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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 8/25/23. Two complaints were substantiated (intake #NC203945 and #NC190161) and one was unsubstantiated (intake #NC205302). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 4 current clients and 1 former client.	V 000		
V 293	27G .1701 Residential Tx. Child/Adol - Scope 10A NCAC 27G .1701 SCOPE (a) A residential treatment staff secure facility for children or adolescents is one that is a free-standing residential facility that provides intensive, active therapeutic treatment and interventions within a system of care approach. It shall not be the primary residence of an individual who is not a client of the facility. (b) Staff secure means staff are required to be awake during client sleep hours and supervision shall be continuous as set forth in Rule .1704 of this Section. (c) The population served shall be children or adolescents who have a primary diagnosis of mental illness, emotional disturbance or substance-related disorders; and may also have co-occurring disorders including developmental disabilities. These children or adolescents shall not meet criteria for inpatient psychiatric services. (d) The children or adolescents served shall require the following: (1) removal from home to a	V 293		

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V 293	Continued From page 1 community-based residential setting in order to facilitate treatment; and (2) treatment in a staff secure setting. (e) Services shall be designed to: (1) include individualized supervision and structure of daily living; (2) minimize the occurrence of behaviors related to functional deficits; (3) ensure safety and deescalate out of control behaviors including frequent crisis management with or without physical restraint; (4) assist the child or adolescent in the acquisition of adaptive functioning in self-control, communication, social and recreational skills; and (5) support the child or adolescent in gaining the skills needed to step-down to a less intensive treatment setting. (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to provide individualized supervision; and coordinate with other individuals and agencies within the child or adolescent's system of care affecting 4 of 4 current clients (#1- #4) and 1 of 1 audited former client (FC) #8. The findings are:	V 293		

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V 293	Continued From page 2 Finding #1 Review on 7/28/23 of FC #8's record revealed: - Admission date: 4/26/22 - Discharge date: 5/26/23 - Age: 13 - Diagnoses: Disruptive Mood Dysregulation Disorder (DMDD); Attention Deficit Hyperactivity Disorder (ADHD); and Post-Traumatic Stress Disorder (PTSD) Review on 7/31/23 of FC #8's Child and Family Treatment Team (CFT) Meeting notes revealed: - 12/20/22 CFT Meeting: "Next Action: Schedule eye exam; Responsible party [TGH (Licensee)]; Target Date for Completion: 2/9/23" - 1/19/23 CFT Meeting: "Next Action: Schedule eye exam; Responsible party [TGH]; Target Date for Completion: 2/9/23" - 2/10/23 CFT Meeting: "Eye Appointment: 2/14/23" - 3/14/23 CFT Meeting: There was nothing documented about her eye appointment. Interviews on 8/4/23 and 8/8/23 with the Office Assistant at FC #8's Optometry Office revealed: - FC #8 was a "no show" for 3 "new patient" eye appointments on 7/29/22, 12/12/22 and 2/14/23. - Their office stopped taking Medicaid in March 2023; however, if a Medicaid patient already had an appointment after March 2023 their office would have still seen the patient. - FC #8 did not have an appointment in September 2022 at their Optometry Office. Interview on 7/28/23 with FC #8's Department of Social Services (DSS) Legal Guardian (LG) revealed: - In July 2022 FC #8 had a physical and her	V 293		

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doctor made a recommendation for her to see an eye doctor.
- "There were multiple eye appointments canceled."
- On 9/1/22, 12/16/22, 2/14/23 FC #8 had eye appointments that she missed.
- On 3/14/23, she had been told by the QP/Billing Staff that FC #8's former Optometry Office no longer accepted Medicaid and that another Optometry Office had been found. She was further told the QP/Billing Staff was in the process of making an appointment with the new Optometry Office. Then on 4/19/23 she learned that no eye appointment had been made.
- FC #8 was discharged from the group home on 5/26/23 and placed in a foster home. Her new foster mother took her to a new Pediatrician on 7/24/23. The new Pediatrician told the foster mother that "[FC #8's] vision was horrible, and they didn't know how she was seeing anything."

Review on 8/4/23 of FC #8's Optometry Visit dated 7/25/23 revealed:
- FC #8 was examined by an Optometrist on 7/25/23 for eyeglasses prescription, "floaters," and trouble seeing close up and at distance.
- " ... Impression/Plan: Elevated IOP (Intraocular Pressure) noted today ... Hyperopia OU (Oculus Uterque (both eyes)) ... Ocular Hypertension OU ... Expectations: Ocular Hypertension is elevated intraocular pressure that may cause glaucoma and require treatment ..."

