STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601513	A. BUILDING: _____ B. WING _____	R 02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 000	INITIAL COMMENTS An annual, complaint, and follow up survey was completed on 02/06/2024. The complaint was substantiated (intake #NC00211010). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minors with Developmental Disability The survey sample consisted of audits of 1 current client and 1 former client.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's	V 105		

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	MHL0601513	A. BUILDING: _____ B. WING _____	R 02/06/2024

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V 105	Continued From page 1 needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (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; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (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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V 105	Continued From page 2	V 105		

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to implement discharge policies and procedures. The findings are:

Review on 01/30/2024 of FC #2's record revealed:
-Admitted 11/17/2023.
-Discharged 12/17/2023.
-Diagnosed with Autism Spectrum Disorder, Mild Intellectual Development Disability, Acute Stress Disorder, Conduct Disorder Childhood Onset, Attention Deficit Hyperactivity Disorder, and Dissociative Identity Disorder.
-No discharge notice for FC #2.

Review on 01/29/2024 of a document tiltled "Discharge Summary" for FC #2 dated and signed by the Clinical Director on 12/18/2023 revealed:
-"During his (FC #2) stay, the clinical team (CFT (Child and Family Treatment Team)) worked diligently to address his needs and provide appropriate care and support. He was discharged on 12/17/2023."

Interview on 01/31/2024 with FC #2's Guardian revealed:
-"We were not given a discharge notice, they (facility management) just said he could not come back. They just dropped him (FC #2) off at the hospital (on 12/16/2023) and said he could not come back (to the facility)."

Interview on 01/31/2024 with FC #2's Care Coordinator revealed:

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	MHL0601513	A. BUILDING: _____ B. WING _____	R 02/06/2024

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V 105	Continued From page 3 -"No written discharge notice was given (for FC #2)." -FC #2 was hospitalized on 12/16/2023 due to escalating behaviors. -The facility would not allow FC #2 to come back to the facility due to safety concerns for the other client (Client #1). -FC #2 remains at the local hospital emergency department. Interview on 01/30/2024 with the Clinical Director revealed: -"He (FC #2) was refusing to leave [Client #1]'s room and was having a meltdown. The police came and he assaulted the police and was taken to [local hospital] (on 12/16/2023), and we did not take him back after that." -FC #2 was hospitalized on 12/16/2023. -FC #2 was discharged from the facility on 12/17/2023. -"We have everything in writing (discharge) and submitted our 30 day notice (discharge)." Interview on 02/06/2024 with the Qualified Professional (QP)/Licensee (L) revealed: -FC #2 was hospitalized on 12/16/2023. -FC #2 was discharged from the facility on 12/17/2023. -"We submitted a 30 day notice (discharge) to Managed Care Organization (MCO)." -"I was not aware that the notice (discharge) was not in writing." -The Clinical Director was responsible for submitting the discharge notice for FC #2.	V 105		
V 107	27G .0202 (A-E) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS	V 107		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601513	A. BUILDING: _____ B. WING _____	R 02/06/2024

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V 107	Continued From page 4 (a) All facilities shall have a written job description for the director and each staff position which: (1) specifies the minimum level of education, competency, work experience and other qualifications for the position; (2) specifies the duties and responsibilities of the position; (3) is signed by the staff member and the supervisor; and (4) is retained in the staff member's file. (b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility: (1) is at least 18 years of age; (2) is able to read, write, understand and follow directions; (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry. (c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying. (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided. (e) A file shall be maintained for each individual employed indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification.	V 107		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601513	A. BUILDING: _____ B. WING _____	R 02/06/2024

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V 107	Continued From page 5	V 107		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure a complete personnel file was maintained for 1 of 1 Registered Nurse (RN). The findings are:

Review on 01/30/2024 of the RN's personnel record revealed:
-No documentation of a hire date.
-No job description specifying the minimum level of education, competency, work experience, skills, and other qualifications for the position.

Interview on 01/31/2024 with the RN revealed:
-Was hired (date unknown) by the Clinical Director and completed the Medication Administration Training for the facility staff on 11/17/2023.
-Did not provide the facility documentation of her level of education, competency, work experience, skills, and other qualifications for the position.

