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	MHL0601492	A. BUILDING: _____ B. WING _____	C 12/10/2024

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V 000	INITIAL COMMENTS A complaint survey was completed on 12-10-24. The complaint was substantiated (intake #NC00222835). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27 G .1700 Residential Treatment Staff Secure For Children Or Adolescents. This facility is licensed for 4 and currently has a census of 3. The survey sample consisted of audits of 1 former client.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to develop and implement strategies to meet the needs of the client, former client #4 (FC #4). The findings are:

Review on 11-26-24 of FC #4's record revealed:
-Date of admission: 7-8-24.
-Date of discharge: 9-20-24.
-Age: 15.
-Diagnoses: Major Depressive Disorder; Disruptive Mood Dysregulation Disorder; Attention Deficit Hyperactive Disorder, by history; Post-Traumatic Stress Disorder, by history; Frotteurism.
-Admission Assessment dated 7-8-24 and completed by the Executive Director (ED) documenting the following:
"Challenging Behaviors/Behavioral History: SI (suicidal ideation)/Suicide Attempts.
Refusal to take responsibility for actions.
AWOL (absent without leave).
Frequent hospitalizations.
Manipulation.
Hallucinations (auditory)."
-Person Centered Plan (PCP) Update/Revision dated: 7-8-24 documenting the following goals:
"Goal: [FC #4] will follow program rules and directions from staff with no more than two prompts on 4 out of 5 occasions.

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V 112	Continued From page 2 -No Verbal/Physical Aggression -Completing assign chores daily -No Horse playing/Teasing -Being in his assign room at assigned times - No stealing from others - AWOL Goal: [FC #4] will participate in the level program to improve his interpersonal relationships, as evidenced by: Improve communication and relationship with his family and peers. Regulate his mood and improve self-esteem, rely less on others to make him happy or reduce his sadness or anxiety. Develop healthy relationships and appropriate social with peers and staff. Develop healthy boundaries through peer groups, assignments, activities, and/or therapy at least twice a week. Learning about and practicing appropriate social skills through peer groups, assignments, activities and/or therapy at least twice a week. Goal: [FC #4] will identify and manage feelings (i.e., anger, anxiety, stress, frustration) on a daily basis with less than 2 incidence a week as measured by Staff documentation and ; 1. Accept NO for an answer. 2. Recognize signs of frustration and communicate with staff. 3. Manage unreasonable fears by requesting to talk to the therapist and using coping skills. 4. Select an appropriate strategy to alleviate anxiety. 5. Make positive statements about self and not resort to suicide ideation/attempt." -No documentation of updated goals or strategies to address FC #4's ongoing suicidal ideation, AWOL's, property destruction and aggressive	V 112		

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V 112	Continued From page 3 behaviors. Review on 11-26-24 of the facility's General Event Reports (GER) from 7-8-24 to 9-20-24 revealed: -8-16-24: "Consumer (FC #4) was threatening and attempting to jump out of the window. Consumer (FC #4) did get the window up and seem as he was trying to do so. DCS (direct care staff) [Associate Professional (AP)] had to try and restrain him (FC #4) to not allow him to do so (jump from the window). Consumer had to be restrained for a few minutes, as he was trying to attempt this (jump from the window) in multiple rooms. Consumer was expressing SI. Consumer had also had a moment where he was hitting his head on the wall in his closet. Consumer was also hitting the wall in the room with his guitar. Consumer mentioned and tried to call 911 so they (police) can take him to jail and so he can make up a reason to get everyone fired. Consumer had later on settled some and went for a walk with DCS. After the walk, the consumer had just a little bit more of disturbance before calming completely down and going to sleep." -8-19-24: "Consumer [FC #4] stated to staff that he was mad that another consumer was lying on him about a vape. Consumer (FC #4) stated that he wanted to kill himself and die because he does not like people lying on him. Consumer then threatened other staff wanting to fight (FC #4 attempted to fight staff). Staff intervened and used the safety precautions that was in place. Consumer was able to calm down by talking and being able to go outside to release some stress. Consumer then asked to go to [Local department store} to just walk around. Staff told consumer that staff was not allowed to drive the company vehicle. Consumer got mad and	V 112		

