STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-230	A. BUILDING: _____ B. WING _____	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE-WAY HOMES	1141 AMBERLIGHT CIRCLE SALISBURY, NC 28144

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual, follow-up and complaint survey was completed on June 5, 2024. The complaint was substantiated (intake #NC00215449). 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 3 and has a current census of 3. The survey sample consisted of audits of 3 current clients and 1 former client.	V 000		
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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire and disaster drills were held	V 114		

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V 114	Continued From page 1 at least quarterly and repeated for each shift. The findings are: -No documentation of a 1st shift fire drill and a 1st and 3rd shift disaster drill during the 1st quarter (January, February, March). -No documentation of a 1st shift fire drill and a 1st shift disaster drill during the 2nd quarter (April, May, June). -No documentation of a 1st and 2nd shift fire drill and a 1st and 2nd shift disaster drill during the 3rd quarter (July, August, September). Interview on 5/29/24 with Client #1 revealed: -He had been living at the facility for "one year and a couple of months." -He participated in a facility drill the middle of the previous week (5/22/24). -"I've not had the opportunity to do one of those (disaster drill) that I know of." Interview on 5/29/24 with Client #2 revealed: -He was admitted to the facility in July 2023. -He participated in a fire drill at the facility 4 to 5 days ago. -"I haven't done one of those (disaster drill)." Interview on 5/29/24 with Client #3 revealed: -He was admitted to the facility in December 2023. -"We do fire drills ... We don't do any kind of disaster drill." Interview on 5/30/24 with Staff #1 revealed: -She worked as a paraprofessional for almost 2 years. -She conducted a fire drill this week on 2nd shift. -She had not conducted a disaster drill. Interview on 5/29/24 with Staff #2 revealed:	V 114		

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V 114	Continued From page 2 -He started as a group home staff in March 2023. -He usually worked from 5 pm to 11:00 pm two to three days a week. -Fire drills were conducted "weekly or every 2 weeks. There might have been a time we have missed a few." -Responded to disaster drills with "No, I've not done any." Interview on 5/29/24 with Staff #3 revealed: -He was the house manager. -There were 3 shifts: 1st shift was from 8 am-3 pm or 4 pm, 2nd shift was from 3 pm to 11 pm, and 3rd shift was from 11 pm to 8 am. -The last fire drill was conducted this month. -There usually was not a first shift unless a client was placed in out of school suspension or school was out for a holiday or the summer. -Responded to disaster drills with "I personally haven't done a disaster drill-other staff may have." -"We try to do drills every month and on every shift." Interviews on 5/31/24 and 6/5/24 with the Director revealed: -She thought the fire and disaster drills were being conducted each month. -Facility staff usually documents each fire and disaster drill.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION 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	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 3 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 record review, observation and interview, the facility failed to ensure disposal of discontinued medications to guard against diversion or accidental ingestion. The findings are: Reviews on 5/29/24 and 5/30/24 of Client #1's record revealed:	V 118		

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V 118	Continued From page 4	V 118		

-Admission date of 5/17/23.
-Diagnoses of Major Depressive Disorder, Attention-Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), Unspecified Traumatic Stress Disorder, Encopresis not due to a physiological condition.
-4/23/24 physician-ordered Fluticasone Propionate 50 mcg (microgram) Spray (allergies), 2 sprays each nostril every day.

Review on 5/29/24 of Client #1's MAR for March 2024, April 2024 and May 2024 revealed:
-No documentation of Fluticasone Propionate administration for the months March 2024 through May 2024.

Reviews on 5/29/24 and 5/30/24 of Client #2's record revealed:
-Admission date of 7/25/23.
-Diagnoses of Disruptive Mood Dysregulation Disorder, ADHD-combined presentation, and Post-Traumatic Stress Disorder.
-3/4/24 physician-ordered Fluticasone Propionate 50 mcg Spray (allergies), 2 sprays each nostril every day.

Review on 5/29/24 of Client #2's MAR for March 2024, April 2024 and May 2024 revealed:
-Documentation of Fluticasone Propionate administration at 7 pm during the months of March 2024 through May 2024.