Interview on 01/30/2024 with the Qualified Professional/Licensee revealed:
-"We interviewed 6 nurses and I had to choose one to do it (Medication Administration Training). It's hard to find people that want to work these days."
-"I do not have copies of her (RN) credentials. I can't find her number (telephone)."
-"I did not know I needed to have a file

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V 107	Continued From page 6 (personnel) on her (RN)."	V 107		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter.	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 109	Continued From page 7	V 109		

This Rule is not met as evidenced by:
Based on record reviews and interviews, 1 of 1 Qualified Professionals (QP/Licensee (L)) failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are:

Review on 01/30/2024 of the QP/L's record revealed:
-Hire date: 01/02/2023.
-Education: Bachelor of Arts in Sociology and Master of Science in Psychology.
-A job description dated 09/22/2022 revealed: "...This position is responsible for ensuring best practice, compliance with all state, federal, and agency standards as required for assigned services."

Interview on 02/06/2024 with the QP/L revealed:
-"I am responsible for overall operations and oversight of the facility. I have to start delegating some of my responsibilities. I got to start coming in every other day to make sure things are running right."
-Did not issue a 30 day written discharge notice for FC #2.
-Did not maintain a personnel record for the Registered Nurse hired to provide medication administration training to facility staff.
-Did not ensure fire and disaster drills were completed as required.
-Did not ensure monitor the medication administration process for accuracy.
-Did not ensure Health Care Personnel Registry

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	MHL0601513	A. BUILDING: _____ B. WING _____	R 02/06/2024

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V 109	Continued From page 8 (HCPR) was notified of the allegation of abuse incident for Staff #2 within 24 hours as required. -Did not ensure level I and III incidents were documented as required, -Did not ensure his Evidence Based Protective Interventions (EBPI) Training in alternatives to restrictive intervention was current. -Did ensure the facility was properly maintained as required. -"I will be hiring a new QP to oversee the program."	V 109		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills.	V 110		

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	MHL0601513	A. BUILDING: _____ B. WING _____	R 02/06/2024

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V 110	Continued From page 9 (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 audited Staff (#2) demonstrated competency in knowledge, skills, and abilities required by the population served. The findings are: Review on 01/30/2024 of Staff #2's personnel record revealed: -Hire date 11/25/2023. -Job title Paraprofessional. Review on 01/30/2024 of an Internal Investigative Report dated 12/05/2023 revealed: -"Upon careful examination of the recorded incident involving staff [Staff #2], it was observed that she made an ambiguous comment while talking to another staff member (Staff #1) in the presence of [Client #1]. In her statement, 'he just kicked your a*s, go to your room', while inappropriate and against our professional conduct guidelines, there was no direct cursing, threat, or intent to harm [Client #2]." Interview on 01/29/2024 with Staff #1 revealed: -Did not witness Staff #2 behave inappropriately with Client #1 or FC #2. Interview on 01/31/2024 with Staff #2 revealed:	V 110		

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	MHL0601513	A. BUILDING: _____ B. WING _____	R 02/06/2024

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V 110	Continued From page 10 -Did not direct inappropriate comments to Client #1. -Made inappropriate statements about Client #1 to Staff #1 in the presence of Client #1 and FC #2. -"I was frustrated, and I was talking to the other girl (Staff #1) and I was explaining what happened at the hospital." Interview on 01/29/2024 with Staff #3 revealed: -Did not witness Staff #2 behave inappropriately with Client #1 or FC #2. Interview on 02/06/2024 with the Qualified Professional/Licensee revealed: -There was an allegation of verbal abuse for Client #1 against Staff #2. -"[Staff #2] was disciplined. It was grounds for immediate termination." -"[Staff #2] was re-trained (on Professionalism and Code of Conduct)"	V 110		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (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. (d) Each facility shall have basic first aid supplies accessible for use.	V 114		

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	MHL0601513	A. BUILDING: _____ B. WING _____	R 02/06/2024