Review on 8/8/23 of FC #8's Guardian Ad Litem email sent to the surveyor dated 8/8/23 revealed:
- "One exchange specifically that I wished to share took place on 3/14/23 during an in-person CFT at [the facility]. Toward the end of the meeting, during which we had discussed that [FC #8's previous Optometry Office] no longer

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accepted Medicaid and that another provider had been identified, [QP #1] mentioned that she was aware of how bad [FC #8's] vision was because she had seen her standing very close to the TV so she could see what was on the screen. The subtext of the comment was that she was aware of how important it was to schedule an eye exam ASAP (as soon as possible)."

Review on 7/28/23 of DSS LG's "Monthly Foster Care Contact Record Group Home Version" revealed:
- 8/18/22: "Eye Appointment- 7/29/22 no show; 9/22/22 at 10:45am." Name of staff who participated: FQP #2
- 9/1/22: "Eye Exam- 9/22/22" Name of staff who participated: staff #2
- 11/10/22: "Eye- [FC #8] is still in need of an eye appointment." Name of staff who participated: FQP #2
- 12/20/22: "[FC #8] did not attend her eye appointment on 12/16/22." Names of staff who participated: QP/Billing Staff and the Licensee
- 3/14/23: " ...[FC #8] reported that she did not go to the eye doctor. [QP/Billing Staff] reported that [FC #8's previous Optometry Office] no longer accepting Medicaid. Another eye doctor has been found and theyre in the process of getting the girls (clients) scheduled." Names of staff who participated: QP/Billing Staff and staff #6
- 4/19/23: "Eye-Needs to be scheduled." Names of staff who participated: QP/Billing Staff and QP #1

Review on 8/7/23 of FC #8's DSS LG's emails revealed:
- 11/2/22 email from FC #8's DSS LG to FQP #2: "She hasn't had an eye appointment since being at [TGH] both appointments (July and Sept (September)) were no shows. Can you please try

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and get her seen in November (2022). She is on the cancellation list and she has an upcoming appointment on December."
- 12/15/22 email from FC #8's DSS LG to QP/Billing Staff: "...I've also been asking about the eye appointment. I believe she is scheduled for an appointment tomorrow 12/16/22 can you please confirm and please make sure she attends this. I think it's [FC #8's previous Optometry Office]? Her last 2 she was a no show."
- 1/5/23 email from QP #2 to FC #8's DSS LG: "Hello [FC #8's DSS LG] Her (FC #8) eye appointment is scheduled for 2/14/23 at 2pm."

Interview on 7/28/23 with FC #8 revealed:
- When she lived at S & S Residential Services she did not know if she was supposed to have eye appointments.
- She did not tell staff at the group home she had vision issues. However, she did tell her teacher at the beginning of the 2022 school year "I couldn't see, and the teacher told [the Licensee]."

Interview on 8/4/23 with FC #8's teacher revealed:
- He was FC #8's teacher last school year (2022-2023).
- He did not recall FC #8 telling him she had vision issues but recalled FC #8 vomiting 3 or 4 times at the beginning of the school year and complaining of headaches while taking tests.
- Each time this occurred he told the Licensee or FQP #2 what occurred.

Interview on 7/28/23 with FC #8's foster mother revealed:
- She became FC #8's foster mother on 5/26/23.
- She had noticed that FC #8 did a lot of "squinching" with her eyes and noticed she

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"stumbled into things."
- "At first, I thought she was clumsy. Now I know it was her eyes not her being clumsy."

Interviews on 8/7/23 and 8/8/23 with the Licensee revealed:
- The FQP #2 would have been the staff responsible for taking FC #8 to her 7/29/22 eye appointment. Because FQP #2 no longer worked there she did not have any information regarding FC #8's 7/29/22 eye appointment.
- The current QP #1 would have been the staff responsible for taking FC #8 to her 12/12/22 and 2/14/23 eye appointment.
- She was not aware that FC #8 had an eye appointment in September 2022.

