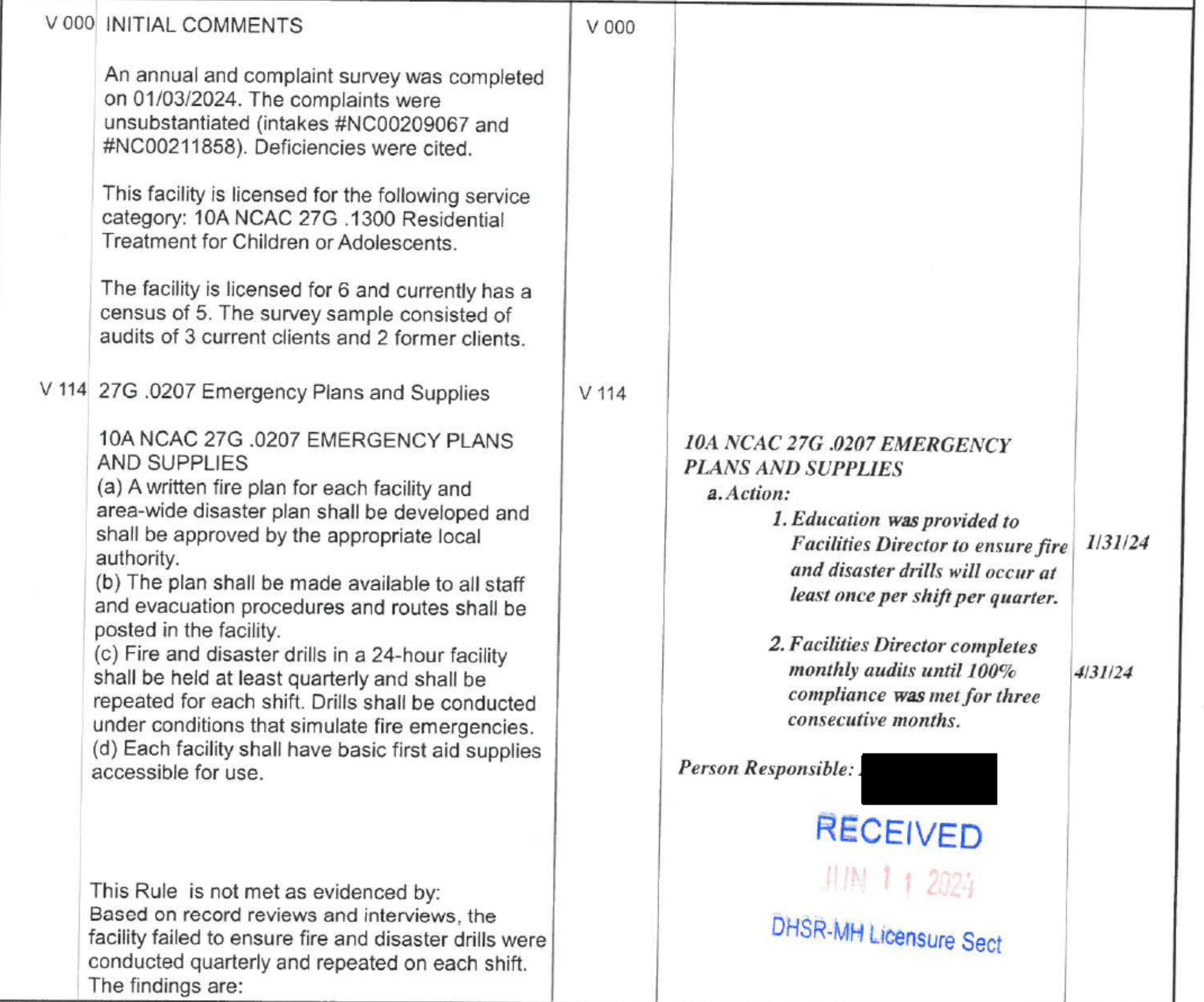
Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601558	A. BUILDING: ______ B. WING ______	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT ACADEMY	**10450 BRIEF ROAD CHARLOTTE, NC 28227**



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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 01/03/2024. The complaints were unsubstantiated (intakes #NC00209067 and #NC00211858). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents. The facility is licensed for 6 and currently has a census of 5. The survey sample consisted of audits of 3 current clients and 2 former clients.	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 reviews and interviews, the facility failed to ensure fire and disaster drills were conducted quarterly and repeated on each shift. The findings are:	V 114	*10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES* *a. Action:* *1. Education was provided to Facilities Director to ensure fire and disaster drills will occur at least once per shift per quarter.* *2. Facilities Director completes monthly audits until 100% compliance was met for three consecutive months.* *Person Responsible:* [redacted] RECEIVED JUN 11 2024 DHSR-MH Licensure Sect	*1/31/24* *4/31/24*