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V 114	Continued From page 11 This Rule is not met as evidenced by: 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: Review on 01/29/2024 of the Facility's Fire and Disaster Drill Logs from 10/10/2023 - 12/31/2023 revealed: -No first shift (7 am-3 pm) or third shift (11 pm-7 am) disaster drills for the fourth quarter. Interview on 01/29/2024 with Client #1 revealed: -Practiced fire and disaster drills. Interview on 01/29/2024 with Staff #1 revealed: -Completed fire and disaster drills monthly. Interview on 01/29/2024 with Staff #3 revealed: -Completed fire and disaster drills but was not sure how often. Interview on 02/06/2024 with the Qualified Professional/Licensee revealed: -Facility shifts were first shift (7 am-3 pm), second shift (3 pm-11 pm), and third shift (11 pm-7 am). -Was not aware that fire and disaster drills were required to be conducted on every shift and quarter. -Would ensure completion of fire and disaster drills as required moving forward.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION	V 118		

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V 118	Continued From page 12 REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered on the written	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601513	A. BUILDING: _____ B. WING _____	R 02/06/2024

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V 118	Continued From page 13	V 118		

order of a physician and the MARs kept current affecting 1 of 1 Client (#1) and 1 of 1 Former Client (FC #2). The findings are:

Finding #1:

Review on 01/29/2024 of Client #1's record revealed:
-14-years-old.
-Admitted 10/06/2023.
-Diagnosed with Conduct Disorder Childhood Onset, Attention Deficit Hyperactivity Disorder (ADHD), and Mild Intellectual Developmental Disability (IDD).
Medication orders for:
-11/01/2023; Clonidine HCL (Hydrochloric Acid) 0.1 mg (milligram) (ADHD)- Take 1 tablet (tab) by mouth 3 times daily.
-11/30/2023; Chlorpromazine 25 mg (Mood Stabilization)- Take 1 tab by mouth twice daily at noon and bedtime.
-12/02/2023; Divalproex SOD (Sodium) DR (Delayed Release) 500 mg (Mood Stabilizer)- Take 1 tab by mouth 3 times daily

Review on 01/29/2024 of Client #1's MARS from 10/06/2023 - 01/28/2024 revealed:
-Medications listed above were transcribed on Client #1's MAR.
-Missed medication doses with no staff initials for administration:
-01/24/2024 at 12 noon; Chlorpromazine 25 mg.
-01/25/2024 at 12 noon; Chlorpromazine 25 mg.
-01/26/2024 at 12 noon; Chlorpromazine 25 mg.
-01/27/2024 at 12 noon; Chlorpromazine 25 mg.
-01/27/2024 at 12 noon; Clonidine HCL 0.1 mg.
-01/27/2024 at 12 noon; Divalproex SOD DR.
-01/28/2024 at 12 noon; Clonidine HCL 0.1 mg.
-01/28/2024 at 12 noon; Chlorpromazine 25 mg.
-01/28/2024 at 12 noon; Divalproex SOD DR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601513	A. BUILDING: _____ B. WING _____	R 02/06/2024

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V 118	Continued From page 14 -Client #1 had a total of 9 missed medication doses with no staff initials for administration. Observation on 01/29/2024 at approximately 11:55 am of Client #1's medication container revealed: -Chlorpromazine 25 mg was present and dispensed by the pharmacy on 01/10/2024. -Clonidine HCL 0.1 mg was present and dispensed by the pharmacy on 01/02/2024. -Divalproex SOD DR as present and dispensed by the pharmacy on 01/02/2024. Finding #2: Review on 01/30/2024 of FC #2's record revealed: -14-years-old. -Admitted 11/17/2023. -Discharged 12/17/2023. -Diagnosed with Autism Spectrum Disorder, Mild IDD, Acute Stress Disorder, Conduct Disorder Childhood Onset, ADHD, and Dissociative Identity Disorder. Medication orders for: -09/14/2023; Citalopram 10 mg (ADHD)- Take 1 tab by mouth every day. -09/14/2023; Divalproex SOD ER (Extended Release) 250 mg tab (Mood Stabilizer)- Take 1 tab by mouth every morning. -09/14/2023; Guanfacine 2 mg (ADHD)- Take 2 tabs by mouth 3 times daily -09/14/2023; Mirtazapine 15 mg ODT (Orally Disintegrating Tab) (Mood Stabilizer)- Dissolve one-half tab under the tongue at bedtime. -09/14/2023; Trazodone 50 mg (Sleep Aid)- Take 1 tab by mouth at bedtime. -09/14/2023; Quetiapine 100 mg (Mood Stabilizer)- Take 1 tab by mouth at bedtime. -09/14/2023; Quetiapine 50 mg- Take 1 tab by	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 118	Continued From page 15	V 118		

mouth twice daily with breakfast and lunch.
No Medication orders for:
-Cetirizine HCL (Allergies) 10 mg tab- Take 1 tab by mouth every day.
-Divalproex SOD ER 500 mg tab (Mood Stabilizer)- Take 1 tab by mouth every morning.