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V 112	Continued From page 4	V 112		

stated that he should not be in the house all day and would contact state. Consumer then proceeded to punch wall multiple times and was tampering with alarm system panel. Consumer then went outside without permission and being destructive of property (mailbox). Upper management (QP and ED) and the in house therapist was contacted. Coping interventions were in placed but consumer refused to use them. Consumer stated that he was going to run away because he didn ' t want to be in the house. Consumer asked again about going out to the store and staff again replied no. Consumer then proceeded to speak of more suicidal threats and then became to bang his head against the wall. The above incident was reported (to the QP and ED) and local authorities were contacted."
8-23-24: "Staff took consumer to [Local Store] at 12:30pm to get snacks for the day. Consumer decided he
didn ' t want to get snacks and decided to get something different which was equivalent to the price of snacks? Staff agreed and consumer was happy. Around 5:00 pm staff took consumer to pharmacy to get medication. Consumer wanted to get ice cream but staff told consumer no. Consumer did not like being told no so consumer walked out the store and walked to the car. Once in car staff explained to consumer why staff said no and why it ' s not ok to walk off from staff when everyone needs to stay together. Consumer disregarded what staff said and kept ignoring staff.
Consumer was mumbling so staff couldn ' t hear exactly what was being said. Arrived back to facility and consumer decided to call the house manager with suicidal thoughts. Then proceeded to call the suicidal hotline. House manager was notified and staff was advised to call the local authorities. The local authorities and medics

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V 112	Continued From page 5 arrived. The medics took the consumer to the hospital to be evaluated. The above incident was reported. Arrived back to facility and consumer decided to call the house manager with suicidal thoughts. Then proceeded to call the suicidal hotline. House manager was notified and staff was advised to call the local authorities. The local authorities and medics arrived. The medics took the consumer to the hospital to be evaluated. The above incident was reported." -9-5-24: "Consumer [FC #4] was roughhousing with the other consumers. [FC #4] decided to grab [peer] from behind and pick him up. [Peer] told him (FC #4) stop and proceed to grab his (FC #4's) genitals. [FC #4] then sprayed a cleaning supply solution in [peers] face, [FC #4] tried to apologize but the other consumer (peer) was not receptive to hear it (FC #4's apology). [FC #4] then asked staff to call the House Manager. After two failed tries, the consumer then asked to call the police because he said he was hurting in his genital area. Called another house manager to confirm. Consumer (FC #4) spoke to house manager and in house therapist on three way phone call. Consumer was then fine and decided he did not want to go to the hospital. Consumer went to room to finish folding clothes and get ready for next day and laughing with staff. Staff was on phone with manager while having this interaction with consumer. Then all of a sudden [FC #4] decided to go downstairs to ask other staff to call 911 because he felt unsafe. Staff asked what he felt unsafe about and [FC #4] stated he did not want to be in the house with the other consumer (peer) because the other consumer did not accept his apology. So [FC #4] started packing a bag. [FC #4] stated that if staff didn ' t call 911 fast enough that he would go AWOL. Then [FC #4] stated he did not feel safe within his thoughts.	V 112		

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V 112	Continued From page 6	V 112		

Staff called 911, consumer was happy and went outside in the porch to wait for the medics to arrive. The above incident was reported."
9-7-24: "Consumer (FC#4) was threatening with SI (suicide ideation). He was putting the window up and being defiant with staff. Consumer said that he didn't care about the rules. He said that he doesn't give a "F" (F**k). Consumer was banging on the wall and the window. Consumer was also walking back and forth out of the house after hours. Consumer then went AWOL and left the house. The police did arrive soon after that and caught him up the street."
9-20-24: "[FC #4] had his school laptop in is possession. He mentioned that he was talking to a girl who he knew from the PRTF (psychiatric residential treatment facility) where he came from. He (FC #4) mentioned that the girl was about to go to jail and that she needed a little more money because she didn't have enough. [FC #4] says that he told the young lady that he would help her out and get her the money. He didn't know how he was going to get it for her. He mentioned that he told her that it probably is going to take a while for him to get it to her. After this, he said she told him to go and kill himself. [FC #4] started threatening that he should go ahead and kill himself. He lifted his window and sat in it as he was going to jump. [FC #4] said that he should have just put the heroine needle in his arm at school, that he said someone had. [FC #4] proceeds to break one of the doors in the home that had cleaning items in it, along with peroxide. He attempted to drink it. I did manage to take it from him and escort him out of the room. [FC #4] then goes in his room, takes the charger for his laptop and attempted to

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strangle himself with it. He did use pressure because at one point, his body seem as he was about to fall. A staff member and myself had to remove the cord from his neck and take it from him. After this, [FC #4] left the house and was walking up and down the street. He went AWOL for a little bit but eventually came back. Staff did attempt to follow him but he ran off. Police were called. [FC #4] was back at the home before police arrived."