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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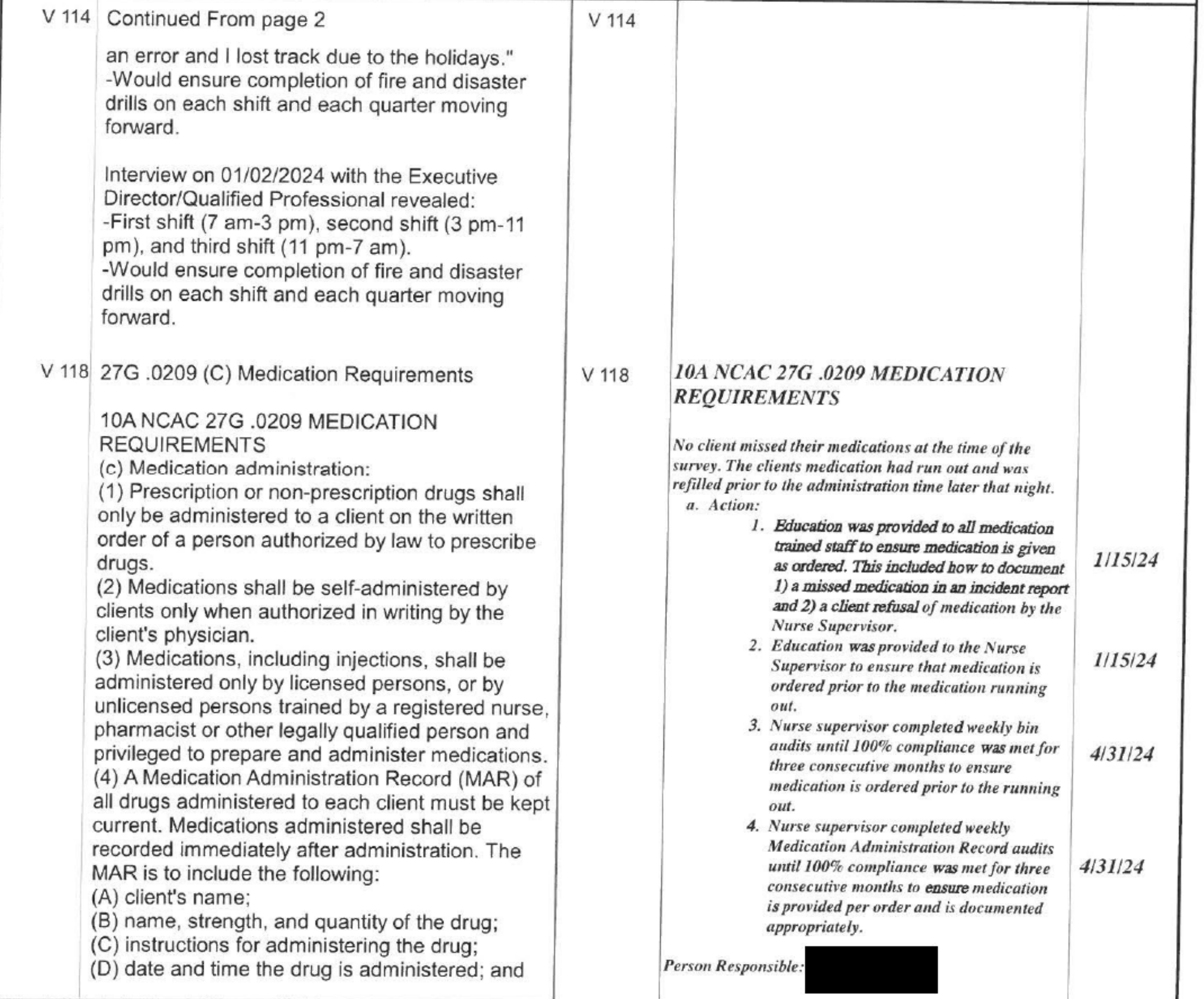
V 114	Continued From page 1 Reviews on 12/19/2023 and 01/02/2024 of the facility's fire and disaster drills log from 10/01/2023-12/31/2023 revealed: -No third shift (11 pm-7 am) fire drill for the fourth quarter. -No first shift (7 am-3 pm) or third shift (11 pm-7 am) disaster drills for the fourth quarter. Interview on 12/20/2023 with Client #1 revealed: -Practiced fire and disaster drills monthly. -"We go to the green sign out front when it is a fire drill." Interview on 12/20/2023 with Client #2 revealed: -Practiced fire and disaster drills monthly. Interview on 12/20/2023 with Client #3 revealed: -Practiced fire and disaster drills. -"We go down to the little green sign in the front yard." Interview on 12/20/2023 with Client #4 revealed: -Practiced fire and disaster drills once or twice per month. Interview on 12/20/2023 with Staff #1 revealed: -Completed fire and disaster drills once a quarter. Interview on 12/20/2023 with Staff #2 revealed: -Completed fire and disaster drills once a month or once a quarter. Interview on 01/03/2024 with the Facilities Manager revealed: -Was responsible for ensuring the completion of fire and disaster drills for the facility. -"I try to be sensitive to the clients with the overnight drills. I did not get it (fire and disaster drills) done by the first of January (2024). It was	V 114		



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V 114	Continued From page 2 an error and I lost track due to the holidays." -Would ensure completion of fire and disaster drills on each shift and each quarter moving forward. Interview on 01/02/2024 with the Executive Director/Qualified Professional revealed: -First shift (7 am-3 pm), second shift (3 pm-11 pm), and third shift (11 pm-7 am). -Would ensure completion of fire and disaster drills on each shift and each quarter moving forward.	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 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	V 118	***10A NCAC 27G .0209 MEDICATION REQUIREMENTS*** *No client missed their medications at the time of the survey. The clients medication had run out and was refilled prior to the administration time later that night.* *a. Action:* *1. **Education was provided to all medication trained staff to ensure medication is given as ordered. This included how to document 1) a missed medication in an incident report and 2) a client refusal of medication by the Nurse Supervisor.*** *2. Education was provided to the Nurse Supervisor to ensure that medication is ordered prior to the medication running out.* *3. Nurse supervisor completed weekly bin audits until 100% compliance was met for three consecutive months to ensure medication is ordered prior to the running out.* *4. Nurse supervisor completed weekly Medication Administration Record audits until 100% compliance was met for three consecutive months to ensure medication is provided per order and is documented appropriately.* *Person Responsible:* [redacted]	*1/15/24* *1/15/24* *4/31/24* *4/31/24*