Review on 01/30/2024 of FC #2's MARS from 11/17/2023 - 12/16/2023 revealed:
Transcribed medications that differ from medication order listed above from 11/17/2023 - 11/30/2023:
-Citalopram 20 mg (med order specified 10 mg)- Take 1 tab by mouth every day.
-Guanfacine 1 mg (med order specified 2 mg)- Take 2 tabs by mouth 3 times daily
-Mirtazapine 7.5 mg ODT (med order specified 15 mg)- Dissolve one-half tab under the tongue at bedtime.
No transcription for:
-Quetiapine 50 mg (med order specified 100 mg)- Take 1 tab by mouth twice daily with breakfast and lunch.
-No MARS from 12/01/2023 - 12/16/2023.

FC #2's medication bin was not observed on 01/29/2024 due to his discharge from the facility on 12/17/2023.

Interview on 01/29/2024 with Staff #1 revealed:
-"Staff (Staff #2) said she forgot to sign off on administering the medications (Client #1's medications)."

Interview on 01/31/2024 with Staff #2 revealed:
-"I forgot to sign in the book (MAR) but [Client #1] got his medications. We always make sure he gets his medications in the morning, noon, and night."
-"We (staff) are required to sign off on the MAR if

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V 118	Continued From page 16 we give medications." Interviews on 01/29/2024 and 02/06/2024 with the Qualified Professional/Licensee revealed: -Was not aware that Client #1's medications were not initialed to signify administration as required. -FC #2's MARs and medication orders were placed in storage since his discharge on 12/17/2023. -"I will complete another one (medication administration training) and check the books (MARS) twice a day." Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.	V 118		
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 the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g).	V 318		

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V 318	Continued From page 17 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure Health Care Personnel Registry (HCPR) was notified of all allegations of abuse against personnel within 24 hours as required affecting 1 of 3 audited Staff (#2). The findings are: Review on 01/30/2024 of Staff #2's personnel record revealed: -Hire date 11/25/2023. -Job title Paraprofessional. Review on 01/29/204 of the Facility's records revealed: -No HCPR 24 Hour Initial Report for Staff #2. Review on 01/29/2024 of the North Carolina Incident Response Improvement System for the facility's reports from 10/10/2023 - 01/28/2024 revealed: -A level III incident report for Client #1's allegation of abuse against Staff #2 incident dated 12/04/2023 and submitted on 12/11/2023. Interview on 01/30/2024 with the Clinical Director revealed: -Client #1's alleged abuse incident occurred on 12/04/2023. -Became aware of the allegation against Staff #2 on 12/05/2023. -Notified HCPR of the alleged abuse incident against Staff #2 on 12/07/2023 when the IRIS report for Client #1 was completed. Interview on 02/06/2024 with the Qualified Professional/Licensee revealed: -Client #1's alleged abuse incident with Staff #2 occurred on 12/04/2023.	V 318		

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V 318	Continued From page 18 -Became aware of the allegation against Staff #2 on 12/05/2023. -"[Clinical Director] was in charge of that and she said she reported it (Client #1's alleged abuse incident against Staff #2 dated 12/04/2023)." -"I don't know why it (HCPR report for Staff #2) was not done within 24 hours." -Would ensure allegations against staff were reported to HCPR within 24 hours moving forward.	V 318		
V 366	27G .0603 Incident Response Requirements 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	V 366		

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V 366	Continued From page 19	V 366		

Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.
(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:
(1) immediately securing the client record by:
(A) obtaining the client record;
(B) making a photocopy;
(C) certifying the copy's completeness; and
(D) transferring the copy to an internal 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

