Client (FC) #1's record revealed: -20 year old male admitted 12/9/22 and discharged 6/19/23. -Diagnoses included disruptive mood dysregulation disorder (DMDD); autism spectrum disorder; attention deficit hyperactive disorder (ADHD), combined type; and borderline intellectual developmental disorder. -Hospitalized 5/15/23 - 5/24/24 following a bicycle	V 366		

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V 366	Continued From page 12 accident. He sustained a fracture of his right arm and fracture of his mandible. Cast was applied to his arm and his mandible (jaws) was wired. Review on 7/5/23 and 7/6/23 of FC #1's 4/1/23 - 5/31/23 Medication Administration Records (MARs) revealed missed medications due to client refusal (CR) or not administered by staff as follows: -16 CR for Anafranil 50 mg (milligrams) scheduled daily (QD), to include 10 CR between 5/21/23 and 5/31/23. Anafranil 50 mg not administered on 5/22/23. -15 CR for Benztropine 1 mg, scheduled QD, to include 10 CR were between 5/21/23 and 5/31/23. -15 CR for Clonidine 0.2 mg, scheduled QD, to include 10 CR were between 5/21/23 and 5/31/23. Clonidine 0.2 mg was not administered on 5/22/23. -24 CR for Desmopressin (DDAVP) 0.2 mg, scheduled QD, to include 11 CR were between 5/21/23 and 5/31/23. DDAVP was not administered on 5/20/23. -39 CR for Depakote 750 mg, scheduled twice daily (BID), to include 21 CR were between 5/21/23 and 5/31/23. Depakote 750 mg was not administered on 5/22/23. -40 CR for Levetiracetam 750 mg, scheduled BID, to include 21 CR were between 5/21/23 and 5/31/23. Levetiracetam 750 mg was not administered on 5/22/23. -30 CR for Olanzapine 10 mg, scheduled BID, to include 15 CR were between 5/21/23 and 5/31/23. Olanzapine 10 mg was not administered on 5/22/23 and 5/25/23. -In summary, no medications were documented as administered between 5/21/23 - 5/31/23. Refer to V118 for FC#1's medication orders and	V 366		

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indications.

Finding #2:
Review on 7/5/23 and 7/6/23 of client #3's record revealed:
-20 year old male admitted 5/4/23.
-Diagnoses included schizophrenia, unspecified; major depressive disorder, recurrent episode with anxious distress; alcohol use disorder, moderate, in sustained remission; cocaine use disorder, severe, in sustained remission; cannabis use disorder, moderate in sustained remission; tobacco use disorder, moderate.

Review on 7/5/23 and 7/6/23 of client #3's 5/1/23 - 7/5/23 MARs revealed client #3's refusal of medications as follows:
-5 CR for Clozapine 150 mg, scheduled BID.
-4 CR for Risperidone 1 mg, scheduled BID.
-2 CR for Rosuvastatin 20 mg scheduled at bedtime.
-3 CR for Vitamin D, scheduled QD.
-2 CR for Hydroxyzine 50 mg, scheduled BID.

Refer to V118 for client #3's medication orders and indications.

II. Review of incident reports on 7/5/23 and 7/6/23 revealed no level 1 incident reports for medication omissions.

Interviews on 7/5/23 and 7/6/23 the Lead Residential Advisor (LRA) stated:
-FC#3 had a lot of medication refusals.
-Some of FC#1's refusals were because his jaws had been wired after his bike accident in May 2023, and he had difficulty swallowing medications.
-The staff had crushed some of the medications for FC#1; some could not be crushed.

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V 366	Continued From page 14 -A liquid form of medications had not been ordered when FC#3 was discharged from the hospital, so the facility had to request orders for liquid medications. -He had questioned client #3 about his refusals, and the client had stated he "slept in." -If a client did not show up for their medications, the missed dose was considered and documented as a refusal. -He reported medication refusals to the facility nurse practitioner who was on site weekly, but did not document missed medications as level 1 incidents. Interviews on 7/5/23 and 7/6/23 the Program Director (PD) stated: -Some missed doses of medications could be due to some electronic systems issues that had recently been corrected. -A major system improvement was to allow the PD and LRA to enter orders into the system and not have to wait for orders to be entered by off site corporate staff. -There was not a "back up" documentation system for medication administration if the electronic record became unavailable. -They would instruct staff to use the comment field to document why a medication was not administered. -There was no incident report for FC#1's physical restraint on 6/12/23.	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	V 367		

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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 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

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(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 meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.

