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 |
|---|---|---|---|
| | MHL054-159 | A. BUILDING: ______ B. WING ______ | 08/17/2023 |

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| **MAPLEWOOD FACILITY** | **2002-G SHACKLEFORD ROAD KINSTON, NC 28502** |

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| V 000 | INITIAL COMMENTS<br><br>A complaint and follow up survey was completed on August 17, 2023. The complaint was substantiated (intake #NC00205534). Deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .1900 Psychiatric Residential Treatment for Children and Adolescents.<br><br>This facility is licensed for 18 and currently has a census of 18. The survey sample consisted of audits of 1 current client. | V 000 | | |
| V 105 | 27G .0201 (A) (1-7) Governing Body Policies<br><br>10A NCAC 27G .0201 GOVERNING BODY POLICIES<br>(a) The governing body responsible for each facility or service shall develop and implement written policies for the following:<br>(1) delegation of management authority for the operation of the facility and services;<br>(2) criteria for admission;<br>(3) criteria for discharge;<br>(4) admission assessments, including:<br>(A) who will perform the assessment; and<br>(B) time frames for completing assessment.<br>(5) client record management, including:<br>(A) persons authorized to document;<br>(B) transporting records;<br>(C) safeguard of records against loss, tampering, defacement or use by unauthorized persons;<br>(D) assurance of record accessibility to authorized users at all times; and<br>(E) assurance of confidentiality of records.<br>(6) screenings, which shall include:<br>(A) an assessment of the individual's presenting problem or need; | V 105 | | |

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| V 105 | Continued From page 1<br>(B) an assessment of whether or not the facility can provide services to address the individual's needs; and<br>(C) the disposition, including referrals and recommendations;<br>(7) quality assurance and quality improvement activities, including:<br>(A) composition and activities of a quality assurance and quality improvement committee;<br>(B) written quality assurance and quality improvement plan;<br>(C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services;<br>(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;<br>(E) strategies for improving client care;<br>(F) review of staff qualifications and a determination made to grant treatment/habilitation privileges:<br>(G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death;<br>(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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This Rule is not met as evidenced by:
Based on record reviews and interview, the facility failed to implement written standards that assured operational and programmatic meeting applicable standards of practice to (1) report serious occurrences to the State designated Protection and Advocacy system and (2) implement a written policy for adoption of standards of practice related to federal requirements that prohibit the use of restrictive interventions as planned interventions. The findings are:

Finding #1:
Review on 8/16/23 of LME-MCO (Local Management Entity-Managed Care Organization) communication Bulletin #J287, "Clarifying the Reporting Standards for Psychiatric Residential Treatment Facilities (PRTF)" dated 5/11/18 revealed:
-" ...Serious Occurrences are any event that result in Restraint or Seclusion, Resident's Death, Any Serious Injury to a Resident, and a Resident's Suicide Attempt. NC § 483.374 specifies that facilities must report each Serious Occurrence to both the State Medicaid agency (Division of Medical Assistance - DMA) and, unless prohibited by State law, the State-designated Protection and Advocacy system (Disability Rights North Carolina - DRNC)."
-"DRNC reports are to be faxed to (919) 856-2244."

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| V 105 | Continued From page 3<br><br>Review on 4/17/23 of the LME-MCO (Local Management Entity-Managed Care Organization) communication Bulletin #J272, "Abuse, Neglect and Exploitation of an Individual by a Staff Member" dated 11/15/17 revealed:<br>-" Due to concerns about the safety of individuals and the need for review of safety plans for individuals who are receiving services, the Department of Health and Human Services (DHHS) has determined that all allegations of abuse, neglect and exploitation by a staff member will become Level III incidents effective December 4, 2017 . . . If the agency is a PRTF, the agency must also follow the submission process for serious occurrence reporting as specified in the PRTF Attestation letter."<br><br>Review on 8/16/23 of a Division of Health Service Regulation survey dated 4/18/23 revealed the facility failed to report an allegation of sexual abuse of a client by a staff person as a serious occurrence to DRNC.<br><br>Finding #2:<br>Review on 8/16/23 of LME-MCO Communication Bulletin J287 dated 5/11/18 revealed the Conditions of Participation, 42 Code of Federal Regulation (CFR) 483.356(a)(2) requirements would prohibit restrictive interventions from being included as planned intervention in a client's treatment plan.<br><br>Review on 8/16/23 of PRTF Interpretive Guidelines from the Center for Medicaid Services revealed:<br>- "The use of restraint or seclusion must not be a planned or anticipated intervention . . . There should not be a specific plan in place for restraints and seclusion . . . " | V 105 | | |