Interview on 8/7/23 with the QP #1 revealed:
- She would have been the "point person" to take FC #8 to her 12/12/22 and 2/14/23 eye appointment.
- She did not take FC #8 to her 12/12/22 eye appointment because "I think around that time she was hospitalized ..." She later stated, "it was not me (who would have taken FC #8 to the 12/12/22 appointment)."
- She did not take FC #8 to her 2/14/23 appointment because "that one I am not sure why that was a no show. It would have been myself who would have taken her. I was not aware she had an appointment (on 2/14/23)." QP/Billing Staff: had not communicated the appointment time with her.

Interview on 8/4/23 with the QP/Billing Staff revealed:
- She no longer was responsible for QP duties. Currently she was responsible for billing and authorizations.
- Prior to June 2023 she did consulting and

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restructuring with the program. She also did the CFT meetings and "keeping up with appointments for clients."
- She scheduled FC #8's first eye appointment on 2/14/23.
- "I am not sure if she did or did not attend that appointment or not."

Finding #2

Review on 8/18/23 of client #1's record revealed:
- Admission date: 12/23/22
- Age: 15
- Diagnoses: Major Depressive Disorder; Attention Deficit Hyperactivity Disorder (ADHD); and Post-Traumatic Stress Disorder (PTSD)
- Admission assessment dated 12/20/22 revealed: " ...has a history of substance abuse/use involving alcohol and marijuana. [Client #1] will need continued therapy to address her issues with substance abuse/use."
- Treatment plan dated 12/20/22 revealed: " ...will address and begin to resolve her history with substance abuse ...TGH Behavioral Health Services Inc level three residential services staff will: Provide one on one supervisions while out in the community setting."

Review on 8/21/23 of client #2's record revealed:
- Admission date: 6/8/23
- Age: 14
- Diagnoses: Unspecified ADHD; Generalized Anxiety Disorder; Disruptive Mood Dysregulation Disorder; and PTSD
- Review on 8/21/23 of client #2's treatment plan dated 8/1/23 revealed: "will eliminate use of all substances while working towards a path to recovery for the duration of placement ... TGH Behavioral Health Services Inc level three residential services staff will: Provide one on one

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V 293	Continued From page 8 supervisions while out in the community setting." Review on 8/18/23 of client #3's record revealed: - Admission date: 3/17/23 - Age: 16 - Diagnoses: Major Depressive Disorder; Oppositional Defiant Disorder; ADHD; and PTSD - Review on 8/18/23 of client #3's treatment plan dated 8/1/23 revealed: " ...will address and begin to resolve her issue with partaking in negative peer influence and utilizing vape pens ... TGH Behavioral Health Services Inc level three residential services staff will: Provide one on one supervisions while out in the community setting." Review on 7/31/23 of client #4's record revealed: - Admission date: 6/5/23 - Age:17 - Diagnoses: Autism Spectrum Disorder; Disruptive Mood Dysregulation Disorder; and Unspecified Intellectual Disorder - Review on 7/31/23 of FC #4's treatment plan dated 7/1/23 revealed: "TGH Behavioral Health Services Inc level three residential services staff will: Provide one on one supervisions while out in the community setting." Review on 8/22/23 of email dated 7/31/23 revealed: - "From: [the Qualified Professional (QP #1)] - Sent: Monday, July 31, 2023 10:39 AM - To: [Client #4's DSS LG] - Cc: [the Licensee]; [the Licensed Professional (LP)] - Subject: [Client #4's] Incidents - ...On Sunday, it was discovered that [client #4] has possession of a marijuana pen and passed it to one of her peers. When processing with [client #4] regarding that incident, she stated again that she just wanted to feel something. This is very	V 293		

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concerning to hear. [LP] could you further process with [client #4] in session about this? Please let me know if you all have any questions and/or concerns at this time."

Review on 8/22/23 of email dated 7/31/23 revealed:
- "From: [the QP #1]
- Sent: Monday, July 31, 2023 7:30 PM
- To: [the LP]
- Cc: [The Licensee]; [Client #4's DSS LG]
- Subject: Re: [Client #4's] Incidents
- ...After processing with [client #4] several times today, she stated that it (weed pen) was found at the park."