Reviews on 5/29/24 and 5/30/34 of Client #3's record revealed:
-Admission date of 12/20/23.
-Diagnoses of Diagnoses: Disruptive Mood Dysregulation Disorder, Unspecified Trauma and Stressor related Disorder, ADHD- combined presentation, and Parent-adopted child conflict.
-Undated physician order for Pataday Eye Drops

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V 118	Continued From page 5 0.2% (allergies), instill 1 drop into each eye daily, and Lotrimin Antifungal 2% spray (tinea pedis), spray between toes twice daily for 4 weeks and then as needed. Review on 5/29/24 of Client #3's MAR for March 2024, April 2024 and May 2024 revealed: -No documentation of Pataday Eye Drops administration for the months March 2024 through May 2024. -No documentation Lotrimin Antifungal 2% spray administration for the months March 2024 through May 2024. Observation on 5/29/24 at 1:18 pm of Client #1's medications revealed: -His medications were stored in a plastic bin with his name on the bin. -Fluticasone Propionate 50 mcg Spray, 2 sprays each nostril every day with a dispense date of 5/23/24 was in Client #1's medication bin. Observation on 5/29/24 at 1:09 pm of Client #2's medications revealed: -His medications were stored in a plastic bin with his name. -Fluticasone Propionate 50 mcg (microgram) Spray (allergies), 2 sprays each nostril every day with a dispense date of 5/23/24 was in Client #2's medication bin. Observation on 5/29/24 at 1:40 pm of Client #3's medications revealed: -His medications were stored in a plastic bin with his name on the bin. - Pataday Eye Drops and Lotrimin Antifungal 2% spray were in Client #3's medication bin. Interview on 5/29/24 with Client #1 revealed: -He did not know the names of all of his	V 118		

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V 118	Continued From page 6 medications. -He took medication for blood pressure, diabetes, mood stabilizer, depression and sleep. -The only change in his medication he knew of was his sleep medication was now Trazadone. Interview on 5/29/24 with Client #2 revealed: -He took medications for mood management, vitamins and an antidepressant. -"I wouldn't know if my medication changed. [Director] would tell me if anything changed." Interview on 5/29/24 with Client #3 revealed: -He took medication for his allergies, ADHD, and he used a foot spray for Athlete's foot. Interview on 5/29/24 with the Facility Director revealed: -Client #1 no longer used his Fluticasone Propionate nasal spray; this medication was discontinued on 3/4/24. -Client #1 used this spray for "a brief period when he was sick." -Client #2 came to his admission with his Fluticasone Propionate nasal spray; this medication was discontinued on 4/29/24. -Client #3 came to his admission with Pataday Eye Drops; this medication was discontinued on 1/8/24. -Client #3 never used the Lotrimin foot spray while he was here.	V 118		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against	V 132		

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V 132	Continued From page 7 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: 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. b. Misappropriation of the property of a resident 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. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). 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.	V 132		

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V 132	Continued From page 8	V 132		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to notify the Health Care Personnel Registry of all allegations of abuse, neglect and exploitation. The findings are:

Review on 6/4/24 of facility incident reports for Former Client (FC#4) revealed:
-A North Carolina Incident Response Improvement System (IRIS) report dated 3/21/24 stated on 3/19/24 at 12:00 am, an incident occurred at the facility that included an allegation against a facility staff (not identified). The provider learned of the incident on 3/20/24.
-An internal facility event report dated 3/19/24 revealed:
-FC #4 alleged a staff (not identified) walked into his room on 3/19/24 at approximately 11:30 pm, sat on his bed, "tapped him on his genital area, then his leg."
-FC#4 stated the staff had been making "sexual advances toward him for the last 2 month."
-The staff and clients at the facility were interviewed as part of an internal investigation; they denied they saw or heard anything related to the allegation.
-On 3/21/24, the Facility Director's conclusion from the internal investigation was an unsubstantiated finding.

Interview on 6/5/24 with the Facility Director revealed:
-She identified former staff (FS #1) as the staff FC#4 made the allegation against.
-FS #1 no longer worked at the facility.
-She faxed internal investigation information to the Health Care Registry within 5 days that

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V 132	Continued From page 9 included information on FS#1 -She did not provide any documentation that she notified the Health Care Registry about this allegation and information on FS #1. Interview on 6/5/24 with a staff of the North Carolina Personnel Registry revealed: -No information had been received from the Facility Director since October, 2023. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 132		
V 294	27G .1702 Residential Tx. Child/Adol -Req. for Q P 10A NCAC 27G .1702 REQUIREMENTS OF QUALIFIED PROFESSIONALS (a) Each facility shall utilize at least one direct care staff who meets the requirements of a qualified professional as set forth in 10A NCAC 27G .0104(18). In addition, this qualified professional shall have two years of direct client care experience. (b) For each facility of five or less beds: (1) the qualified professional specified in Paragraph (a) of this Rule shall perform clinical and administrative responsibilities a minimum of 10 hours each week; and (2) 70% of the time shall occur when children or adolescents are awake and present in the facility. (c) For each facility of six or more beds: (1) the qualified professional specified in Paragraph (a) of this Rule shall perform clinical and administrative responsibilities a minimum of 32 hours each week; and (2) 70% of the time shall occur when children or adolescents are awake and present in	V 294		