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This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to report Level II incidents as required to the LME (Local Management Entity) within 72 hours. The findings are:

Review on 7/5/23 and 7/6/23 of facility Incident Response Improvement System (IRIS) reports for April - June 2023 revealed:
-1 IRIS report for Former Client (FC) #1's aggressive and assaultive behaviors that required law enforcement intervention as follows:
-FC#1's behaviors began at 5:45 pm when he was "suddenly highly escalated shouting threats toward Staff and other members. Threats include violence via knife
and vandalism/destruction of property."
-Staff were on the phone with 911 at 6:40 pm.
-Between 5:45 pm and 7:45 pm staff continued to try and de-escalate FC#1's behaviors.
-"Member (FC#1) assaulted program director via punching their face and spitting on them. Member eventually grabbed their bicycle and attempted to flee before PD (Program Director) and other Staff surround them. An RA (Residential Advisor) made multiple commands to dismount the bicycle and also warned them (FC#1) more than once that they would be forced to physically restrain the member if they made one more move toward anyone. Member did not comply with commands or warnings and made a threatening movement toward PD and was subsequently taken to the ground by RA where they lay until LE (law enforcement) pulled up."
-FC#1 was arrested by the police.

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V 367	Continued From page 18 -There was no documentation of a physical restraint within the IRIS report for the 6/12/23 incident. -There was no separate IRIS report for a physical restraint on 6/12/23. Interview on 7/6/23 Staff #1 stated: -He was working on 6/12/23 when FC#1 was arrested. -The staff tried to de-escalate the situation without using any physical restraints. -Just prior to the arrival of the police, FC#1 assaulted the PD. -Staff #1 said to FC#1, "I need for you to stop. If you make an attempt to spit on her (PD), I'm going to have to restrain you. Law Enforcement is on the way." -Staff #1 repeated 3 times to FC#1 to not hit the PD, but FC#1 moved to "strike her." -At that point Staff #1 placed FC#1 in a standing restraint. -He tried to remove FC#1 away from his bike, and they fell to the ground where Staff #1 maintained FC#1 in the hold until police arrived very shortly thereafter. Interview on 7/6/23 the PD stated: -She completed the IRIS report for FC#1's behaviors and arrest on 6/12/23. -She did not report a physical restraint of FC#1 in the IRIS system.	V 367		
V 518	27E .0104(e1-2) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions	V 518		

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V 518	Continued From page 19 may be used, the policy and procedures shall be in accordance with the following provisions: (1) the requirement that positive and less restrictive alternatives are considered and attempted whenever possible prior to the use of more restrictive interventions; (2) consideration is given to the client's physical and psychological well-being before, during and after utilization of a restrictive intervention, including: (A) review of the client's health history or the client's comprehensive health assessment conducted upon admission to a facility. The health history or comprehensive health assessment shall include the identification of pre-existing medical conditions or any disabilities and limitations that would place the client at greater risk during the use of restrictive interventions; (B) 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 by staff who are physically present and trained in the use of emergency safety interventions; (C) continuous monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being during the use of manual restraint; and (D) continued monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a restrictive intervention; This Rule is not met as evidenced by:	V 518		

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V 518	Continued From page 20 Based on record review and interview the facility failed to develop and implement policy and procedures for restrictive interventions as required. The findings are: Review on 7/7/23 of the facility policy for restrictive interventions, "Management of Disruptive Behaviors Policy" revealed: -The facility used a "hands off" approach with clients except under "the most extreme situations." -Staff were trained on the "CPI" Model (Crisis Prevention Institute) which "maintains" physical restraints could be used when the safety and security of the individual and others was at "imminent risk." -The following required procedures were not included in the policy: -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 by staff who are physically present and trained in the use of cardiopulmonary resuscitation -continued monitoring by an individual trained in the use of cardiopulmonary resuscitation of the client's physical and psychological well-being for a minimum of 30 minutes subsequent to the termination of a restrictive intervention. Interview on 7/7/23 the Program Director stated there was no other policy for the use of restrictive interventions.	V 518		
V 519	27E .0104(e3-7) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED	V 519		

