STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-087	A. BUILDING: _____ B. WING _____	C 06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY SUPPORT AGENCY	809 SOUTH MADISON STREET WHITEVILLE, NC 28472

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on June 9, 2023. The complaints were unsubstantiated (intake #NC00203012 and #NC00203026). Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G .1200 Psychosocial Rehabilitation facilities for Individuals with severe and persistent mental illness, 10A NCAC 27G .1400 Day Treatment for Child and Adolescents with Emotional or Behavioral Disturbances, 10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program (SAIOP) and 10A NCAC 27G .4500 Substance Abuse Comprehensive Outpatient Treatment (SACOT). This facility has a current census of 7. The survey sample consisted of audits of 2 current clients.	V 000	DHSR - Mental Health JUL 28 2023 Lic. & Cert. Section	
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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to access the Health Care Personnel	V 131	***Human Resources will perform a registry check on all employees being considered for hire prior to offering the potential employee a position with Community Support Agency, LLC.*** ***Once the above has been reviewed and approved, the potential employee is then offered the position.*** ***No person is offered a position at Community Support Agency without the proper background and registry check in place.***	

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

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V 131	Continued from page 1 Registry (HCPR) prior to hire for 2 of 3 audited staff (Former Staff (FS)#3 and Former Program Manager). The findings are: Review on 6/9/23 of FS #3's personnel record revealed: -Hire date: 11/28/22. -Job: Paraprofessional -The HCPR was accessed on 6/8/23. Interview on 6/8/23 FS #3 stated: -She worked at the facility as a paraprofessional since December 13, 2022. Review on 6/9/23 of the Former Program Manager's personnel record revealed: -Hire date: 4/19/23 -Job: Program Manager. -The HCPR was accessed on 6/8/23. Attempts to interview the Former Program Manager on 6/8/23 and 6/9/23 were unsuccessful. Interview on 6/9/23 the Executive Director stated: -The HCPR was accessed at hire. -She was unable to locate the HCPR accessed at hire.	*V 131*	***Please reference listed above per CSA policy.***	

V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of	V 318	***Per CSA'S company policy All incidents reported will undergo inner agency investigation via Community Support Agency's Human Rights Committee. As a routine the committee meets quarterly (or more often when necessary) to review and analyze the incident as well as provide recommendations to aid in the prevention of similar incidents from occurring in the future. Incidents requiring immediate attention; the Human Rights Committee will meet 24 to 36 hours after incident has occurred to ensure appropriate steps are taken.***	

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V 318	Continued from page 2 the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g). This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report all allegations against health care personnel within 24 hours of the health care facility becoming aware of the allegation. The findings are: Review on 6/9/23 of the Qualified Professional's personnel record revealed: -Hire date: 1/28/22. -Job: Qualified Professional. Review on 6/8/23 of client #1's record revealed: -12-year-old male. -Admitted on 5/27/21. -Diagnoses of Attention Deficit Hyperactivity Disorder and Disruptive Mood Dysregulation Disorder. Review on 6/8/23 of client #2's record revealed: -9-year-old male. -Admitted on 4/22/22. -Diagnoses of ADHD, DMDD, Post Traumatic Stress Disorder and Generalized Anxiety Disorder. Review on 6/8/23 and 6/9/23 of the North Carolina Incident Response Improvement System	V 318	***Per CSA'S company policy All incidents reported will undergo inner agency investigation via Community Support Agency's Human Rights Committee. As a routine the committee meets quarterly (or more often when necessary) to review and analyze the incident as well as provide recommendations to aid in the prevention of similar incidents from occurring in the future. Incidents requiring immediate attention; the Human Rights Committee will meet 24 to 36 hours after incident has occurred to ensure appropriate steps are taken.***	

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V 318	Continued from page 3 (IRIS) revealed: -On 6/8/23 there was no evidence of an IRIS report. -On 6/9/23, an IRIS report was submitted on 6/8/23 for allegations of abuse against the Qualified Professional. Interview on 6/8/23 and 6/9/23 the Executive Director stated: -The Former Program Manager was responsible for reporting allegations of abuse to the HCPR. -She was unsure if a report had been made to the HCPR. -She located incomplete HCPR paperwork in the Former Program Manager's office. -She was unsure if a report had been made through the IRIS. -She had completed the incomplete information on the HCPR report and faxed it to HCPR on 6/8/23. -She understood allegations of abuse should be reported to HCPR within 24 hours of becoming aware of an allegation.	V 318	***Please reference listed above per CSA policy***	
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 provider's 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	V 367	***CSA policy reads: All incidents reported will undergo inner agency investigation via Community Support Agency's Human Rights Committee. As a routine the committee meets quarterly (or more often when necessary) to review and analyze the incident as well as provide recommendations to aid in the prevention of similar incidents from occurring in the future. Incidents requiring immediate attention; the Human Rights Committee will meet 24 to 36 hours to ensure appropriate steps are taken.***	