Interview on 8/17/23 with client #3 revealed:
- Sometime after 7/27/23 client #4 stole a "weed pen" from staff #4's car on a Friday. This occurred while she, client #1 and client #2 were out shopping with staff #5. While they were out shopping, client #4 stayed at the group home with staff #4.
- When she got home, client #4 told her, "hey, I have a dab pen, basically a weed pen."
- Client #4 told her that she stole the "weed pen" while the other clients were out shopping. Client #4 gave her the "weed pen" and she smoked it. The pen was red and had liquid in it. "I know it said cake on it."
- She smoked the "weed pen" in her bedroom and there was no odor. "It gave me a buzz, but it didn't give me a high." After she smoked the "weed pen" by herself, she smoked it again with client #1 and then gave it back to client #4 who smoked it in her bedroom. Only she, client #1 and client #4 smoked the "weed pen" on Friday. On Saturday all the clients (including client #2) smoked the "weed pen." After they smoked the "weed pen" on Saturday, she gave it to client #1.

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"I am guessing [client #1] put it in my drawer."
- The QP #1 knew the "weed pen" was somewhere in the group home and started asking a lot of questions. The QP #1 found the "weed pen" inside her drawer. She told the QP #1 that client #4 got the "weed pen" out of staff #4's car.
- "Everyone was put on 72 hours restriction of no TV, no sweet snacks, no juice, we could only drink water."
- The Licensee told the clients they would be drug tested but the clients were not drug tested.
- She knew what was in the "weed pen" because, "I had weed before but not in the group home until that day."
- On another occasion this past summer (2023) prior to the "weed pen" incident, she obtained weed in the park. All four clients (clients #1- #4) were at the park. The QP #1 and staff #4 were at the park with them. She walked away from the others and found a group of unknown people smoking a "blunt" and "they gave it to me." The QP #1 was doing a Child and Family Team meeting inside of her car while she obtained the "blunt" and staff #4 was either standing beside of her car or was inside of her car.
- While at the park she smoked the "blunt" with client #1 and client #2 behind the "play area."
- When they returned to the group home she gave the "blunt" to client #4
- Client #4 later claimed to have eaten the "blunt."
- "Someone snitched. I think it was [client #2] who snitched to [QP #1]."
- " ...[The QP #1] gathered everyone up and we had to talk about it."
- [Client #4] ate the last bit of it (the blunt) so staff did not find any of the pot (marijuana)."

Interviews on 8/21/23 and 8/23/23 with client #3's DSS LG revealed:
- She had not been contacted by the group home

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staff about a marijuana pen or marijuana being found in the group home and passed around by the clients.

Interviews on 8/17/23 and 8/23/23 with client #2 revealed:
- The QP #1, staff #4 and staff #5 worked on the Monday when the "weed pen" was found recently.
- All the clients were outside on that Monday and the QP #1 had come outside and told everyone to come inside. "Nothing was said (by the clients) it was silent." She did see "a little bit" of the "weed pen" because the QP #1 had the "weed pen." The pen was red.
- She did not know who obtained the "weed pen."
- The QP #1 put all the clients on restriction because "no one would answer the question" about the "weed pen."
- The restriction was "72 hours of no sweet snacks, no TV."

Interview on 8/22/23 with client #2's DSS LG revealed:
- On 7/31/23 (Monday), the QP #1 contacted her and said that client #2 wanted to talk to her on the phone. Client #2 told her that someone threw down a "blunt" at the park on Saturday (7/29/23) and client #2 said she smoked the blunt. Client #2 also told her that one of "her peers" had a "weed pen."
- On 7/31/23, the QP #1 told her that the clients had gone to the park on Saturday. While at the park some "random people" were smoking marijuana and "threw down a blunt." Client #2 obtained the "blunt" and smoked it. She was not told which staff were at the park with the clients.
- The QP #1 told her that she did not believe the story and the clients knew they could be drug tested.
- The QP #1 also told her one of the other clients

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(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
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got a marijuana pen and snuck it in the group home. The QP #1 never told her where the marijuana pen had come from.
- "[QP #1] said the home was on restriction due to the girls finding the vape pen (marijuana pen) and [client #2] smoking (a blunt) in the park."
- Client #2 had smoked marijuana in the past.
- She felt "[client #2] told the story about finding a "blunt" in the park to cover for someone bringing in a vape (marijuana pen) in the house."

Interview on 8/17/23 with client #1 revealed:
- Denied that she or the other clients had obtained a marijuana pen or a vape.
- Denied ever being put on restriction because a marijuana pen was found in the group home.

Interview on 8/23/23 with client #1's LG revealed:
- He received a telephone call from the QP #1 "probably 3 weekends ago ....she called maybe on a Sunday."
- The QP #1 told him that client #1 went up to some unknown teenagers at the park who were smoking marijuana and smoked marijuana.
- Client #1 had a history of using "alcohol, cannabis and nicotine."