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V 519	Continued From page 21 FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (3) the process for identifying, training, assessing competence of facility employees who may authorize and implement restrictive interventions; (4) the duties and responsibilities of responsible professionals regarding the use of restrictive interventions; (5) the person responsible for documentation when restrictive interventions are used; (6) the person responsible for the notification of others when restrictive interventions are used; and (7) the person responsible for checking the client's physical and psychological well-being and assessing the possible consequences of the use of a restrictive intervention and, in such cases there shall be procedures regarding: (A) documentation if a client has a physical disability or has had surgery that would make affected nerves and bones sensitive to injury; and (B) the identification and documentation of alternative emergency procedures, if needed; This Rule is not met as evidenced by: Based on record review and interview the facility failed to develop and implement policy and procedures for restrictive interventions as required. The findings are: Review on 7/7/23 of the facility policy for restrictive interventions, "Management of Disruptive Behaviors Policy" revealed: -The facility used a "hands off" approach with client except under "the most extreme situations." -Staff were trained on the "CPI" Model (Crisis	V 519		

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V 519	Continued From page 22 Prevention Institute) that "maintains" physical restraints could be used when the safety and security of the individual and others was at "imminent risk." -The following requirements were not included in the policy: -duties and responsibilities of responsible professionals regarding the use of restrictive interventions. -person responsible for documentation when restrictive were used. -person responsible for the notification of others when restrictive interventions are used. -person responsible for checking the client's physical and psychological well-being and assessing the possible consequences of the use of a restrictive intervention. -procedures for documentation if a client had a physical disability or has had surgery that would make affected nerves and bones sensitive to injury. -procedures for the identification and documentation of alternative emergency procedures, if needed. Interview on 7/7/23 the Program Director stated there was no other policy for the use of restrictive interventions.	V 519		
V 521	27E .0104(e9) Client Rights - Sec. Rest. & ITO 10A NCAC 27E .0104 SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT AND PROTECTIVE DEVICES USED FOR BEHAVIORAL CONTROL (e) Within a facility where restrictive interventions may be used, the policy and procedures shall be in accordance with the following provisions: (9) Whenever a restrictive intervention is utilized,	V 521		

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V 521	Continued From page 23 documentation shall be made in the client record to include, at a minimum: (A) notation of the client's physical and psychological well-being; (B) notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior; (C) the rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used; (D) a description of the intervention and the date, time and duration of its use; (E) a description of accompanying positive methods of intervention; (F) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of seclusion, physical restraint or isolation time-out to eliminate or reduce the probability of the future use of restrictive interventions; (G) a description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and (H) signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to document the minimum requirements for restrictive interventions in the client's record affecting 1 of 1 former client (FC) audited (FC#1). The findings are:	V 521		

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Review on 7/5/23 and 7/6/23 of FC #1's record revealed:
-20 year old male admitted 12/9/22 and discharged 6/19/23.
-Diagnoses included disruptive mood dysregulation disorder (DMDD); autism spectrum disorder; attention deficit hyperactive disorder (ADHD), combined type; and borderline intellectual developmental disorder.
-No documentation of a physical restraint on 6/12/23.

Review on 7/5/23 and 7/6/23 of FC#1's Incident Response Improvement System (IRIS) report for his behaviors and arrest by police on 6/12/23 revealed:
-FC#1's behaviors began at 5:45 pm when he was "suddenly highly escalated shouting threats toward Staff and other members. Threats include violence via knife and vandalism/destruction of property."
-Between 5:45 pm and 7:45 pm staff continued to try and de-escalate FC#1's behaviors.
-"Member (FC#1) assaulted program director via punching their face and spitting on them. Member eventually grabbed their bicycle and attempted to flee before PD (Program Director) and other Staff surround them. An RA (Residential Advisor) made multiple commands to dismount the bicycle and also warned them (FC#1) more than once that they would be forced to physically restrain the member if they made one more move toward anyone. Member did not comply with commands or warnings and made a threatening movement toward PD and was subsequently taken to the ground by RA where they lay until LE (law enforcement) pulled up."

