STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL077-088	A. BUILDING: _____ B. WING _____	Sect R-C 07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILD FAC BASED CRISIS OF RICHMOND-DAYMARK	523 NORTH US HIGHWAY 1, SUITE C ROCKINGHAM, NC 28379

(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 A complaint and follow up survey were completed on July 19, 2024. The complaints were substantiated (intake #NC00219206, #NC00219326,). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5000 Facility Based Crisis Service for Individuals of All Disability Groups. This facility is licensed for 16 and has a current census of 15. The survey sample consisted of audits of 3 current clients.	V 000	In response to the DHHS report for CFBC Richmond/Daymark Recovery Services, please find our plan of correction outlined below. As these infractions are all concerning reporting to proper agencies in the case of a Level II or III incident, I have summaried our POC along with ongoing efforts to avoid this type of situation in the future. • Initial steps taken prior to our meeting with DHHS: 1. Employee in question was from current duties at the CFBC and reassigned to an adult facility. Employee has not returned to CFBC Richmond due to ongoing DSS investigation. Upon their findings, a decision will be made as to how to proceed with this employee. 2. All staff and employees were interviewed by the Regional Operations Director ([redacted]) and Chief Program Officer ([redacted]). 3. Those findings were reported to DHHS [redacted] upon her visit on July 11, 2024. 4. Staff meeting held with all staff both in person and via Zoom to address proper protocol for utilizing restrictive holds, when to use, and then a process began to assign each employee a recertification class for Mindset Foundations and Restrictive Interventions. 5. The Center Director at that time was relieved of duty and is no longer with Daymark Recovery Services. Post DHHS visit on July 11, 2024 1. Violations V132, V367, V500 As these violations are all related to non-reporting, the following steps were taken and policy/procedure put in place. a. V132: After the initial visit by DHHS on 7/11/24, the incident was reported to HCPRon 7/12/24 via the IRIS Reporting System. b. V367: The MCO had already been informed about the cited incident; however, in keeping with DHHS policy/procedure, the Regional Director reached out to the case manager for the patient to report. A follow up email and call was placed on 8/7/24 to update the case manager	
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		

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V 132	Continued From page 1 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 record review and interviews, the facility failed to ensure an allegation of abuse was reported to Health Care Personnel Registry (HCPR) within five working days. The findings are: Review on 7/12/24 and 7/15/24 of staff #1's personnel record revealed: -Hire date of 5/28/24. -Position of Crisis Worker. Review on 7/12/24 of an in-house incident report revealed: -7/1/24- "At 7:15pm [client#1] was given several verbal redirections to stop disrespecting movie	V 132	on the process of the investigation. c. V500: Again, after the initial visit by DHHS, the Regional Director contacted each DSS case worker/ guardian for all patients to alert that there had been an incident at the center and that DHHS was investigating. Upon learning of the infractions on 7/11/24, the staff were briefed during a mandatory staff meeting that was held at the center via Zoom. In the following weeks, staff members attended weekly staff meetings/trainings concerning behavioral de-escalation, company policy and procedures, and proper reporting of any incident on site. 1. To continue with compliance, both clinicians, our support supervisor, and Regional Director are monitoring daily for any incidents that should be reported. Currently, staff understand: a. Stabilize the situation to make sure that patient and staff are safe. Contact proper authorities/medical support if needed. b. Report to the Center Director/Regional Director/Provider immediately. c. Write the incident report and upload to aforementioned staff so it can be properly vetted and reported. d. Call al stakeholders/agencies/guardians to report as necessary. To continue staff compliance, multiple bi-weekly trainings have been implemented and are mandatory for all staff. These trainings are all focused on patient-centered care, proper intervention techniques and tools, as well as following all company policies and procedures.	

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V 132	Continued From page 2 night so others can enjoy. [Client #1] continued with disturbing others and was asked to process in his bedroom. [Client #1] begin banging on his wall, for which he was again prompted to refrain from [client #1] disruptive behavior. [Client #1] began using profanity while refusing to comply with directives. [Staff #2] utilized trained physical restraint to aid [client #1] with stopping his attempt at property damage. Restrictive intervention was utilized to deter [client #1] from banging a hole in the wall of [client #1] bedroom." Review of the North Carolina Incident Response Improvement System (IRIS) on 7/12/24 revealed: -There was no level III incident report submitted by the facility for the incident on July 1, 2024. Interview on 7/16/24 with the Former Facility Director (FFD) revealed: -"I was not aware of the incident until July 6, 2024." -"The [Facility Physician #1] notified me via text on July 5, 2024, at 9:45pm on my day off." -"I did not check my messages until July 6, 2024, because I was on vacation." -"The [Facility Physician #1] informed me that [client #1] told her during medical rounds that a staff member pulled him off the bed, hit his head, and hurt his wrist." -"I notified my boss on July 9, 2024, of the incident." -"I don't know if anyone notified Local Management Entity (LME) or the Health Care Personnel Registry (HCPR)." -"I didn't notify the LME or HCPR because I was out on vacation when the incident was reported." -"I felt like [Facility Physician #1] had contacted all the proper authorities and thinking everything was already in place."	V 132		