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V 294	Continued From page 10 the facility. (d) The governing body responsible for each facility shall develop and implement written policies that specify the clinical and administrative responsibilities of its qualified professional(s). At a minimum these policies shall include: (1) supervision of its associate professional(s) as set forth in Rule .1703 of this Section; (2) oversight of emergencies; (3) provision of direct psychoeducational services to children or adolescents; (4) participation in treatment planning meetings; (5) coordination of each child or adolescent's treatment plan; and (6) provision of basic case management functions. This Rule is not met as evidenced by: Based on interview and record review the facility failed to utilize one staff person who meets the requirements of a Qualified Professional (QP). The findings are: Review on 5/16/24 of QP's personnel record revealed: -Date of hire 7/19/23. -Job title QP. -Bachelor's degree in mathematics and a master's degree in education. -Her resume documented one year of experience with students with developmental disabilities, no other experience with the Mental Health/	V 294		

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V 294	Continued From page 11 Developmental Disability/ Substance Abuse population (MH/DD/SAS). Interview on 5/29/24 with the QP revealed: -Worked with children with developmental disabilities. -No work experience with the MH/SAS population. -The Facility Director trained her on treatment plans and how to update treatment plans. Interview on 6/3/24 with the Facility Director revealed: -Thought the QP's master's degree qualified her as a QP. -She (Facility Director) will act as the QP until she can hire a QP.	V 294		
V 295	27G .1703 Residential Tx. Child/Adol - Req. for A P 10A NCAC 27G .1703 REQUIREMENTS FOR ASSOCIATE PROFESSIONALS (a) In addition to the qualified professional specified in Rule .1702 of this Section, each facility shall have at least one full-time direct care staff who meets or exceeds the requirements of an associate professional as set forth in 10A NCAC 27G .0104(1). (b) The governing body responsible for each facility shall develop and implement written policies that specify the responsibilities of its associate professional(s). At a minimum these policies shall address the following: (1) management of the day to day day-to-day operations of the facility; (2) supervision of paraprofessionals regarding responsibilities related to the implementation of each child or adolescent's	V 295		

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V 295	Continued From page 12 treatment plan; and (3) participation in service planning meetings. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the staffing of a fulltime direct care staff as an Associate Professional (AP). The findings are: Review on 5/31/24 of Staff #2's personnel record revealed: -Hire date of 3/18/23. -A signed job description dated 5/20/23 as an AP. Review on 5/31/24 of Staff #3's personnel record revealed: -He was hired on 9/15/23. -His highest level of education was General Education Development (GED). Interview on 5/29/24 with Staff #2 revealed: -His usual work schedule was from 5 pm to 11:00 pm two to three days a week. -His job duties included assisting Clients #1, #2 and #3 to complete their daily chores, hygiene, and supervision needs. -His direct supervisor was the group home manager. Interviews on 5/31/24 and 6/5/24 with the Facility Director revealed: -"I don't have one (AP) right now." -The AP had quit the job. -Staff #2 had a job outside the facility and did not want the AP responsibility.	V 295		

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 295	Continued From page 13 -She was looking for a staff to become an AP.	V 295		
V 296	27G .1704 Residential Tx. Child/Adol - Min. Staffing 10A NCAC 27G .1704 MINIMUM STAFFING REQUIREMENTS (a) A qualified professional shall be available by telephone or page. A direct care staff shall be able to reach the facility within 30 minutes at all times. (b) The minimum number of direct care staff required when children or adolescents are present and awake is as follows: (1) two direct care staff shall be present for one, two, three or four children or adolescents; (2) three direct care staff shall be present for five, six, seven or eight children or adolescents; and (3) four direct care staff shall be present for nine, ten, eleven or twelve children or adolescents. (c) The minimum number of direct care staff during child or adolescent sleep hours is as follows: (1) two direct care staff shall be present and one shall be awake for one through four children or adolescents; (2) two direct care staff shall be present and both shall be awake for five through eight children or adolescents; and (3) three direct care staff shall be present of which two shall be awake and the third may be asleep for nine, ten, eleven or twelve children or adolescents. (d) In addition to the minimum number of direct care staff set forth in Paragraphs (a)-(c) of this Rule, more direct care staff shall be required in the facility based on the child or adolescent's	V 296		