Interview on 7/6/23 Staff #1 stated:
-He was working on 6/12/23 when FC#3 was

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V 521	Continued From page 25 arrested. -The staff tried to de-escalate the situation without using any physical restraints. -Just prior to the arrival of the police, FC#1 assaulted the PD. -Staff #1 said to FC#1, "I need for you to stop. If you make an attempt to spit on her (PD), I'm going to have to restrain you. Law Enforcement is on the way." -Staff #1 repeated 3 times to FC#1 to not hit the PD, but FC#1 moved to "strike her." -At that point Staff #1 placed FC#1 in a standing physical restraint. -He tried to remove FC#1 from his bike, and they fell to the ground where Staff #1 maintained FC#1 in the hold until police arrived very shortly thereafter. Interview on 7/6/23 the PD stated: -The facility used CPI (Crisis Prevention Institute) training and skills when restrictive interventions were necessary. -This curriculum included both alternatives and physical restraint skills. -On 6/12/23 Staff #1 used his CPI skills to restrain FC#1 because the client was threatening to ride his bike into traffic, and threatening to commit suicide and kill the staff. -Police and Emergency Medical Services (EMS) responded and EMS evaluated FC#1 on site after he was in police custody. -She informed the facility Nurse Practitioner of the incident. -The client was arrested and subsequently discharged. -There was no documentation completed for the physical restraint of FC#1.	V 521		

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V 536	Continued From page 26	V 536		
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 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;	V 536		

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V 536	Continued From page 27 (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; (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	V 536		

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V 536	Continued From page 28	V 536		

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 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.

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V 536	Continued From page 29 (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. (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 staff completed training on alternatives to restrictive interventions prior to providing services affecting 2 of 3 audited staff (Staff #1 and #2) and completing formal refresher training at least annually affecting 1 of 3 audited staff (Program Director). The findings are: Review on 7/7/23 of the facility policy, "Management of Disruptive Behaviors Policy" (not dated) revealed: -Direct care staff were required to complete training in verbal de-escalation in Crisis Prevention Institute (CPI) within 90 days of hire and recertified annually. Review on 7/7/23 of the Program Director's personnel record revealed:	V 536		

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V 536	Continued From page 30 -Hire date: 10/18/21. -Position: Program Director. -CPI Refresher - Blended training class dated 5/26/22. -Letter from the CPI Instructor dated 7/5/23 read, "... the letter ... shall remain valid for training confirmation purposes until 11/19/23." Review on 7/7/23 of Staff #1's personnel record revealed: -Hire date: 6/27/22. -Position: Residential Advisor. -No documentation of CPI training for alternatives to restrictive interventions. Interview on 7/6/23 Staff #1 stated: -He worked full time as a direct care staff. -He had worked for other agencies as a behavioral technician and had prior training. -He had received training about crisis interventions and de-escalation in the past. Review on 7/7/23 of Staff #2's personnel record revealed: -Hire date: 3/6/23. -Position: Residential Advisor. -No documentation of CPI training for alternatives to restrictive interventions. Interview on 7/6/23 Staff #2 stated: -He was a direct care staff working since April 2023. -He thought CPI was covered with his orientation training.	V 536		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN	V 537		

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SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT
(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

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V 537	Continued From page 32 the use of restrictive interventions; (2) guidelines on when to intervene (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	V 537		

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V 537	Continued From page 33 and isolation time-out. (3) Trainers shall demonstrate competence 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	V 537		

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V 537	Continued From page 34 documentation of initial and refresher instructor training for at least three years. (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 physical restraints were employed only by staff who had been trained and demonstrated competency in the proper use of physical restraints for 1 of 3 staff audited (Staff #1); and ensure staff authorized to employ and terminate physical restraints were retrained and demonstrated competence at least annually, affecting 1 of 3 staff audited (Program Director). The findings are: Review on 7/7/23 of the Program Director's personnel record revealed: -Hire date: 10/18/21.	V 537		

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V 537	Continued From page 35 -Position: Program Director. -CPI Refresher - Blended training class dated 5/26/22. -Letter from the CPI Instructor dated 7/5/23 read, "... the letter ... shall remain valid for training confirmation purposes until 11/19/23." Review on 7/7/23 of Staff #1's personnel record revealed: -Hire date: 6/27/22. -Position: Residential Adviser. -No documentation of CPI training for alternatives to restrictive interventions. -No documentation of CPI training for the use of restrictive interventions. Interview on 7/6/23 Staff #1 stated: -He worked full time as a direct care staff. -He had worked for other agencies as a behavioral technician and had prior training in restrictive interventions. -He had physically restrained Former Client #1 (FC#1) on 6/12/23 for safety reasons.	V 537		