Review on 11-29-24 of FC #4's CFT (Child and Family Team meeting) action plan notes revealed:
-8-5-24: "[DSS SW] will drop off some things he (FC #4) took from parents. Need sexualized behavior therapy."
-8-26-24: "Will include group home in med (medication) management appt (appointment)."
-9-6-24: "Will begin other placement search. Will forward list of PRTFs (Psychiatric Residential Treatment Facility)."

Interview on 11-22-24 with the Qualified Professional (QP) revealed:
-QP and Executive Director (ED) were responsible for updating the PCP plan.
-"I (QP) will write the plans and complete the updates after the CFT's (Child and Family Team Meetings) and [ED] will review them (PCP's).
-Thought FC #4's PCP had been updated to address FC #4's increased behaviors (suicidal ideation, aggression and AWOL behavior).
-"We (QP, ED, Therapist and FC #4's Department of Social Services (DSS) guardian) had meeting after meeting about [FC #4's] behaviors. We would discuss his behaviors during CFT's, emergency CFTs. We would call his guardian , we were pretty much talking with his guardian almost everyday about his behaviors. I'm pretty sure we documented them

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V 112	Continued From page 8 (meetings)." -"I will look through my emails and phone for some dates (of FC #4's CFT and other team meeting/discussions dates) and get with ED to get the documentation of the meetings." -No documentation of CFT meetings, discussions (with ED or Therapist or with FC #4's DSS guardian) addressing FC #4's increase in suicidal ideation, AWOL's, property destruction and aggressive behaviors received prior to survey exit. Interview on 11-27-24 and 12-4-24 with the ED revealed: -She and the QP are responsible for updating the PCP. -"We (QP, Therapist and ED) had several meetings (discussing FC #4's behaviors) with his guardian (DSS guardian). We addressed the behaviors in his CFTs and made a plan to address the behaviors during that time."	V 112		
V 300	27G .1708 Residential Tx. Child/Adol - Trans or dischg 10A NCAC 27G .1708 TRANSFER OR DISCHARGE (a) The purpose of this Rule is to address the transfer or discharge of a child or adolescent from the facility. (b) A child or adolescent shall not be discharged or transferred from a facility, except in case of emergency, without the advance written notification of the treatment team, including the legally responsible person. For purposes of this Rule, treatment team means the same as the existing child and family team or other involved persons as set forth in Paragraph (c) of this Rule. (c) The facility shall meet with existing child and	V 300		

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V 300	Continued From page 9 family teams or other involved persons including the parent(s) or legal guardian, area authority or county program representative(s) and other representatives involved in the care and treatment of the child or adolescent, including local Department of Social Services, Local Education Agency and criminal justice agency, to make service planning decisions prior to the transfer or discharge of the child or adolescent from the facility. (d) In case of an emergency, the facility shall notify the treatment team including the legally responsible person of the transfer or discharge of the child or adolescent as soon as the emergency situation is stabilized. (e) In case of an emergency, notification may be by telephone. A service planning meeting as set forth in Paragraph (c) of this Rule shall be held within five business days of an emergency transfer or discharge. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to coordinate service planning decisions prior to discharge affecting 1 of 1 former client (FC #4). The findings are: Review on 11-26-24 of FC #4's record revealed: -Date of admission: 7-8-24. -Date of discharge: 9-20-24. -Age: 15. -Diagnoses: Major Depressive Disorder; Disruptive Mood Dysregulation Disorder; Attention Deficit Hyperactive Disorder, by history; Post-Traumatic Stress Disorder, by history; Frotteurism.	V 300		