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Review on 8/16/23 of client #17's record revealed:
- 12 year old male admitted 10/19/22.
- Diagnoses included Attention Deficit Hyperactivity Disorder (ADHD); Disruptive Mood Dysregulation Disorder; and Unspecified psychosis not due to a substance or know psychological condition.
- "Person Centered Profile" dated 10/19/22 included "Crisis Prevention and Intervention Plan" with "In order to ensure the safety of the patient and others, physical restraint may be used as a planned restrictive intervention; as ordered/prescribed by the treating physician. Physical restraint will be utilized whenever the patient presents an imminent danger to themselves and/or others, and less restrictive behavioral interventions have failed or are not appropriate."

During interview on 8/17/23 the Director of PRTF Services stated:
- The allegation of sexual abuse of a client by a staff person was not reported to DRNC as a serious occurrence following the survey completed 4/18/23..
- Allegations of sexual abuse did not "meet the definition of serious occurrence" and therefore were not reportable to DRNC.
- She was not aware physical restraint was included in client #17's Crisis Prevention and Intervention Plan.
- "It's not supposed to be there."
- She would have client #17's plan revised to remove the use of physical restraint as a planned intervention.

This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.

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| V 512 | 27D .0304 Client Rights - Harm, Abuse, Neglect<br><br>10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION<br>(a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66.<br>(b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter.<br>(c) Goods or services shall not be sold to or purchased from a client except through established governing body policy.<br>(d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter.<br>(e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews 1 of 3 audited staff (#1) abused 1 of 18 current clients (#17). The findings are:<br><br>Review on 8/16/23 of the North Carolina Incident Response Improvement System for incident reports from the facility 5/22/23 - 8/16/23 revealed: | V 512 | | |

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- Level III incident report for client #17.
- Allegation of abuse by staff #1 dated 7/27/23; client #17 alleged staff #1 bent his hand back, tackled him, pushed him into a wall, and hit his face with a closed fist.
- Facility internal "Inquiry Form" included interview with staff #1 ". . . . (staff #1) stated he used force which resulted in them being at the wall . . . he does not remember if he bent or forced the consumer's hand back while the consumer was on the wall . . . "
- Facility internal "Inquiry Form" included interview with staff #2 " . . . consumer (client #17) had become upset because he wanted to go on a walk . . . the consumer remained upset but he was calm and she could talk to him . . . [staff #1] begin to exchange words because the consumer would not sit down . . . [staff #1] proceeded to grab the consumer (client #17) to complete a physical restraint . . . the consumer was not aggressive prior to [staff #1] grabbing the consumer, but she recalled [staff#1] stating the consumer had something in his hand . . . [staff #1] grabbed the consumer's hand and [staff #1] forced the consumer to the wall. she reports she observed [staff #1] forcing the consumer's hand back . . . the consumer proceeded to grab a chair . . . held the chair in the air as if he was going to hit [staff #1] . . . [staff #1] grabbed the chair and blocked the consumer in the chest area to move him back . . . she did not feel [staff #1] should have been so forceful with the consumer . . . "
- The allegation was unsubstantiated during the facility's internal investigation.