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V 118	Continued From page 3 (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 order of a physician and the MARs kept current affecting 2 of 2 audited Clients (#1 and #2). The findings are: Finding #1: Reviews on 12/19/2023 and 12/20/2023 of Client #1's record revealed. -17-years-old. -Admitted 10/05/2023. -Diagnosed with Bipolar Disorder, Post-Traumatic Stress Disorder (PTSD), Disruptive Mood Dysregulation Disorder, Cannabis Use Disorder, Hallucinogen Use Disorder, and Obsessive Compulsive Disorder. -Medication order dated 10/09/2023 for Docusate Sodium (Stool Softner) 100 milligram (mg)-Take 1 soft gel daily by mouth at 800 (8 am). -Medication order dated 11/28/2023 for Risperidone (Mood Stabilizer) 2 mg- Take 1 tablet (tab) by mouth twice daily. -No medication order for Docusate Sodium 100 mg-Take 1 capsule (cap) by mouth 3 times a day.	V 118		

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V 118	Continued From page 4 Reviews on 12/20/2023 and 12/21/2023 of Client #1's Electronic MARS from 10/23/2023-12/19/2023 revealed: -Transcriptions for Docusate Sodium 100 mg-Take 1 soft gel daily by mouth at 800 and Risperidone 2 mg- Take 1 tab by mouth twice daily. -No transcription for Docusate Sodium 100 mg-Take 1 cap by mouth 3 times a day. -No staff signatures for the administration of Risperidone 2 mg on 11/28/2023 at 8 pm or 11/29/2023 at 8 am. Review on 12/21/2023 of Client #1's Paper MAR revealed: -Staff signature for the administration of Risperidone 2 mg on 11/29/2023 at 8 am. -No staff signature for the administration of Risperidone 2 mg on 11/28/2023 at 8 pm. Observation on 12/20/2023 at approximately 1:04 pm of Client #1's medication bin revealed: -Docusate Sodium 100 mg-Take 1 cap by mouth 3 times a day dispensed on 10/03/2023 and Risperidone 2 mg dispensed on 11/21/2023 were present. -No Docusate Sodium 100 mg-Take 1 soft gel daily by mouth at 800 dispensed by the pharmacy and available administration. Interview between 12/20/2023 with the Executive Director (ED)/Qualified Professional (QP) revealed: -Would inquire about the 11/29/2023 missing Risperidone dose with the Nurse. Interview on 12/21/2023 with the Nurse revealed: -"Docusate came from a different provider. She (Client #1) came in with that medication."	V 118		

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V 118	Continued From page 5	V 118		

-Did not provide explanation for the label, MAR, and medication order not matching for Client #1's Docusate.
-"I gave the (medication) med (Risperidone at 8 am on 11/29/2023)."
-"(Risperidone) 11/28/2023 @ 8 pm may have been a missed med. The order fell off and I know she (Client #1) got it twice a day, so we got the doctor to add it back in."
-Completed the paper MAR for Client #1's missed Risperidone dose on 11/29/2023 at 8 am but could not account for the missed Risperidone dose on 11/28/2023 at 8 pm.

Finding #2:

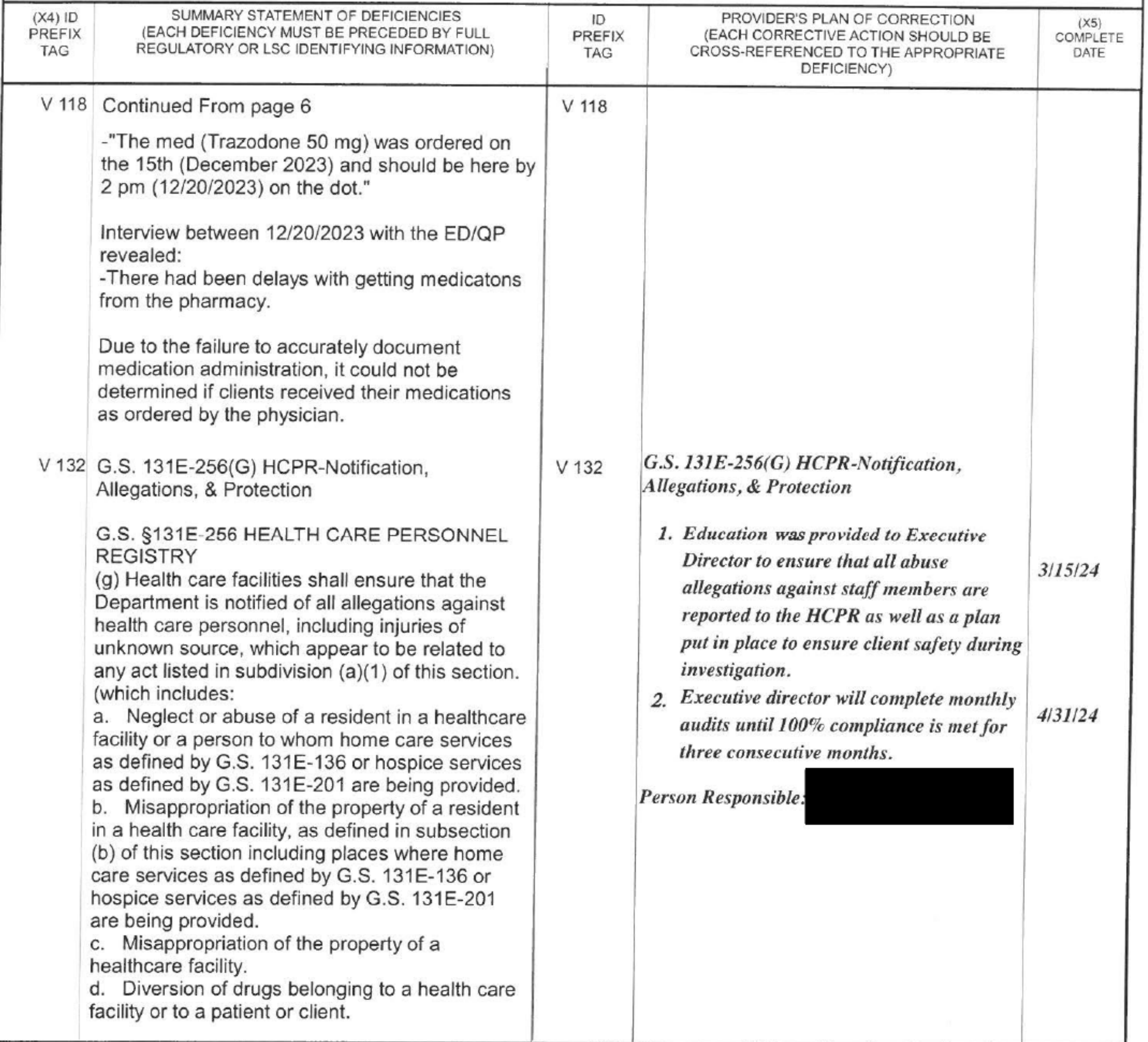
Reviews on 12/19/2023 and 12/20/2023 of Client #2's record revealed:
-14-years-old.
-Admitted 10/06/2023.
-Diagnosed with PTSD and Major Depressive Disorder.
-Medication order dated 10/12/2023 for Trazodone 50 mg (Sleep Aid)- Take 1 tab daily at 8 pm.