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V 300	Continued From page 10 -Admission Assessment dated 7-8-24 and completed by the Executive Director (ED) documenting the following: "Challenging Behaviors/Behavioral History: SI (suicidal ideation)/Suicide Attempts. Refusal to take responsibility for actions. AWOL (absent without leave). Frequent hospitalizations. Manipulation. Hallucinations (auditory)." -No documentation of discharge planning prior to discharge letter dated 9-5-24. -No documentation of therapy notes, progress notes, or CFT (Child and Family Team) notes to address FC #4's ongoing suicidal ideations, AWOL's, property destruction and aggressive behaviors. Review on 11-26-24 of FC #4's discharge letter to FC #4's DSS guardian dated 9-5-24 documenting the facility's 30 day discharge notice with discharge to be effective on 10-4-24. Review on 11-29-24 of FC #4's CFT notes revealed: -8-5-24 note documenting "continue care." -8-26-24 note documenting "continue care." -9-6-24 note documenting "will begin placement search." Interview on 12-10-24 with the Associate Professional (AP) revealed: -"I'm sure that [QP], [ED] and [Therapist] were discussing [FC #4's] discharge before they let us (staff) know (informed staff of discharge) but we (AP and direct care staff) were not informed of his discharge until he went to he hospital on 9-5-24. Interview on 11-22-24 with the Qualified Professional (QP) revealed:	V 300		

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V 300	Continued From page 11 -"We (QP, Executive Director (ED), and Therapist) began discussing discharge when he (FC #4) started acting on his threats of committing suicide (August 2024). At first he was just saying things like, I don't want to be here, I wish I were dead, I'm going to kill myself but he wasn't really acting on that, he didn't have a plan (to commit suicide). But when he actually tried to do it (commit suicide) we knew we couldn't keep him, we started discussing his discharge plan at that time (unknown date)." -"I'm not sure of the date. Myself, [ED] and [Therapist] did a phone conference and discussed the discharge. I will look back at my phone and try to get you the date (the date QP, ED and Therapist discussed FC #4's discharge)." -"Yes, we were talking to his social worker (Department of Social Services (DSS) guardian) and telling her we could not keep him because of his behaviors. We discussed discharge (FC #4's discharge) at his CFTs." -"[FC #4] was given an 30 day discharge notice on 9-5-24. [ED] contacted his (FC #4's) social worker (DSS guardian) on 9-5-24 and informed her of the discharge (FC #4's 30 day discharge date)." -"After he attempted to jump out his window then tried to hang himself and went to the hospital (9-20-24), we couldn't bring him back. We (ED, and Therapist) decided that we couldn't keep him safe so we couldn't bring him back after that (9-20-24 incident)." Interview on 11-26-24 with the Therapist revealed: -"We were unaware of [FC #4's] behaviors when he was admitted. No one told us that he was having suicidal ideation and hallucinations. He did well for the first couple of weeks he was at the facility. We did not learn of these behaviors until	V 300		

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V 300	Continued From page 12 after he (FC #4) got here (after admission) and started having these behaviors (August 2024). As soon as the behaviors became apparent we knew that his behaviors were beyond our scope of service. We (QP, ED and Therapist) could not care for this client." -"Yes, all of this was discussed during his CFTs. We had emergency CFTs discussing his behaviors and discharge was discussed during these meetings. I'm sure [ED] has those meetings documented. I've preached for years and years and years about how important documentation is. I will look back at my notes and emails and send you any dates and notes that I have on these meetings." -No documentation of CFT meetings, dates of other team meetings or discussions or therapy notes received from the therapist at survey exit. Interview on 11-27-24 and 12-4-24 with the ED revealed: -[FC #4) did very well for a little while when he was admitted. He had some behaviors but we thought that the behaviors were attention seeking. Then he began to try to hurt himself and he was telling us he did not want to be here (at the facility). He was hospitalized 3 or 4 times during this time (August 2024 and September 2024) and each time after each hospitalization the behaviors would increase. We (ED, QP and Therapist) started discussing discharge when the behaviors (SI, AWOL's, property destruction and aggressive behaviors) didn't stop (unable to provide date when discharge discussions began). We realized that we could not care for him, we could not keep him safe." -"When he went to the hospital (9-5-24), I think it was when he tried to throw himself down the stairs, we decided we had to discharge him for his safety.	V 300		

