| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL0601487 | A. BUILDING: _____ B. WING _____ | R 03/13/2023 |

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|---|---|
| WILLIAMSON COTTAGE-THOMPSON CHILD AI | 6700 SAINT PETERS LANE MATTHEWS, NC 28105 |

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| V 000 | INITIAL COMMENTS<br><br>An annual, complaint and follow up survey was completed on 03/13/2023. The complaint (intake #NC00196461) was substantiated. Deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .1800 Intensive Residential Treatment for Children or Adolescents.<br><br>This facility is licensed for 9 and currently has a census of 6. The survey sample consisted of audits of 2 current clients and 1 former client.<br><br>This Statement of Deficiencies was amended on 02/23/24 as a result of additional information received and the Settlement Agreement dated 2/05/24. Thompson Child & Family Focus, Licensee, presented additional information to the Agency showing that the Facility had appropriate policies and procedures in place regarding the use of restrictive interventions prior to the Type A1 Violation. Following the Type A1 Violation, Thompson Child & Family Focus implemented corrective measures to achieve and maintain compliance with all applicable statutes and rules, including 10A NCAC 27E .0108 (V537). Based on the additional information, Thompson Child & Family Focus met all criteria set forth in N.C. Gen. Stat. § 122C-24.1(a)(2a) and the citation was amended from the original survey findings. | V 000 | | |
| V 114 | 27G .0207 Emergency Plans and Supplies<br><br>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES<br>(a) A written fire plan for each facility and area-wide disaster plan shall be developed and | V 114 | | |

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| V 114 | Continued From page 1<br>shall be approved by the appropriate local authority.<br>(b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.<br>(c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies.<br>(d) Each facility shall have basic first aid supplies accessible for use.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure fire and disaster drills were conducted quarterly and repeated on each shift. The findings are:<br><br>Review on 02/22/2023 of the facility's fire and disaster drills log from 02/01/2022- 01/31/2023 revealed:<br>-No documentation to support completion of 3rd shift (11pm-7am) fire and disaster drills for the 1st quarter from February 2022 - April 2022, 2nd quarter from May 2022 - July 2022, or 4th quarter from November 2022 - January 2023.<br><br>Interview on 02/22/2023 with Client #1 revealed:<br>-Admitted 2 weeks ago.<br>-"I have not done one (fire or disaster drill) since I have been here."<br><br>Interview on 02/22/2023 with the Team Lead revealed:<br>-"Yes, we do drills during the overnight hours."<br>-"I worked overnight in January 2023, and I did | V 114 | | |

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| V 114 | Continued From page 2<br>one then. We do them between 4 and 5 in the morning."<br><br>Interview on 02/28/2023 with the Residential Supervisor/Qualified Professional revealed:<br>-Maintenance Department was responsible for completing fire and disaster drills.<br><br>Interview on 02/22/2023 with the Quality Improvement Specialist revealed:<br>-Shifts were 1st (7a-3p), 2nd (3-11pm) and 3rd (11pm-7am).<br>-Switched to 12 hours shift on February 1, 2023.<br><br>Interview on 02/28/2023 with the Chief Facilities Officer revealed:<br>-Was the head of the Maintenance Department and responsible for ensuring completion of fire and disaster drills.<br>-"We have to have 1 while they are sleep. So, if they were still in bed at the time, we would consider it part of 3rd shift." | V 114 | | |
| V 132 | G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection<br><br>G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY<br>(g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes:<br>a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.<br>b. Misappropriation of the property of a resident | V 132 | | |

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| V 132 | Continued From page 3<br>in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.<br>c. Misappropriation of the property of a healthcare facility.<br>d. Diversion of drugs belonging to a health care facility or to a patient or client.<br>e. Fraud against a health care facility or against a patient or client for whom the employee is providing services).<br>Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.<br><br>This Rule is not met as evidenced by:<br>Based on records reviews and interviews, the facility failed to ensure that the Health Care Personnel Registry (HCPR) was notified of all allegations against health care personnel. The findings are: | V 132 | | |

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| V 132 | Continued From page 4<br><br>Review on 01/19/2023 of the facility's record revealed:<br>-No documentation of notification to HCPR for Former Staff (FS) #3 placing a pillowcase over the head of Former Client (FC) #5 and Former Therapist placing a N95 face mask over the nose and mouth of FC #5 during a physical restraint dated 12/06/2022.<br><br>Interview on 02/28/2023 with the Residential Supervisor/Qualified Professional revealed:<br>-Was responsible for HCPR notifications.<br>-"I guess we just did not consider it abuse."<br>-Did not notify HCPR of incidents dated 12/06/2022 for FS #3 and Former Therapist.<br><br>Interview on 01/19/2023 with the Quality Improvement Specialist revealed:<br>-Was responsible for HCPR notifications.<br>-"12/06/2022 incident with [FS #3] placing a pillowcase over the head of [FC #5] did happen. Staff [FS #3] no longer work here. She was let go as a result of the incident."<br>-Did not notify HCPR of incidents dated 12/06/2022 for FS #3 and Former Therapist.<br><br>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. | V 132 | | |
| V 366 | 27G .0603 Incident Response Requirements<br><br>10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS<br>(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: | V 366 | | |