Review on 12/20/2023 of Client #2's Electronic MARS from 10/07/2023-12/19/2023 revealed:
-Transcription for Trazodone 50 mg- Take 1 tab daily at 8 pm.
-No missing staff signatures for administration.

Observation on 12/20/2023 at approximately 01:21 pm of Client #2's medication bin revealed:
-Empty container of Trazodone 50 mg dispensed on 11/16/2023.

Interview on 12/20/2023 with the Nurse revealed:
-"It just ran out (Client #1's Trazodone 50 mg)."

Division of Health Service Regulation



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V 118	Continued From page 6 -"The med (Trazodone 50 mg) was ordered on the 15th (December 2023) and should be here by 2 pm (12/20/2023) on the dot." Interview between 12/20/2023 with the ED/QP revealed: -There had been delays with getting medicatons from the pharmacy. 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 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 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.	V 132	*G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection* 1. *Education was provided to Executive Director to ensure that all abuse allegations against staff members are reported to the HCPR as well as a plan put in place to ensure client safety during investigation.* 2. *Executive director will complete monthly audits until 100% compliance is met for three consecutive months.* *Person Responsible:*	3/15/24 4/31/24

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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.

This Rule is not met as evidenced by:
Based on records review and interviews, the facility failed to ensure that the Health Care Personnel Registry (HCPR) was notified of all allegations against health care personnel, provide evidence that alleged acts were investigated, and protect clients during an investigation. The findings are:

Review on 12/21/2023 of the facility records revealed:
-No documentation of an investigation into the allegations made by Former Client (FC) #7 that Staff #3 and Staff #4 sexually assaulted her on 10/20/2023.
-No documentation to support systems were put

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in place to protect clients during an investigation after sexual assault allegations were made against Staff #3 and Staff #4 on 10/20/2023.
-No HCPR notifications for the alleged sexual assault incident dated 10/20/2023 against Staff #3 and Staff #4.

Review on 12/21/2023 of facility incident report for FC #7 dated 10/25/2023 revealed:
-"Date of Incident: 10/25/2023 at 03:32 pm.
-Type: Mandated Report.
-Clients Involved: [FC #7].
-Staff Involved: No staff selected.
-Contacted Family on 10/20/2023 at 08:33 pm.
-Description: Client (FC #7) stated that staff (Staff #3 and Staff #4) were sexually assaulting her when staff were trying to get the phone back from the client.
-Action Taken: DHSR (Division of Health Service Regulation) report. Staff supported client.
-Outcome: Client gave phone back, and talked to mother on the phone.
-Incident Created: [Executive Director (ED)/Qualified Professional (QP)] 10/25/2023 at 03:36 pm."

Reviews between 12/19/2023 and 01/02/2024 of the North Carolina Incident Response Improvement System (IRIS) from 10/05/2023-12/19/2023 revealed:
-No IRIS report submitted for the allegation of sexual assault incident dated 10/20/2023 for FC #7.
-No HCPR notifications for the alleged sexual assault incident dated 10/20/2023 against Staff #3 and Staff #4.

Review on 12/21/2023 of a facility's document untitled, undated, unsigned, and provided by the ED/QP revealed:

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-"Date of incident: 10/20/2023.
-Type of incident: Client/Staff Sexual Assault Allegation.
-Synopsis of incident: On Friday 10/20/2023 Client (FC #7) stole staff phone and ran into her bathroom... and was making statements that staff (Staff #3 and Staff #4) were sexually assaulting her while she was in the bathroom. Multiple staff (Staff #3, Staff #4, and Former Nurse) were present and were asking client to return the phone...
-Incident Substantiated/or Unsubstantiated: This incident is unsubstantiated secondary to there is no evidence that the client was sexually assaulted.
-Reporting Entities Notified: DHSR 10/24/2023."
-There was no additional documentation provided to support the investigation of the alleged sexual assault of FC #7 or how the determination of "unsubstantiated" was rendered.
-There were no HCPR notifications for the alleged sexual assault incident dated 10/20/2023 against Staff #3 and Staff #4.

