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	MHL090-204	A. BUILDING: _____ B. WING _____	C 09/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE GERALD SERVICES	1918 EAST ROOSEVELT BOULEVARD, SUITE H MONROE, NC 28112

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V 000	INITIAL COMMENTS A complaint survey was completed on September 3, 2024. The complaints were unsubstantiated (intake #NC00220407, #NC00220404 and #NC00220660). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1400 Day Treatment for children and adolescents with emotional or behavioral disturbances. This facility has a current census of 11. The survey sample consisted of audits of one current client and two former clients.	V 000		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and	V 366	This page was intentionally left blank. RECEIVED SEP 30 2024 DHSR-MH Licensure Sect	

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

Operations Manager | 09/26/2024

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V 366	Continued From page 1 (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 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	V 366	This page was intentionally left blank.	

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V 366	Continued From page 2 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. This Rule is not met as evidenced by: Based on record reviews and interviews, the	V 366	LGS will review and revise existing incident response policies to align with NC DHHS Rule 27G .0603. LGS will develop comprehensive written policies for Level II and Level III incident responses, including clear reporting procedures, investigation protocols, and timelines. LGS will ensure policies reflect the need for immediate response, containment, and documentation of all incidents, especially critical incidents involving serious injury, abuse, or deaths. The facility's Program Director will be responsible for informing the Program Manager of all incidents within 24 hours. Full policy review and update will be completed and implemented within 45 days. LGS will also conduct mandatory training for all staff members on the updated incident reporting policies, including response protocols for Level II and Level III incidents. LGS will ensure that all employees understand the specific requirements for documenting and reporting incidents as per NC DHHS guidelines. LGS will provide specialized training for clinical and management teams on investigating critical incidents. LGS will establish clear lines of communication for reporting incidents internally, ensuring incidents are escalated appropriately to management and external bodies, including DHHS, as needed. LGS will utilize a tracking log to document all incidents and monitor progress on each case, from report to resolution to be weekly.	10/18/24

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V 366	Continued From page 3 facility failed to implement written policies governing their response to level II and level III incidents as required. The findings are: Review on 8/29/24 of the facility's internal incident reports from March 2024- August 2024 revealed: -On 3/13/24 FC #2 hit FC #3 in the head with a brick while on the facility's transportation van. -FC #2 concealed the brick under his shirt, then sat behind FC #3 and hit him (FC #3) with the brick. -FC #3 was transported to the hospital by Emergency Medical Services and required sutures in his head. -On 7/31/24, Client #1 attacked Staff #1. -Staff #1 sustained a busted lip and a concussion. -Staff #1 was on medical leave from 8/1/24 to 8/9/24 as a result of the attack. -No documentation of the following: -determining the cause; -developing and implementing corrective measures; -developing and implementing measures to prevent; -assigning persons to be responsible for implementation; -adhering to confidentiality requirements; and -maintaining documentation. Attempted interview on 8/28/24 with Client #1 revealed: -She was unable to answer questions or engage in conversation. -When asked questions her answers would be unrelated and random thoughts. Attempted interview on 8/30/24 and 9/3/24 with FC #2 by phone but it went to voicemail. A voicemail message was left and FC #2 did not return the phone call prior to the exit date 9/3/24.	V 366	This page was intentionally left blank.	

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V 366	Continued From page 4 Attempted interview on 8/30/24 with FC #3 revealed: -Mother answered the phone and advised she did not want FC #3 to give an interview. Interview on 8/28/24 with the Program Director (PD) revealed: -"[Client #1] had a behavior on 7/31/24. She (Client #1) hit [Staff #1] in the face for trying to get her on the bus." -He and Staff #2 put Client #1 in a "therapeutic hold until she calmed down." -"[Client #1] hit [Staff #1] in the face a second time and threw a bottle of water in her face." -He and Staff #2 separated Client #1 anf Staff #1. -Emergency Medical Service was called for Staff #1. -Staff #1 was out of work for a week with a concussion. -Staff #1 wrote a statement and gave it to him. -He completed an internal investigation report but did not complete an IRIS report. -"I didn't think it (incident report) needed to go to IRIS." -Client #1 was moved to a different classroom where she would have no contact with Staff #1. Interview on 9/3/24 with the Operations Manager Revealed: -"The Program Manager is responsible for doing internal incident reports and submitting incident reports to IRIS."	V 366	This page was intentionally left blank.	
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS	V 367		

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V 367	Continued From page 5 (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 (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	V 367	This page was intentionally left blank.	

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V 367	Continued From page 6 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 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.	V 367	This page was intentionally left blank.	

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V 367	Continued From page 7 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to submit a level II and III incident reports within 72 hours of becoming aware of the incident. The findings are: Review on 8/29/24 of the facility's internal incident reports from March 1, 2024 to August 28, 2024 revealed: -On 3/13/24 FC #2 hit FC #3 in the head with a brick while on the facility's transportation van. -FC #2 concealed the brick under his shirt then sat behind FC #3 and hit him with the brick. -FC #3 was transported to the hospital by Emergency Medical Services and required sutures in his head. -On 7/31/24, Client #1 attacked Staff #1. -Staff #1 sustained a busted lip and a concussion. -Staff #1 was on medical leave from August 1, 2024 to August 9, 2024 as a result of the attack. Review on 8/29/24 of Incident Response Improvement System (IRIS) revealed: -No level II or III incidents reported by the Licensee. Interview on 8/28/24 with Staff #2 revealed: -"I wrote a statement and gave it to [PD]." -"He [PD] handles incidents." Interview on 8/28/24 with the Program Director (PD) revealed: -"[Staff #1] had a behavior on 7/31/24. She (Client #1) hit [Staff #1] in the face for trying to get her on	V 367	LGS will implement a streamlined notification process for incident reporting. All staff must notify the designated staff (Program Manager) within 24 hours of becoming aware of any Level II or III incident. This will ensure that the reporting process begins promptly, allowing adequate time for submission within the required 72-hour window. Additionally, all staff involved in incident reporting, including managers and direct care staff, will undergo mandatory training and annual refreshers on NC DHHS Incident Reporting, with a specific focus on the 72-hour reporting requirement for Level II and III incidents. This will ensure all staff understand the importance of timely reporting, the types of incidents that require reporting, and the steps involved in the submission process. Training sessions will be conducted within the next 30 days and documented. LGS will establish monthly audit meetings on all Level II and III incident reports to ensure they were submitted within the 72-hour window. Any delays in submission will be documented, investigated, and addressed immediately. The continuous monitoring of compliance with the reporting requirement will aid in prevention of future delays. Audit meetings will be led by the Program Manager and will include clinical and management staff.	10/3/24

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V 367	Continued From page 8 the bus." -"[Client #1] hit [Staff #1] in the face a second time and threw a bottle of water in her face." -Staff #1 wrote a statement and gave it to him. -He completed an internal investigation report. -Did not complete an incident report in IRIS. -"I didn't think it (incident report) needed to go to IRIS since they (FC #2 and FC #3) never returned after the incident." -Did not know he had to complete an IRIS report for Client #1 because she (Client #1) was not injured. Interview on 9/3/24 with the Operations Manager Revealed: -"The Program Manager is responsible for doing internal incident reports and submitting incident reports to IRIS."	V 367	This page was intentionally left blank.	