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| V 366 | Continued From page 5<br>(1) attending to the health and safety needs of individuals involved in the incident;<br>(2) determining the cause of the incident;<br>(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;<br>(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;<br>(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;<br>(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<br>(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.<br>(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.<br>(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:<br>(1) immediately securing the client record by:<br>(A) obtaining the client record;<br>(B) making a photocopy;<br>(C) certifying the copy's completeness; and<br>(D) transferring the copy to an internal review team; | V 366 | | |

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| V 366 | Continued From page 6<br>(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:<br>(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;<br>(B) gather other information needed;<br>(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<br>(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<br>(3) immediately notifying the following:<br>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;<br>(B) the LME where the client resides, if | V 366 | | |

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| V 366 | Continued From page 7<br>different;<br>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;<br>(D) the Department;<br>(E) the client's legal guardian, as applicable; and<br>(F) any other authorities required by law.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to implement written policies governing their response to level I, II, and III incidents affecting 1 of 1 audited Former Clients (FC #5). The findings are:<br><br>Review on 01/19/2023 of the facility records revealed:<br>-No Risk/Cause/Analysis or documentation to support submission of the written preliminary findings of fact to the Local Management Entity/Managed Care Organization (LME/MCO) within five working days for Former Staff (FS) #3 placing a pillowcase over the head of FC #5 and Former Therapist placing a N95 face mask over the nose and mouth of FC #5 during a physical restraint dated 12/06/2022.<br><br>Interview on 02/28/2023 with the Residential Supervisor/Qualified Professional revealed:<br>-Was responsible for but did not complete the Risk/Cause/Analysis or submit the written | V 366 | | |

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| V 366 | Continued From page 8<br>preliminary findings of fact to the LME/MCO within five working days for the incidents dated 12/06/2022.<br>-Residential Director and Performance Quality Improvement Department were also responsible for completing the Risk/Cause/Analysis and submission of the written preliminary findings of fact for the incidents dated 12/06/2022.<br><br>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. | V 366 | | |
| V 367 | 27G .0604 Incident Reporting Requirements<br><br>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS<br>(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:<br>(1) reporting provider contact and identification information;<br>(2) client identification information;<br>(3) type of incident;<br>(4) description of incident;<br>(5) status of the effort to determine the cause of the incident; and | V 367 | | |

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| V 367 | Continued From page 9<br>(6) other individuals or authorities notified or responding.<br>(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:<br>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or<br>(2) the provider obtains information required on the incident form that was previously unavailable.<br>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:<br>(1) hospital records including confidential information;<br>(2) reports by other authorities; and<br>(3) the provider's response to the incident.<br>(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).<br>(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: | V 367 | | |

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| V 367 | Continued From page 10<br>(1) medication errors that do not meet the definition of a level II or level III incident;<br>(2) restrictive interventions that do not meet the definition of a level II or level III incident;<br>(3) searches of a client or his living area;<br>(4) seizures of client property or property in the possession of a client;<br>(5) the total number of level II and level III incidents that occurred; and<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to report all level II and III incidents in the Incident Response Improvement System (IRIS) and notify the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident affecting 1 of 1 audited Former Clients (FC #5). The findings are:<br><br>Review on 01/19/2023 of the facility records revealed:<br>-No IRIS report submitted for Former Staff (FS) #3 placing a pillowcase over the head of FC #5 or Former Therapist placing a N95 face mask | V 367 | | |

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| V 367 | Continued From page 11 | V 367 | | |

over the nose and mouth of FC #5 during a physical restraint dated 12/06/2022.
-No documentation of LME/MCO notification.

Review on 01/19/2023 of the IRIS from 12/06/2022-01/18/2023 revealed:
-IRIS report submitted for a physical restraint involving FC #5 dated 12/06/2022 but no updates to the report after learning on 12/15/2022 that Former Staff (FS) #3 placed a pillowcase over the head of Former Client (FC) #5 and Former Therapist placed a N95 face mask over the nose and mouth of FC #5 during the physical restraint dated 12/06/2022.

Interviews on 01/19/2023 and 02/28/2023 with the Residential Supervisor/Qualified Professional (QP) revealed:
-Did not have knowledge of the pillowcase incident when the IRIS report was completed on 12/07/2022.
-QIS informed him of the pillowcase incident on 12/15/2022.
-Did not update the IRIS report with additional information or notify the LME/MCO within 72 hours of becoming aware aware of the pillowcase and face mask incidents dated 12/06/2022.

Interview on 01/19/2023 the QIS revealed:
-Was informed by Registered Nurse #2 that FS #3 placed a pillowcase over the head of FC #5 on 12/15/2022.
-Conducted an internal investigation for the pillowcase incident.
-Did not conduct an internal investigation for the face mask incident.
-Did not update the IRIS report with additional information or notify the LME/MCO within 72 hours of becoming aware of the pillowcase and

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| V 367 | Continued From page 12<br>face mask incidents dated 12/06/2022.<br><br>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. | V 367 | | |