Interview on 8/17/23 with client #4 revealed:
- Denied that she or the other clients had obtained marijuana since living in the group home.
- Denied that a marijuana pen had been stolen or found in the group home.
- Denied that she saw a marijuana pen in the car of a staff member.
- Denied ever being put on restriction because a marijuana pen was found in the group home.
- "We (she and the other clients) talk about marijuana in the group home but I have not seen anybody with marijuana. We, me and the other

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V 293	Continued From page 13 girls, joke about it." Interview on 8/21/23 with client #4's DSS LG revealed: - On 7/31/23 the QP #1 notified her that client #4 had been "acting high" and they searched client #4's bedroom on 7/30/23. - "[QP #1] said that [client #4] had been passing off the pen (marijuana pen) to other consumers." - On 7/31/23 client #4 told her that she found a "blunt" in the park and said she stole a "marijuana pen" out of staff's car. Client #4 never told her which staff's car she found the marijuana pen in. - She told this information to the QP #1. - The QP #1 referred to the pen as a "marijuana pen." - On 8/11/23, she requested a drug test be completed on client #4. It came back negative. Interview on 8/23/23 with anonymous staff revealed: - Client #3 and client #4 were the only clients who provided information about what occurred over the weekend of 7/29/23 and 7/30/23. - Client #4 told her that the clients got weed in the park from "a guy." Client #4 told her the clients were walking around the park while staff had a meeting. Client #4 did not provide the name of staff who were with them in the park. Client #4 told her that client #3 gave her the marijuana when they returned to the group home and she ate the marijuana with an orange. - Client #3's story was that she got the "weed" in the park as well. - Client #4 then said she stole the marijuana pen from staff #4's car. - Client #3 said when the clients got home from the park client #4 gave her a marijuana pen. - Both client #3 and client #4 said they both smoked the marijuana pen.	V 293		

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V 293	Continued From page 14 Interviews on 8/23/23 and 8/24/23 with the QP #1 revealed: - Client #1 told her father that her peers found weed in the park and that she had nothing to do with it. She told client #1's father "it was impossible (that the clients found weed) because when the clients went to the park on 7/29/23 they complained it was hot and left. All four clients (#1 - #4) went to the park on 7/29/23. - She wrote in her email (7/31/23) to client #4's DSS LG, "On Sunday, it was discovered that [client #4] has possession of a marijuana pen and passed it to one of her peers." - "She (client #4) did not have a weed pen; it was a regular writing pen. I wrote back to the social worker (client #4's DSS LG) that it was not possible as to what she (client #4) was stating." She was unable to find the email she wrote to client #4's DSS LG. - Client #2 told her DSS LG that she found a "blunt" in the park. She told client #2's DSS LG that was not possible because when the clients got to the park, they complained it was hot and left. Client #2 also told her DSS LG that client #4 found a marijuana pen, but client #2 said she did not use the marijuana pen. She told the DSS LG "that was not accurate." - She talked to the two staff, staff #4 and staff #5, about what occurred at the park (7/29/23). Staff #4 and staff #5 both said when they got to the park the clients complained it was hot and they left. She did not document what the staff reported. Interviews on 8/21/23 and 8/24/23 with staff #4 revealed: - Clients had never obtained a marijuana pen from her car. Clients had never been in her car. - She worked with staff #5 over the weekend on	V 293		

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7/29/23 and 7/30/23. She did not take the clients to the park on 7/29/23 nor on 7/30/23 "because the company van didn't work. No one went to the park that weekend (7/29/23 nor on 7/30/23)."
- On 7/30/23 client #4 had come out of her room and stated, "she was getting high."
- She called the QP #1, who came over to the group home and searched client #4's bedroom and "nothing was found." Later client #4 had come out of her bedroom with a blue ink pen and said, "I am getting high."
- She could not recall the last time she took the clients to the park.

Attempted interview on 8/24/23 staff #5:
- Unable to interview due to staff #5 being sick.

Interview on 8/24/23 with the Licensee revealed:
- She had not been told about any incidents regarding a marijuana pen nor a "blunt."
- QP #1 handled most of the responsibilities at the group home.
- She had a copy of the 7/31/23 email from client #4's DSS LG but "I must have not read all the way through it. I did not know about the marijuana pen."