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	MHL080-230	A. BUILDING: _____ B. WING _____	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE-WAY HOMES	1141 AMBERLIGHT CIRCLE SALISBURY, NC 28144

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 296	Continued From page 14 individual needs as specified in the treatment plan. (e) Each facility shall be responsible for ensuring supervision of children or adolescents when they are away from the facility in accordance with the child or adolescent's individual strengths and needs as specified in the treatment plan. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure minimum staffing when clients were present in the facility, and failed to ensure supervision of clients when they were away from the facility. The findings are: Finding #1 Observations of the facility staffing on 5/29/24 and 5/30/24 at 9:00 am revealed: -5/29/24, 1 staff (Staff #3) was alone at the facility at 9:30 am with Clients #1, #2 and #3. -5/30/24, 1 staff (Staff #1) was alone at the facility at 9:00 am with Client #3. Interview on 5/29/24 with Client #1 revealed: "[Staff #1] was supposed to be here this morning. I don't know what happened. She was on her computer and then she left. She was supposed to take us to our day program." Interview on 5/29/24 with Client #2 revealed: -"Last night we had one staff (Staff #1). This morning, I woke up late and figured we didn't	V 296		

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V 296	Continued From page 15 have school because the only staff here was [Staff #3] and that was all." -"It's usually one staff when I get home, then another staff comes in." -Admitted to going in the store unattended at stealing beer. Interview on 5/29/24 with Client #3 revealed: "What I have seen is 1 staff at night. When I wake up in the mornings, it (number of staff) varies-there will be 1 or 2 staff. If one staff is here (in the mornings), the 2nd staff will come in around 10:00." Interview on 5/29/24 with Staff #3 revealed: -Another staff from a sister facility was on their way to the facility to take Clients #1 and #2 to their day treatment program. -"On first shift of the mornings, if there is less than 2 kids (clients) here, it will be me and sometimes someone else (another staff) will be with me." Interviews on 5/29/24 and 6/5/24 with the Facility Director revealed: -She developed the staff schedule. -"There's supposed to be 2 staff every shift. There's usually a 3rd staff on 2nd shift. [Staff #3] and I work together to make sure each shift has at least 2 staff." -Staff could have called out and they (she and Staff #3) were waiting for another staff to come in. -"When a staff calls out, what are we supposed to do?" Finding #2 Reviews on 5/29/24 and 5/30/24 of Client #2's record revealed: -Admission date of 7/25/23.	V 296		

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V 296	Continued From page 16 -Diagnoses of Disruptive Mood Dysregulation Disorder, ADHD-combined presentation, and Post-Traumatic Stress Disorder. -History of behaviors that included elopement. -His treatment plan dated 9/8/23 included a 1:1 staff to assist him with guidance, redirection, psycho-education rewards and consequences. Review on 6/3/24 of a local police call log from 2/7/24 to 3/28/24 revealed: -On 2/19/24 at approximately 12:00 pm, Client #2 was reported to have eloped from his bedroom window. -Client #2 had a history of "missing" and was previously found at a park near a hospital. Report did not specify where or when Client #2 was located and when he returned to the facility. Interview on 5/28/24 and 5/29/24 with Client #2 revealed: -He started a job at a local fast-food restaurant about a week ago. -He worked his job from 6 pm to 10 pm through the weekday. -Staff transported him to work but did not stay at work with him. -He ran away from the facility 1 week before his birthday and walked to a local gym without a staff with him. He did not recall the length of time he was away from the facility. - Admitted he was allowed to go into a convenient store unattended where he and other clients stole beer (date unknown and he would not give the names of the other clients). Interview on 5/29/24 with Staff #1 revealed: -Confirmed Client #2 started work at a local fast-food restaurant about a week and half ago. -Client #2 missed 3 days of work because it (work) was something he no longer wanted to do.	V 296		