Interview on 01/02/2024 with Staff #3 revealed:
-The allegation of sexual assault incident with FC #7 occurred on 10/20/2023.
-Reported the alleged sexual assault incident against her and Staff #4 to her direct supervisor on 10/20/2023.
-"She (FC #7) lifted her shirt up and said we (Staff #3 and Staff #4) were sexually assaulting her."
-"We did an incident report and we made sure management was aware of what happened."
-"He (Direct Supervisor) did not tell me to go home or anything. I stayed and worked my double shift."
-"I reported it (allegation of sexual assault made by FC #7) to [ED/QP] and [Clinical Director] when they debriefed me maybe a day after it happened.

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I would say the 21st (10/21/2023) would be accurate."
-Was not sure if systems were put in place to protect clients during an investigation as she continued to work with clients after the allegation of sexual assault was made against her.

Interview on 01/02/2024 with Staff #4 revealed:
-"She (FC #7) had made the allegation (sexual assault) against me and [Staff #3]."
-"I did not report the allegation (sexual assault) right away, but the next day (10/21/2023), [ED/QP] asked me about it because I wrote it in an incident report. I told her (ED/QP) what happened."
-Continued to work her shift after the sexual assault allegation was made against her and Staff #3.
-Was not sure if systems were put in place to protect clients as she continued to work with clients during an investigation after the allegation of sexual assault was made against her.

Interview on 01/02/2024 with the Former Nurse revealed:
-Worked at the facility on 10/20/2023 when FC #7 made the allegations of sexual assault against Staff #3 and Staff #4.
-"She (FC #7) alleged the care coordinators (Staff #3 and Staff #4) were sexually assaulting her."
-"They were not sexually assaulting her. They tried to get the phone but were not sexually assaulting her (FC #7)."
-Staff #3 and Staff #4 continued to work their shift.
-Was not sure if systems were put in place to protect clients after the sexual assault allegations was made by FC #7 against Staff #3 and Staff #4.

Interview on 01/02/2024 with the Clinical Director

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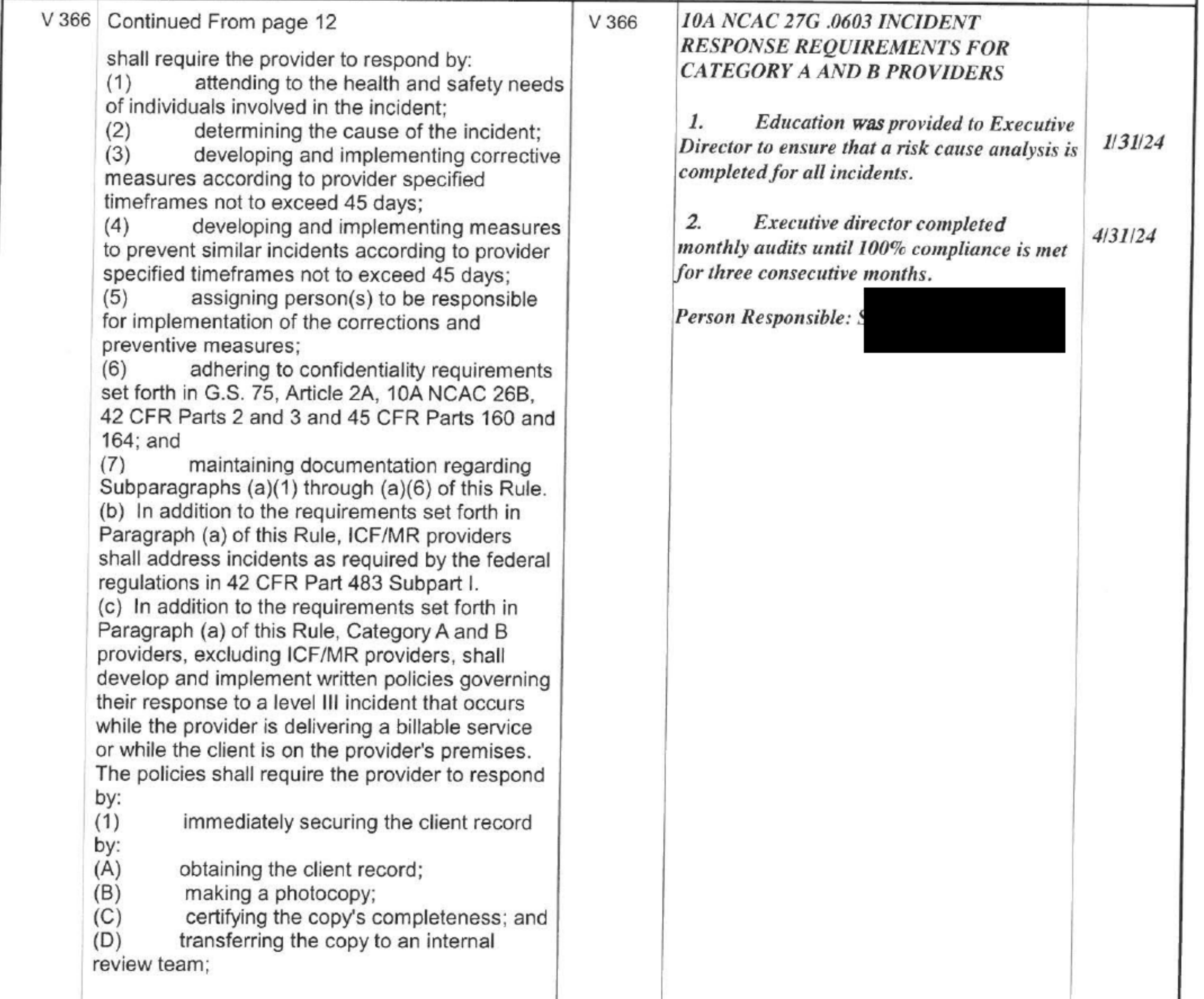
V 132	Continued From page 11 revealed: -"Me and [ED/QP] investigated (FC #7's allegation of sexual assault incident dated 10/20/2023) on Monday (10/23/2023) and that's when it (what staff were involved) came out." -" ...I feel like it was [Staff #3], [Staff #4], and [Former Nurse]. I believe it was all 3 of them that she (FC #7) was alleging were sexually assaulting her." -"No one was placed on administrative leave." -Was not sure if the ED/QP notified HCPR of the sexual assault allegations made against Staff #3 and Staff #4 by FC #7. Interviews between 12/20/2023 and 01/03/2024 with the ED/QP revealed: -"She (FC #7) did not specify who sexually assaulted her. She made the allegation on Friday night (10/20/2023)." -Investigated the allegation of sexual assault incident dated 10/20/2023 for FC #7 but did not provide details regarding the investigation or systems that were put in place to protect clients. -Notified DHSR of the allegation of sexual assault incident dated 10/20/2023 for FC #7 but did not identify Staff #3 or Staff #4 as the alleged perpetrators. -Did not provide evidence to support that Staff #3 and Staff #4 were reported to HCPR for the alleged sexual assault of FC #7 on 10/20/2023.	V 132		
V 366	27G .0603 Incident Response Requirments 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	V 366	*See next page for corrective action plan*	