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V 300	Continued From page 13 -"The QP, [The therapist] and myself we had a meeting and decided we needed to do an emergency discharge. No, I did not document the meeting. It was over the phone, we did a conference call the three of us and discussed the discharge." -FC #4's discharge letter was issued on 9-5-24 to his social worker (DSS social worker). the discharge was going to expire (become effective) on 10-4-24. When he went to the hosptial the last time (9-20-24) we did an emergency discharge (9-20-24) due to his behaviors. We (ED, QP and the Therapist) did not feel that we could keep him safe." Interview on 11-26-24 with FC #4's DSS Guardian: -No, I was not aware of any plans the facility had to discharge until I got a email with the discharge letter on 9-5-24 then [ED] called me and told me that they were discharging him due to his behaviors." -Yes, we (DSS social worker and facility staff) had discussed his behaviors. They (QP) would email me or text me to let me know when they had to take him to the hospital or urgent care. We discussed his behaviors in the CFT's but no one ever said anything about discharge. His (FC #4) behaviors were discussed but it was always discussed as general information basically, like this is what he did this month. They (ED/QP) always talked about his behaviors like they were working with him and trying to manage the behaviors. We never had any meetings or discussions regarding [FC #4] being discharged until I got the call from [ED]. I believe I got the phone call first. [ED] called me and at first she said they were going to do an emergency discharge then when I got the letter it (the emergency discharge) had changed to a 30 day	V 300		

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V 300	Continued From page 14 discharge with the end date being 10-4-24. When he went to the hospital on 9-20-24, the hospital called me after they had reached out to them (provider), I think it was [QP] they spoke with. She (QP) told them they were not taking him back. Then [ED] called me and told me that they were not bringing him back. She (ED) said it was because they couldn't keep him (FC #4) safe."	V 300		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal	V 366		

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V 366	Continued From page 15 regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The	V 366		

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V 366	Continued From page 16 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 facility failed to implement written policies governing their response to level II incidents affecting 1 of 1 audited clients (former client #4 (FC #4). The findings are:	V 366		

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V 366	Continued From page 17 Review on 11-26-24 of the facility's GER (General Event Reports for 7-8-24 to 9-20-24 revealed: -No documentation of an incident where FC #4 attempted to throw himself down a flight of stairs. -No documentation of incidents when FC #4 made statements of his intent to harm himself. -No Risk/Cause/Analysis for the above incidents. Interview on 11-22-24 with the Qualified Professional (QP) revealed: -"When [FC #4] came (was admitted to the facility) he did real good...Then after, I'm going to say, after about a month, after like that second week in August (2024) his behavior started to change. At first he would say things like, 'I'm just going to kill myself or I wish I were dead' and we would redirect him. We (staff) thought that it was attention seeking. He would always say things like that when someone had to tell him no or if he felt like he wasn't getting his way." -"Yeah, he would say it often, I'd say several times a week, if not daily. But he did not try to act on any of the statements. He would say it (threats of self harm), we would redirect him and then he would be alright. He never actually tried to hurt himself until about the middle of August (2024). I think the first time he tried to throw himself down the stairs.... That's when he started acting on the threats." -"No, we didn't document every time he made a threat until then (middle of August 2024) because they were just words, no action. When he actually attempted to self harm, when he had a plan to self harm, that's when we started documenting." Interview on 12-4-24 with the Executive Director revealed: -Direct Care Staff involved in the incident documents in the GER. -ED completes the IRIS reports.	V 366		

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V 366	Continued From page 18 -Was not aware of any incidents that were not documented. "I thought we (staff) had documented that (FC #4 attempting to throw himself down a flight of stairs)."	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:	V 367		

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V 367	Continued From page 19 (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; (4) seizures of client property or property in the possession of a client;	V 367		

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V 367	Continued From page 20 (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 incidents to the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident. The findings are: Review on 11-26-24 of the facility's GER (General Event Reports for 7-8-24 to 9-20-24 revealed: -No documentation of an undated incident where FC #4 attempted to throw himself down a flight of stairs. -No documentation of incidents when FC #4 made statements of his intent to harm himself. Review of the North Carolina Incident Response Improvement System (NC IRIS) for 7-8-24 to 9-20-24 revealed: -No IRIS report for 9-20-24 documenting FC #4's attempt to self harm and his hospitalization on 9-20-24.	V 367		

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V 367	Continued From page 21 Interview on 12-4-24 with the Executive Director revealed: -ED completes the IRIS reports. -Was not aware of any incidents that were not documented. "I thought we (staff) had documented that (FC #4 attempting to throw himself down a flight of stairs)."	V 367		