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V 296	Continued From page 17 -No staff or job coach went with Client #2 to his job. -She did not know whether he continued to have a 1:1 support staff. Interviews on 5/31/24 and 6/5/24 with the Facility Director revealed: -Client #2's 1:1 support ended on 4/30/24 by the Local Management Entity/Managed Care Organization (LME-MCO) because there was "no reason to extend his 1:1." -Staff dropped Client #2 off at work and picked him up from work. -"He worked from 6 pm to 10 pm and was working by himself is what he said." -Staff that allowed clients to go in the convenient store unattended was terminated. -Client #2 would not be allowed to work anymore.	V 296		
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	V 366		

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V 366	Continued From page 18	V 366		

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 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

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	MHL080-230	A. BUILDING: _____ B. WING _____	06/05/2024

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V 366	Continued From page 19 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 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.	V 366		

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V 366	Continued From page 20 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to immediately notify the Local Management Entity (LME) in the catchment area where services were provided for Level II and Level III incident reports. The findings are: Reviews on 5/29/24, 5/31/24, 6/3/24 and 6/4/24 of the North Carolina Incident Response Improvement System (IRIS) revealed: -No submission of Level II or Level III incident reports from 3/1/24 to 6/4/24. Review on 6/3/24 of a local police call log from 2/7/24 to 3/28/24 revealed: -2/15/24 at 8:34 am, Client #1 was reported missing while going to school, which included a police response. -2/19/24 at 12:00 pm, Client #2 eloped from the facility through his bedroom window which led to a police report. -3/20/24 at 5:46 pm, a former client (not identified) alleged an unidentified staff "inappropriately touched him" and the local department of social services (DSS) had information. Review on 6/4/24 of a facility incident reports for Former Client (FC#4) revealed: -An IRIS report dated 3/21/24 stated on 3/19/24 at 12:00 am, an incident occurred at the facility that included an allegation against the facility. The provider learned of the incident on 3/20/24. -Refer to V132 for additional information on the 3/19/24 incident regarding FC #4.	V 366		

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V 366	Continued From page 21 Interviews on 5/29/24, 5/31/24, 6/4/24 with the Facility Director revealed: -She did not believe there were any Level III incident reports between the period 3/1/24 to 5/29/24. -She had created incident reports in IRIS and received a confirmation number for each report. -She did not know why the incident reports were not showing up in IRIS. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	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	V 367		

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V 367	Continued From page 22 cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of 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	V 367		

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V 367	Continued From page 23 include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to submit all Level II and Level III incident reports to the Local Management Entity (LME) in the catchment area within 72 hours of becoming aware of each incident. The findings are: Reviews on 5/29/24, 5/31/24, 6/3/24 and 6/4/24 of the North Carolina Incident Response Improvement System (IRIS) revealed: -No submission of Level II or Level III incident reports from 3/1/24 to 6/4/24. Review on 6/3/24 of a local police call log from 2/7/24 to 3/28/24 revealed: -2/15/24 at 8:34 am, Client #1 was reported	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 24	V 367		

missing while going to school, which included a police response to the report.
-2/19/24 at 12:00 pm, Client #2 eloped from the facility through his bedroom window which led to a police report.
-3/20/24 at 5:46 pm, an unidentified client alleged an unidentified staff "inappropriately touched him" and the local department of social services (DSS) had information.

Review on 6/4/24 of facility incident reports for Former Client (FC#4) revealed:
-An IRIS report dated 3/21/24 stated on 3/19/24 at 12:00 am, an incident occurred at the facility that included an allegation against the facility. The provider learned of the incident on 3/20/24.
-An internal facility event report dated 3/19/24 revealed:
  -An internal investigation was conducted.
  -On 3/21/24, the Facility Director unsubstantiated the allegation.

Interview on 5/29/24 with Staff #3 revealed:
-Client #2 eloped 4 or 5 months ago, walked to a local gym and was gone for about 4 hours. A missing person report was made to the local police, but Client #2 returned to the facility on his own.

Interview on 6/3/24 with IRIS support staff revealed:
-2 incident reports were created for Client #1 on 2/15/24 but the reports were not submitted.
-No submission of a Level II incident report for Client #2 in 2024.
-1 incident report created for FC #4 on 3/19/24 but the report was not submitted.

Interviews on 5/29/24, 5/31/24, 6/4/24 and 6/5/24 with the Facility Director revealed:

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	MHL080-230	A. BUILDING: _____ B. WING _____	06/05/2024

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V 367	Continued From page 25 -She did not believe there were any Level III incident reports between the period 3/1/24 to 5/29/24. -She created incident reports in IRIS and received a confirmation number for each report. -She did not know why the incident reports were not showing up in IRIS. -She created an IRIS report for FC #4. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 367		