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601558	A. BUILDING: ______ B. WING ______	01/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWPORT ACADEMY	10450 BRIEF ROAD CHARLOTTE, NC 28227

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V 366	Continued From page 12 shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record 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;	V 366	***10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS*** *1. Education was provided to Executive Director to ensure that a risk cause analysis is completed for all incidents.* *2. Executive director completed monthly audits until 100% compliance is met for three consecutive months.* ***Person Responsible: S***	*1/31/24* *4/31/24*

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 366	Continued From page 13 (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to 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	V 366		

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 366	Continued From page 14 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, II, and III incidents. The findings are: Reviews on 12/20/2023 and 12/21/2023 of the facility's records revealed: -Incident report log with a total of 42 incidents listed. Reviews on 12/20/2023 and 12/21/2023 of the facility's incident reports from 10/10/2023 - 12/19/2023 revealed: No Incident Reports or Risk/Cause/Analysis for the following: 10/10/2023- Former Client (FC) #7's medication error. 10/12/2023- Client #2's boundary violation. 10/15/2023- Client #2's aggression incident. 10/21/2023- Client #2's self-harm incident 10/26/2023- Client #5's self-harm incident. 10/28/2023- Client #4's injury incident. 11/03/2023- Client #1's property damage incident.	V 366		

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 366	Continued From page 15	V 366		

11/06/2023- Client #5's contraband incident.
11/09/2023- Client #1's property damage incident.
11/12/2023- FC #6's injury incident.
11/13/2023- Client #1's absent without leave (AWOL) incident.
11/17/2023- Client #1's injury incident.
11/18/2023- Client #5's contraband incident.
11/23/2023- Client #1's property damage incident.
12/09/2023- Clients' #3 and 4 self-harm incidents.
12/11/2023- Client #4's self-harm incident.
12/15/2023- Clients' #1 and 2 fire incidents.

No Risk/Cause/Analysis for the following:
10/21/2023- FC #7's physical restraint incident.
10/24/2023- Client #5's cutting herself incident.
10/23/2023- Client #1's allegation against Staff #1's for inappropriateness incident.
10/27/2023- Client #5's suicidal/homicidal ideations that required treatment at a local hospital incident.
10/30/2023- Client #1's absent without leave (AWOL) that required police involvement and psychiatric evaluation at a local hospital incident.
11/03/2023- Client #1's property damage incident.
11/04/2023- Client #1's AWOL that required police involvement and psychiatric evaluation at a local hospital incident.
11/12/2023- Client #4's and FC #6's AWOL that required police involvement incident.
11/14/2023- Client #4's AWOL that required police involvement incident.
11/15/2023- Clients' #2, #4, and #5 AWOL that required police involvement incident.
11/18/2023- Client #1's self-harm that required medic and police involvement incident.
11/19/2023- Client #4's property destruction, self-injury that required treatment for wounds and psychiatric evaluation incident.
11/25/2023- FC #6's cutting herself incident.
11/26/2023- Client #5's cutting herself incident.

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V 366	Continued From page 16	V 366		

11/18/2023- FC #6's AWOL that required police involvement.
12/01/2023- Client #5's AWOL that required police involvement incident.
12/01/2023- Client #5's cutting herself incident.
12/07/2023- Clients #3 and FC #6's physical aggression incident.

No Risk/Cause/Analysis or documentation to support submission of the written preliminary findings of fact report to the Local Management Entity/Managed Care Organization (LME/MCO) within five working days for the following:
10/20/2023- FC #7's allegations that Staff #3 and Staff #4 sexually assaulted her incident.

No documentation to support submission of the written preliminary findings of fact report to the LME/MCO within five working days for the following:
12/07/2023- Client #3's sexual assault by FC #6 incident.