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V 132	Continued From page 3 Interview on 7/15/24 with the Facility Physician revealed: -"I was made aware of the incident on July 5, 2024 by [client #1]." -"[Client #1] told me that [staff #2] grabbed him by legs, pulled him down on the floor, and hit his head." -"I notified the [FFD] of the incident on July 5, 2024, via text." -"The [FFD] was out on vacation on July 5, 2024, and that is why I sent the [FFD] a text." -"I did not notify anyone of the incident except for the [FFD]." -"I was thinking that the [FFD] was going to notify everyone else after I notified the [FFD] on July 5, 2024." -"The [FFD] always relays information to the team and other parties involved." Interview on 7/12/24 with the Regional Operation Director revealed: -"The [FFD] was notified of the incident on July 5, 2024, via text by [Facility Physician #1] while she was on vacation." -"The [Facility Physician #1] told the [FFD] that [client #1] complained to the [Facility Physician #1] about the hole [client #1] was in, and [staff #2] pulled him off the bed, and hit his head." -"All this information was told to the [FFD] by [Facility Physician #1] via text on July 5, 2024." -"The [FFD] did not see the text message until July 6, 2024." -The Facility Physician #1 went on vacation on July 8, 2024, and Facility Physician #2 was filling in. -"The [FFD] did not notify anyone on July 6, 2024, and [Facility Physician #1] said that [client #1] will be ok until July 8, 2024, therefore, [FFD] felt like everything was ok." -The HCPR and IRIS will be completed today	V 132		

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V 132	Continued From page 4 (July 12, 2024) with all other paperwork.	V 132		
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 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	V 367		

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V 367	Continued From page 5 (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; (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	V 367		

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V 367	Continued From page 6 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 ensure incidents were reported to the Local Management Entity/Managed Care Organization (LME/MCO) for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are: Review on 7/12/24 of an in-house incident report revealed: -7/1/24- "At 7:15pm [client#1] was given several verbal redirections to stop disrespecting movie night so others can enjoy. [Client #1] continued with disturbing others and was asked to process in his bedroom. [Client #1] begin banging on his wall, for which he was again prompted to refrain from [client #1] disruptive behavior. [Client #1] began using profanity while refusing to comply with directives. [Staff #2] utilized trained physical restraint to aid [client #1] with stopping his attempt at property damage. Restrictive intervention was utilized to deter [client #1] from banging a hole in the wall of [client #1] bedroom." Review on 7/12/24 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed:	V 367		

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V 367	Continued From page 7 -There were no Level III incident reports submitted by facility for the incident on 7/1/24. Interview on 7/16/24 with the Former Facility Director (FFD) revealed: -"The [Clinician] brought the incident report to me on July 8, 2024." -"The [Clinician] told me that it was under the [Clinician] door, but the [Clinician] was out on vacation last week." -"I said that the incident report was not filled out correctly and I wasn't able to put it into the system." -"Once I got the updated incident report, I was let go, so I never had the chance to put into IRIS." - "As I was talking to [client #1's] guardian on July 8, 2024, the [Care Manager] was calling me." -"The Care Manager told me that [client #1's] guardian had informed the [Care Manager] of the incident with [client #1] and [staff #2] on July 5, 2024." -She confirmed the facility failed to report the above incident to LME/MCO within 72 hours. Interview on 7/15/24 with the Facility Physician revealed: -"I was thinking that the [FFD] was going to notify everyone else after I notified the [FFD] on July 5, 2024." -"The [FFD] always relays information to the team and other parties involved." -"The [FFD] always put the incident reports in IRIS." Interview on 7/12/24 with the Regional Operation Director revealed: -"I said that no report was completed in IRIS on July 5, 2024 because I started the process on July 11, 2024." -"The HCPR and IRIS will be completed today	V 367		

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V 367	Continued From page 8 July 12, 2024 with all other paperwork regarding the incident." -"Normally the [FFD] puts the incident reports in IRIS." -The HCPR and IRIS will be completed today (July 12, 2024) with all other paperwork. -"I had to complete all the paperwork for the incident." -He confirmed the facility failed to report the above incident to LME/MCO within 72 hours. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 367		
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	V 500		

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V 500	Continued From page 9 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 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:	V 500		

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V 500	Continued From page 10 Based on record review and interviews, the governing body failed to report an allegation of abuse to the Department of Social Services (DSS). The findings are: Review on 7/12/24 of an in-house incident report revealed: -7/1/24- "At 7:15pm [client#1] was given several verbal redirections to stop disrespecting movie night so others can enjoy. [Client #1] continued with disturbing others and was asked to process in his bedroom. [Client #1] begin banging on his wall, for which he was again prompted to refrain from [client #1] disruptive behavior. [Client #1] began using profanity while refusing to comply with directives. [Staff #2] utilized trained physical restraint to aid [client #1] with stopping his attempt at property damage. Restrictive intervention was utilized to deter [client #1] from banging a hole in the wall of [client #1] bedroom." Review on 7/12/24 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed: - There were no Level III incident reports submitted by facility for the incident on 7/1/24. Interview on 7/16/24 with the Former Facility Director (FFD) a revealed: -"DSS came out to the facility on July 9, 2024, to interview the kids and the staff." -"I had to call my boss to make sure DSS could interview the kids." -"I don't know who notified DSS they just showed up on July 9, 2024 to do interviews." -She confirmed the agency failed to report the above allegations of abuse to DSS. Interview on 7/12/24 with the Regional Operation Director revealed:	V 500		

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V 500	Continued From page 11 -"The FFD informed me on the night of July 9, 2024, of the incident that happened on July 1, 2024, regarding [staff #1] and [client #1]." -"At that point I notified the owner the same night." -"I came out to the facility on June 10, 2024 to start the process." -"I think that DSS and guardian was notified on July 8, 2024 but I'm not sure." -"I had to complete all the paperwork for the incident." -He confirmed the agency failed to report the above allegations of abuse to DSS.	V 500	Jarod L . Cruthis, MA, Ed.D, D.Min, LCMHCA, LCAS, CCS Regional Operations Director 08/08/2024	