			Upon receiving an allegation of abuse that involves an employee, the Executive Director will ensure that the alleged perpetrator is immediately placed on suspension until the investigation is completed. An allegation that involves an outside party (community member, family member, private/public provider, etc) will be discussed with the DSS to ensure the appropriate party is assigned the investigating duties.	

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V 367	Continued from page 4 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 (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	V 367	***Please reference listed above per CSA policy***	

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V 367	Continued from page 5 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. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure critical incident reports were submitted to the Local Management Entity (LME) within 72 hours as required. The findings	V 367		

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V 367	Continued from page 6 are: Review on 6/9/23 of the Qualified Professional's personnel record revealed: -Hire date: 1/28/22. -Job: Qualified Professional. Review on 6/8/23 of client #1's record revealed: -12-year-old male. -Admitted on 5/27/21. -Diagnoses of Attention Deficit Hyperactivity Disorder and Disruptive Mood Dysregulation Disorder. Review on 6/8/23 of client #2's record revealed: -9-year-old male. -Admitted on 4/22/22. -Diagnoses of ADHD, DMDD, Post Traumatic Stress Disorder and Generalized Anxiety Disorder. Review on 6/9/23 of the North Carolina Incident Response Improvement System (IRIS) revealed: -An IRIS report was submitted on 6/8/23 for allegations of abuse against the Qualified Professional (QP). Interview on 6/8/23 the Executive Director stated: -An allegation of abuse was made against the QP on 6/2/23. -It was the facility's policy to place staff on administrative leave until an internal investigation was complete. -The facility had not submitted any IRIS reports. Interview on 6/9/23 the Executive Director stated: -An IRIS report had was submitted on 6/9/23. -She understood level III incident reports should be submitted to the LME within 72 hours.	V 367	***Please reference listed above per CSA policy***	

Division of Health Service Regulation
Mental Health Licensure and Certification Section
Rule Violation and Client/Staff Identifier List

Facility Name: Community Support Agency LLC MHL Number: 024-087
Exit Date: 6/9/23 Surveyor(s): Tareva Jones

EXIT PARTICIPANTS: Andrea Simmons, Executive Director and Tareva Jones, Surveyor

COVID NOTIFICATION: In the event a COVID positive case is identified within 48 hours of a DHSR survey – the provider or DHSR should notify the other entity to prevent possible continued exposures.

Rule Violation/Tag #/Citation Level: G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY/ V131 / Standard

Rule Violation/Tag #/Citation Level: 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL / V318 / Standard

Rule Violation/Tag #/Citation Level: 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS / V367 / Standard

Client & Staff Identifier List
staff title or number beside each name)

Client #1 [redacted]
Client #2
Client #3
Client #4
Client #5
Client #6
Client #7
Former C

Staff #1 [redacted]
Staff #2
Therapist #
Therapist #2
Qualified Professional (QP),
Former Staff #3
Former Program Manager,
Former QP,

CITATION LEVEL: Number of days from survey exit for citation correction
Standard = 60 days Recite – standard = 30 days Type A = 23 days Type B = 45 days Uncorrected Type A or Type B Imposed = provider should provide written notification of intended correction date

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

June 26, 2023

Andrea Simmons, Executive Director
Community Support Agency, LLC
PO Box 465
Delco, NC 28436

Re: Complaint Survey completed June 9, 2023
Community Support Agency LLC, 809 South Madison Street, Whiteville, NC, 28472
MHL # 024-087
E-mail Address: andreasimmons@1csa.net
Intake #NC00203012 and #NC00203026

Dear Ms. Simmons:

Thank you for the cooperation and courtesy extended during the complaint survey completed June 9, 2023. The complaints were unsubstantiated.

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

Type of Deficiencies Found

- All tags cited are standard level deficiencies.

Time Frames for Compliance

July 19, 2023

Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is August 8, 2023.

What to include in the Plan of Correction

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

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

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

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

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

Sincerely,

Tareva Jones, MSW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

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