Interview on 01/02/2024 with the Clinical Director revealed:
-"Staff do incident reports and between myself, [Executive Director (ED)/Qualified Professional (QP)], and our national team, we review them."

Interviews between 12/20/2023 and 01/03/2024 with the ED/QP revealed:
-Would consult with the compliance to determine if reqested information could be provided.
-Would request the Risk/Cause/Analysis for incidents from the compliance team.
-Was not aware that the Risk/Cause/Analysis was required for level I, II, and III incidents.
-Did not submit the written preliminary findings of fact report to the LME/MCO for FC #7's sexual assault allegations against Staff #3 and Staff #4

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V 366 Continued From page 17 — **V 366**

incident dated 10/20/2023 or Client #3's sexual assault by FC #6 incident dated 12/07/2023.

Multiple requests for required information was made throughout the survey process and not received prior to survey exit on 01/03/2024.

V 367 27G .0604 Incident Reporting Requirements — **V 367**

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

Provider's Plan of Correction (V 367):

10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS

1. We have sought clarification from [redacted] d [redacted] about this [redacted]ning the gap in incident reporting obligations to the LME, given our status as a private provider that does not offer public services, have a contract, or cater to clients served through the LME. See 10A NCAC 27G.0601. Response is pending.

We have reviewed the applicable regulations a definition of "public services" as defined in 122C-3 (30b).

Complete date: *1/31/24*

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V 367	Continued From page 18	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 19	V 367		

(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 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 as required. The findings are:

Reviews between 12/19/2023 and 01/02/2024 of the IRIS from 10/05/2023 - 12/19/2023 revealed:
No level II IRIS reports or LME/MCO notifications for the following incidents:
10/21/2023- Former Client (FC) #7's physical restraint incident.
10/23/2023- Client #1's allegation against Staff #1's for inappropriateness incident.
10/30/2023- Client #1's absent without leave (AWOL) that required police involvement and psychiatric evaluation at a local hospital incident.
11/04/2023- Client #1's AWOL that required police involvement and psychiatric evaluation at a local

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V 367	Continued From page 20	V 367		

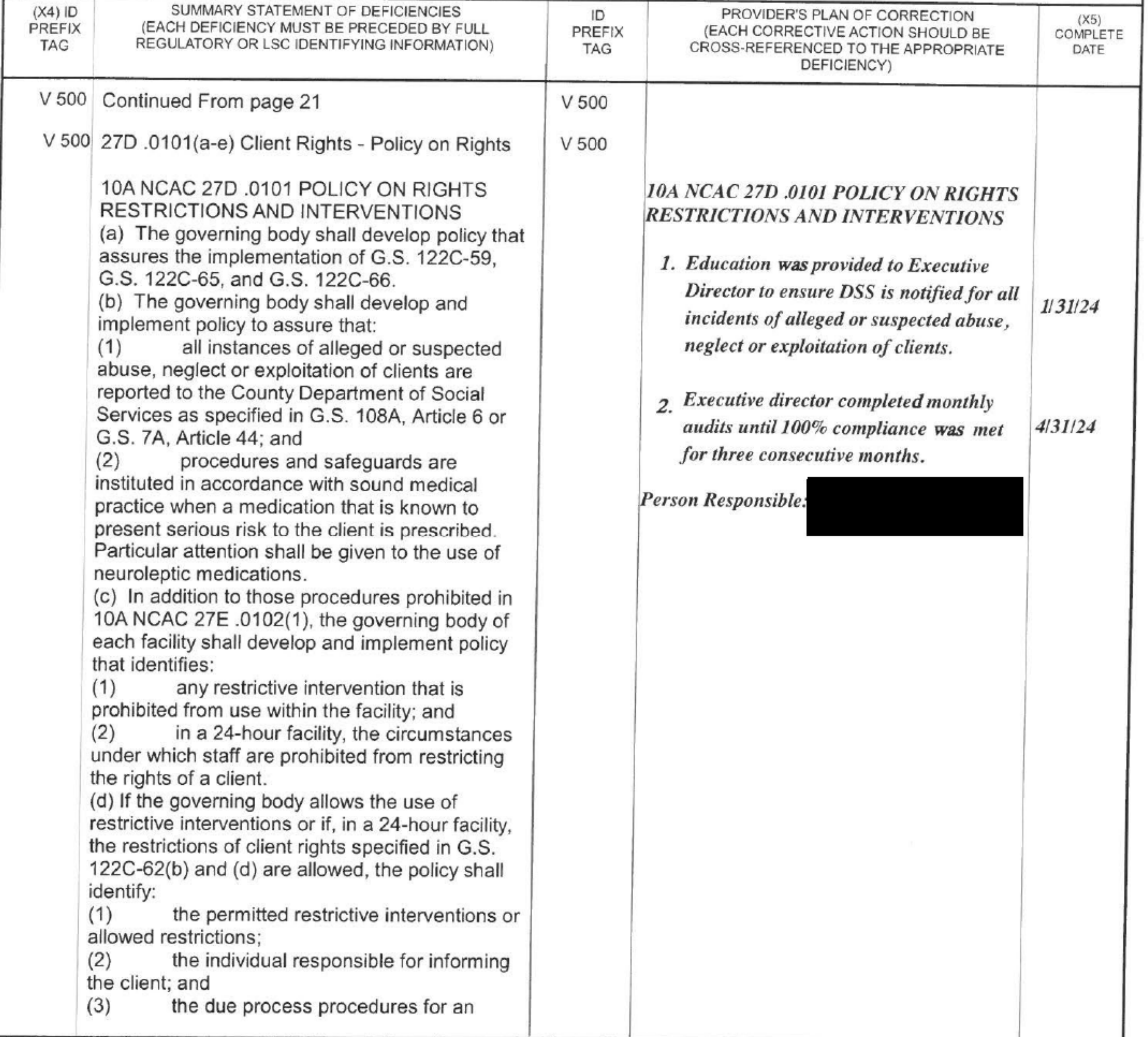
hospital incident.
11/12/2023- Client #4's and FC #6's AWOL that required police involvement incident.
11/14/2023- Client #4's AWOL that required police involvement incident.
11/15/2023- Clients' #2, #4, and #5 AWOL that required police involvement incident.
11/28/2023- FC#6's AWOL that required police involvement incident.
12/01/2023- Client #5's AWOL that required police involvement incident.