Review on 8/7/23 of the Plan of Protection dated 8/7/23 written by the Licensee revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care?
The agency will continue to adhere to 10A NCAC 27G .1701 Scope (f) The residential treatment staff secure facility shall coordinate with other individuals and agencies within the child or adolescent's system of care.
Describe your plans to make sure the above happens.
The agency will continue to utilize [technology company] Calendar to schedule necessary

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medical and clinical appointments.
The agency will add all clinical team members to the scheduled event as follows which allow all members to keep the residents appointments for record and also the ability to attend if applicable or necessary.
Add people to your event
1. On your computer, open [technology company] Calendar.
2. Click an event Edit event .
3. On the right, under "Guests," start typing the name of the person and choose someone from your contacts. You can also type an email address to invite people who aren't in your contacts list. o To mark a guest as optional, next to the guest's name, click Mark optional. If you don't see the icon, hover over the guest's name.
4. When you're done editing your event, click Save.
You can't add people to events that are automatically created from [technology company email], like birthdays, holidays, and sports calendars.
This will also allow for the agency to track responses to the event.
When guests receive the invitation email, they can respond using the Yes, No, or Maybe links in the email. When a guest RSVPs (Respond, if you please) to the event, we receive an email notification and the event updates.
To see who responded to the event, just click the event on the calendar. The agency sees who's attending, RSVP status, and details.
Supervision
In view of the physical, emotional, and intellectual immaturity of the minor, TGH shall provide appropriate structure, supervision and control consistent with the rights given to the minor. Residents may be subject to search upon entering the facility in accordance with the agency

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V 293	Continued From page 17 10A NCAC 27D .0103: Search and Seizure Policy. " The facility served minor children with diagnoses not limited to: Autism Spectrum Disorder; Unspecified Intellectual Disorder; Oppositional Defiant Disorder; Generalized Anxiety Disorder; Major Depressive Disorder; Disruptive Mood Dysregulation Disorder; Attention Deficit Hyperactivity Disorder; and Post Traumatic Stress Disorder. After FC #8 had a physical exam in July 2022, it was recommended that she be seen by an optometrist. While living in the group home FC #8 had three eye appointments scheduled; however, the staff failed to ensure that FC #8 attended any of the appointments. The DSS LG had documented 4 missed optometrist appointments. The DSS LG had numerous conversations in CFT meetings, during group home visits and emails with the group home staff asking about optometrist appointments and reminding the group home staff of FC #8's optometrist appointments. At discharge May 26, 2023, FC #8 had still not been seen by an optometrist. Additionally, three of the four current clients had goals addressing their histories of substance use. However, clients were able to obtain marijuana pen while in the care of staff. This deficiency constitutes a Type B rule violation which is detrimental to the 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 293		
V 366	27G .0603 Incident Response Requirments	V 366		

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V 366	Continued From page 18 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 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	V 366		

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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 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

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V 366	Continued From page 20 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 incidents as required. The findings are: Review on 8/24/23 of the facility's internal reports revealed: - There were no internal reports regarding the 7/29/23 incident of clients obtaining a marijuana pen nor a "blunt." Interviews on 8/23/23 8/24/23 with the Qualified Professional revealed: - She did not have documentation regarding attending to the health and safety needs of the clients involved; did not determine the cause of the incident; did not develop and implement	V 366		

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V 366	Continued From page 21 corrective measures to prevent similar incidents; and did not assign person(s) to be responsible for implementation of the corrective and preventative measures. - She had not notified the Local Management Entity/Managed Care Organization required by law nor all the legal guardians.	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	V 367		

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V 367	Continued From page 22 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 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;	V 367		

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V 367	Continued From page 23 (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 review and interviews the facility failed to submit a Level II incident report to the Local Management Entity (LME) within 72 hours as required. The findings are: Review on 8/24/23 of the Incident Response Improvement System (IRIS) revealed: - There were no IRIS reports regarding the 7/29/23 incident of clients obtaining a marijuana pen nor a "blunt." Interview on 8/24/23 with the Qualified Professional revealed: - She did not complete an IRIS report about the weed pen because "there was no pen found. The pen she (client #4) had was a writing pen." - She did not complete an IRIS report regarding client #2 finding a blunt because client #2 did not find a blunt. - She talked to clients #1 - #3 about what	V 367		

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V 367	Continued From page 24 occurred at the park on 7/29/23 but she never documented this. - She talked to staff #4 and staff #5, about what occurred at the park on 7/29/23), but she did not document what the staff reported.	V 367		