Review on 8/16/23 of client #17's record revealed:
- 12 year old male admitted 10/19/22.
- Diagnoses included Attention Deficit Hyperactivity Disorder (ADHD); Disruptive Mood

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Dysregulation Disorder; and Unspecified psychosis not due to a substance or know psychological condition.
- Comprehensive Clinical Assessment dated 10/29/22 included documented history of anger issues, "difficulties with social interactions with peers and adults," physical aggression and assault, defiance, elopement, and property destruction.

During interview on 8/16/23 client #17 stated:
- He "was mad and depressed" and wanted to go for a walk but was told he could not go for a walk.
- He was trying to get the supervisor's attention by hitting the unit door and was asking why he couldn't go for a walk.
- Staff #1 told him to stop hitting the door and to sit down.
- "He grabbed me and I got him off me and went to my room and threatened to hurt him."
- When he came out of his room, staff #1 grabbed his left hand, let it go and grabbed his right hand and "bent my whole wrist back."
- Staff #1 pushed him into the wall with his forearm.
- "He jacked me up to the wall and growled at me."
- Staff #1 hit his face when attempting to grab his hand.
- Staff #2 witnessed the incident and "was telling him to get off me."

Review on 8/16/23 of client #16's record revealed:
- 12 year old male admitted 7/20/22.
- Diagnoses included ADHD and Disruptive Mood Dysregulation Disorder.

During interview on 8/16/23 client #16 stated:
- Client #17 "was in behavior and tried to go out

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the door and [staff #1] pushed him against the wall and was holding his wrists and was growling at him."
- Staff #1 "had him (client #17) in the corner; staff (staff #2) told him (staff #1) to get off him (client #17); he had him in the corner and was bending his wrist back."
- Staff #1 "took his elbow and just drove him into the door."
- He did not see anything in client #17's hand "he was covered up by [staff #1] so I couldn't see."
- He left area "because I didn't want to see" what was happening.

Review on 8/16/23 of client #18's record revealed:
- 14 year old male admitted 8/25/22.
- Diagnoses included ADHD, Post Traumatic Stress Disorder; and Oppositional Defiant Disorder.

During interview on 8/16/23 client #18 stated:
- Client #17 was "mad."
- Staff #1 was trying to place client #17 in a therapeutic hold; it looked like staff #1 was "trying to rip [client #17's] jacket; there was not reason for it."
- Client #17 got out of the therapeutic hold and picked up a chair; staff #1 "grabbed the chair and pushed [client #17] away."
- Staff #1 then grabbed client #17 and pushed him into the corner "and started growling at him" while holding client #17 in the corner.
- He saw staff #1 hit client #17 in his chest with the heel of his palm.
- Staff #2 was present; "she was trying to call for help and was telling them to stop; she couldn't really do anything."

Review on 8/16/23 of staff #1's personnel record

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revealed:
- Paraprofessional hired 7/11/22.
- Training on alternatives to restrictive interventions and seclusion, physical restraint and isolation time out dated 1/11/23 and 7/03/23.
- Placed on "Administrative Suspension" 7/27/23 due to "possible policy violation."
- "[Staff #1] failed to exhaust least restrictive interventions during a consumer behavior on the date of 7/27/23 . . . violated the following Policies: . . . Prohibited Behavior Management Practices which prohibits the use of excessive or inappropriate application of any sanctioned behavior management practice or intervention . . . "

During interview on 8/17/23 staff #1 stated:
- Client #17 was upset and wanted to go on a walk.
- Client #1 was putting a pencil into the exit door lock and would not accept verbal redirection; he tried to take the pencil away from client #17.
- Client #17 was "trying to swing on me and I was wrapping him."
- He took a pencil away from client #17 and client #17 went to his room and got a second pencil.
- He grabbed client #17 by the forearms and "pushed him to the wall; against the wall; it was not really a push, I just put him to the wall."
- He was not trained to put clients against the wall.
- When he was trying to get the pencil from client #17 he grabbed the client's hand; he did not think he bent the client's hand back; "no I didn't."
- Client #17 was not aggressive towards anyone prior to the incident; "it looked like property destruction; he was writing on the walls and putting the pencil into the door lock."
- "I didn't want him to have anything sharp; I didn't want him to hurt anyone else."