No level III IRIS reports or LME/MCO notifications for the following incidents:
10/20/2023- FC #7's allegation that Staff #3 and Staff #4 sexually assaulted her incident.
12/07/2023- Client #3's sexual assault by FC #6 incident.

Interview on 01/02/2024 with the Clinical Director revealed:
-"We did not know that we had to do IRIS reports until you (Division of Health Service Regulation Surveyor) came. So, we did not do that."

Interviews between 12/20/2023 and 01/03/2024 with the Executive Director (ED)/Qualified Professional (QP) revealed:
-"Okay, this is where I need you (DHSR Surveyor) to educate me. I thought that only medicaid services were to be reported in IRIS."
-"... IRIS reports were not completed."
-Did not submit IRIS reports or notify the LME/MCO for the above level II and level III incidents.

Multiple requests for required information was made throughout the survey process and not received prior to survey exit on 01/03/2024.



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NAME OF PROVIDER OR SUPPLIER: **NEWPORT ACADEMY**

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V 500	Continued From page 21	V 500		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an	V 500	***10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS*** *1. Education was provided to Executive Director to ensure DSS is notified for all incidents of alleged or suspected abuse, neglect or exploitation of clients.* *2. Executive director completed monthly audits until 100% compliance was met for three consecutive months.* *Person Responsible:* [redacted]	*1/31/24* *4/31/24*

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V 500	Continued From page 22 involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure all incidents of alleged abuse are reported to the County Department of Social Services (DSS). The findings are: Review on 12/21/2023 of the facility records revealed: -No documentation to support County DSS notifications for the following incidents: 10/20/2023- Former Client (FC) #7 sexual assault allegation against Staff #3 and Staff #4. 12/07/2023- Client #3's sexual assault by FC #6 incident.	V 500		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 500	Continued From page 23 Reviews between 12/19/2023 and 01/02/2024 of the North Carolina Incident Response Improvement System (IRIS) from 10/05/2023 - 12/19/2023 revealed: -No IRIS report submitted for the allegation of sexual assault incident dated 10/20/2023 for FC #7. -No documentation to support County DSS notifications for the following incidents: 10/20/2023- Former Client (FC) #7 sexual assault allegation against Staff #3 and Staff #4. 12/07/2023- Client #3's sexual assault by FC #6 incident. Interview on 01/02/2024 with the Clinical Director revealed: -"I believe [Executive Director (ED)/Qualified Professional (QP] reported to DSS." Interviews between 12/21/2023 and 01/03/2024 with the ED/QP revealed: -"She (FC #7) did not specify who sexually assaulted her." -"The clinician reported the incident (Client #3's sexual assault incident dated 12/07/2023) to DSS". -There had been no contact from DSS in relation to Client #3's sexual assault incident dated 12/07/2023. -Did not provide evidence to support that the above incidents were reported to DSS.	V 500		
V 513	27E .0101 Client Rights - Least Restictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment.	V 513	*See Response on Next Page*	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601558	A. BUILDING: ______ B. WING ______	01/03/2024

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V 513	Continued From page 24 These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to use the least restrictive and most appropriate settings and method. The findings are: Observation on 12/19/2023 at approximately 11:15 am of the facility's pantry revealed: -Pantry door locked with a padlock. -The Facility Manager obtained the key and removed the padlock. -Food items were on the shelves. -No chemicals or sharps present. Interview on 12/20/2023 with Client #1 revealed: -Was not allowed in the kitchen area.	V 513	*10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE* *1. Clients will still have access to food items without needing assistance from staff. Sharp objects and bulk food items previously stored in the pantry have been moved to a different location, eliminating any confusion about why the large pantry was located.* *2. Executive director completed monthly environment of care audits until 100% compliance was met for three consecutive months.* *Person Responsible:* [redacted]	*1/31/24* *4/31/24*

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 513	Continued From page 25 -Did not know why the pantry was locked. Interview on 12/20/2023 with Client #2 revealed: -"The pantry is always locked." Interview on 12/20/2023 with Client #3 revealed: -"We are not allowed in the kitchen, so I don't know why it is locked." Interview on 12/20/2023 with Client #4 revealed: -"The pantry is always locked. We are not allowed in the kitchen. They (management) just don't want us to go in the kitchen." Interview on 12/19/2023 with the Facilities Manager revealed: -"There are no sharps or chemicals in the pantry. We keep it locked, so the kids don't come in here and do things they are not supposed to do." Interview on 01/02/2024 with the Clinical Director revealed: -"The locked panty is part of programing. The actual pantry has things that are not appropriate for kids. They (clients) have access to food and snacks but for safety they do not go into the pantry." Interview on 12/19/2023 with the Executive Director/Qualified Professional revealed: -"We keep the pantry locked. There is no need for clients to be in there." -Clients had access to food.	V 513		