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V 366	Continued From page 20 (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (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 records review and interviews, the facility failed to implement written policies governing their response to Level I and Level III incidents. The findings are:	V 366		

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V 366	Continued From page 21 Review on 01/29/2024 of a document tiltled "Discharge Summary" for Former Client (FC) #2 dated and signed by the Clinical Director on 12/18/2023 revealed: -"[FC #2] displayed aggressive and noncompliant behaviors, including: Completely destroying his room and clothes; refusing to bathe; creating holes in his wall and 2 in the living area; kicking the mailbox; Inappropriate urination incidents. Peeing in a cup in a car and a water bottle in a housemate's (Client #1) room." Reviews on 01/29/2024 and 01/31/2024 of the Facility's Incident Reports from 10/10/2023 - 01/28/2024 revealed: No Incident Reports or Risk/Cause/Analysis (RCA) for: -FC #2's property and personal clothing destruction incident (date unspecified). -FC #2's refusal to bathe incident (date unspecified). -FC #2's mailbox incident (date unspecified). -FC #2's property destruction incident (date unspecified). -FC #2's urination incidents (date unspecified). No RCA or submission of the written preliminary findings of fact to the Local Management Entity/Managed Care Organization (LME/MCO) within five working days for: -12/04/2023; Client #1's alleged abuse incident against Staff #2. Interview on 02/06/2024 with the Qualified Professional/Licensee revealed: -Did not complete the RCA or submit the written preliminary findings of fact to the LME/MCO for Client #1. -Incident reports and the RCA were not	V 366		

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V 366	Continued From page 22 completed for FC #2. -"I will develop a process to streamline incident reporting to include that everything is documented in 12-24 hours." -Would ensure completion of incident reports and RCA coming forward.	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 shall submit an updated report to all required	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 367	Continued From page 23	V 367		

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;
(3) searches of a client or his living area;

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V 367	Continued From page 24 (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 report level III incidents in the Incident Response Improvement System (IRIS) as required. The findings are: Review on 01/29/2024 of the IRIS from 10/10/2023 - 01/28/2024 revealed: -A level III incident report for Client #1's allegation of abuse against Staff #2 incident dated 12/04/2023. Review on 01/29/2024 of an IRIS Report submitted on 12/11/2023 for Client #1 revealed: -Incident occurred on 12/04/2023. -Facility learned about the incident on 12/04/2023. -Host LME/MCO was notified on 12/11/2023. -HCPR Facility Allegation section was completed, and the resident abuse box was checked. -Staff #2 was identified and accused of resident abuse.	V 367		

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V 367	Continued From page 25 -"Staff member [Staff #2] allegedly used inappropriate language, including a curse word, during her shift while discussing incidents involving Consumer 1 (Client #1) and Consumer 2 (FC #2), leading to allegations by Consumer 2 that the language was directed towards Consumer 1." Interview on 01/30/2024 with the Clinical Director revealed: -Client #1's alleged abuse incident with Staff #2 occurred on 12/04/2023. -Became aware of the allegation against Staff #2 on 12/05/2023. -"We completed the IRIS report, but it didn't go all the way through (not submitted)." -"It (IRIS report) was submitted on 12/07/2023." -Did not submit the IRIS report for FC #2's alleged abuse incident within 24 hours required. Interview on 02/06/2024 with the Qualified Professional/Licensee revealed: -Client #1's alleged abuse incident occurred on 12/04/2023. -Became aware of the allegation against Staff #2 on 12/05/2023. -"[Clinical Director] submitted the IRIS report for [FC #2]." -Assumed the IRIS report for the FC #2's 12/04/2023 alleged abuse incident was submitted as required. -"I will develop a process to streamline incident reporting to include that everything is documented in 12-24 hours." -"I am going to double check IRIS to ensure that reports are submitted."	V 367		
V 536	27E .0107 Client Rights - Training on Alt to Rest. Int.	V 536		