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- Client #17 was not put into the seclusion room; "I just let him process, I guess."

Review on 8/16/23 of staff #2's record revealed:
- Paraprofessional hired 6/26/23.
- Training in alternatives to restrictive interventions and seclusion, physical restraint and isolatin time out 6/27/23

During interview on 8/17/23 staff #2 stated:
- Client #17 wanted to go for a walk prior to the incident on 7/27/23; he was disruptive, kicking the door and making noise, but was not aggressive.
- Staff #1 tried to intervene and redirect client #17 and they began to argue.
- Client #17 went to his room and returned; staff #1 said client #17 had something in his hand.
- She did not see anything in client #17's hand.
- She saw staff #1 bend client #17's hand back; "not like a bad bend though."
- She did not see a pencil; she did not see client #17 drop anything.
- Client #17 picked up a chair as if to hit staff #1 and staff #1 "grabbed the chair and pushed him (client #17) back with his hand on his chest."
- Staff #1 did not "tackle" client #17, if he did it was unintentional.
- She believed staff #1 used excessive force during the incident.

During interview on 8/17/23 the Director of Psychiatric Residential Treatment Facility services stated:
- Staff training did not include bending clients' fingers or wrists or pushing clients against the wall.
- Staff #1 was immediately removed from the unit by the Residential Services Supervisor following the incident.
- Staff #1 was re-trained in the use of least

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| V 512 | Continued From page 11<br>restrictive interventions by the Residential Services Supervisor. | V 512 | | |
| V 736 | 27G .0303(c) Facility and Grounds Maintenance<br><br>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on observation and interviews the facilty was not maintained in a safe, attractive and orderly manner. The findings are:<br><br>Observations on 8/16/23 at approximately 11:40 am revealed:<br>Unit 1 Pod A:<br>- Ceiling light fixtures in the day room were broken.<br>- Damage to the sheetrock in the bedroom hallway by the bathroom door.<br>Unit 1 Pod B:<br>- Dried, brown liquid drip marks on the wall in bedroom #2.<br>Unit 2 Pod A:<br>- Unfinished patches to the sheetrock in bedroom #1<br>- 2 pieces of plywood screwed into the sheetrock as a temporary repair; the wall paint was scuffed; and broken crayons on the floor in bedroom #3.<br>Unit 2 Pod B:<br>- A gallon jug of red liquid on the day room floor.<br>Unit 3 Pod A:<br>- Light fixtures in the day room were broken; an unfinished patch to the sheetrock near an electrical outlet. | V 736 | | |

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Unit 3 Pod B:
- A piece of plywood screwed into the sheetrock as a temporary repair to a hole in the the wall in bedroom #1.
- An unfinished repair to the sheetrock in the bedroom hall.
- A piece of plywood screwed into the sheetrock as a temporary repair to a hole in the the wall in bedroom #3.
- Light fixtures throughout the unit were broken.

During interview on 8/16/23 the Maintenance Manager stated the clients used basketballs to break the light fixtures. The light fixtures were being replaced. The use of plywood on the walls to cover holes was a temporary repair. The plywood would be removed and the holes in the sheetrock would be repaired. Repairs were ongoing.

During interviews on 8/16/23 and 8/17/23 the Director of Psychiatric Residential Treatment Facilty Services stated:
- "We've had a lot of property damage this week; they like to break out the light fixtures; we've got holes in the walls."
- Damage to facility was an ongoing issue; repairs were made and the clients would "re-damage or create new damage in a different way."

This deficiency has been cited 6 times since the original cite on 10/14/21 and must be corrected within 30 days.