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V 536	Continued From page 26 10A NCAC 27E .0107 TRAINING ON ALTERNATIVES TO RESTRICTIVE INTERVENTIONS (a) Facilities shall implement policies and practices that emphasize the use of alternatives to restrictive interventions. (b) Prior to providing services to people with disabilities, staff including service providers, employees, students or volunteers, shall demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. (c) Provider agencies shall establish training based on state competencies, monitor for internal compliance and demonstrate they acted on data gathered. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider wishes to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Staff shall demonstrate competence in the following core areas: (1) knowledge and understanding of the people being served; (2) recognizing and interpreting human behavior;	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 536	Continued From page 27 (3) recognizing the effect of internal and external stressors that may affect people with disabilities; (4) strategies for building positive relationships with persons with disabilities; (5) recognizing cultural, environmental and organizational factors that may affect people with disabilities; (6) recognizing the importance of and assisting in the person's involvement in making decisions about their life; (7) skills in assessing individual risk for escalating behavior; (8) communication strategies for defusing and de-escalating potentially dangerous behavior; and (9) positive behavioral supports (providing means for people with disabilities to choose activities which directly oppose or replace behaviors which are unsafe). (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name; (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualifications and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program.	V 536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601513	A. BUILDING: _____ B. WING _____	R 02/06/2024

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V 536	Continued From page 28	V 536		

(3) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course.
(4) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (i)(5) of this Rule.
(5) Acceptable instructor training programs shall include but are not limited to presentation of:
(A) understanding the adult learner;
(B) methods for teaching content of the course;
(C) methods for evaluating trainee performance; and
(D) documentation procedures.
(6) Trainers shall have coached experience teaching a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least one time, with positive review by the coach.
(7) Trainers shall teach a training program aimed at preventing, reducing and eliminating the need for restrictive interventions at least once annually.
(8) Trainers shall complete a refresher instructor training at least every two years.
(j) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcomes (pass/fail);
(B) when and where attended; and
(C) instructor's name.
(2) The Division of MH/DD/SAS may request and review this documentation any time.

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V 536	Continued From page 29 (k) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (l) Documentation shall be the same preparation as for trainers. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure Refresher Training on alternatives to restrictive interventions was completed affecting 1 of 1 Qualified Professional(QP)/Licensee (L). The findings are: Review on 01/30/2024 of the QP/L's personel record revealed: -Hire date 01/02/2023. -An expired Initial Evidence Based Protective Interventions (EBPI) Training in alternatives to restrictive intervention dated 12/31/2022. -No evidence of a Refresher EBPI Training in alternatives to restrictive intervention. Review on 01/30/2024 of Emailed Correspondence from the QP/L to the Division of Health Service Regulation surveyor revealed: -"For the EBPI (training), it can be used till the end of the month (01/31/2024). Please see the	V 536		

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V 536	Continued From page 30 bottom of the certificate." Interviews on 01/30/2024 and 02/06/2024 with the QP/L revealed: -"I am scheduled for an upcoming training (EBPI)." -"I did not realize that it had expired."	V 536		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (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. This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a clean, attractive, and orderly manner. The findings are: Observation on 01/29/2024 at approximately 11:21 am - 11: 35 pm revealed: Client #1's bedroom: -White blinds with approximately 12-18 slats broken. -2 panel closet doors off the hinges and propped against the wall. Living room: -White extension card on the floor in front of the brown couch. Dining room: -White blinds with 3 broken slats. Refrigerator: -Broken door handle.	V 736		

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V 736	Continued From page 31 Interview on 01/29/2024 with Staff #1 revealed: -"[Client #1] will break pieces of the blind when he gets in his mood. The blinds have been broken since last week." -Was not sure how long the refrigerator door handle or the living room blinds had been broken. Interview on 01/31/2024 with Staff #2 revealed: -"The blinds have not been broken for long." -Refrigerator door handle broke recently. Interview on 01/29/2024 with Staff #3 revealed: -"The blinds and closet (in Client #1's bedroom) broke recently. I want to say it happened this week." -Was responsible for leaving the extension card in the middle of the floor. Interview on 01/29/2024 with the Qualified Professional/Licensee revealed: -"He (Client #1) must have just broken that because it (white blinds in his bedroom) was not like this last Thursday. [Client #1] continues to take it off the hinges. The repairman was just here, so I don't why it was not fixed." -Would replace the blinds in Client #1's bedroom and the dining room. -Would ensure Client #1's closet doors were repaired. -Would ensure that staff placed extension cards away after use. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		