STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
ANDIEAN	SI GORREOTION	IDENTIFICATION NOMBER.	A. BUILDING:		OOM! LETED	
		MHL054-173	B. WING		04/09/201	8
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
HADIEE	MAC GROUP HOME -I	1752 ELIZ	ABETH DRIVE			
HARLEE	WIAC GROUP HOINE -I	KINSTON,	NC 28501			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE CON	(X5) MPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	2018. The complaint (Intake #NC0013741) This facility is license	4). A deficiency was cited. d for the following service 27G .5600A Supervised				
V 367	27G .0604 Incident R	eporting Requirements	V 367			
	level II incidents, except the provision of billable consumer is on the princidents and level II to whom the provider 90 days prior to the ir responsible for the caservices are provided becoming aware of the submitted on a for Secretary. The report in person, facsimile of means. The report information: (1) reporting pridentification informat (2) client identification informat (3) type of incidentification incidentificat	REMENTS FOR B PROVIDERS B providers shall report all ept deaths, that occur during le services or while the roviders premises or level III deaths involving the clients rendered any service within ncident to the LME attchment area where I within 72 hours of the incident. The report shall m provided by the at may be submitted via mail, ar encrypted electronic chall include the following ovider contact and ion; fication information; dent; of incident; e effort to determine the				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

MHL054-173 B. WING 04/09/2	/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
HARLEE MAC GROUP HOME -I KINSTON, NC 28501	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 27E. O104(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;	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL054-173	B. WING		04	1/09/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
HARLEE	MAC GROUP HOME -I		ZABETH DRIVE N, NC 28501			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 367	(4) seizures of the possession of a cl (5) the total nur incidents that occurre (6) a statement been no reportable in incidents have occurr meet any of the criteria.	a client or his living area; client property or property in lient; mber of level II and level III d; and indicating that there have cidents whenever no ed during the quarter that is as set forth in Paragraphs e and Subparagraphs (1)	V 367			
	facility failed to report report to the Local Mawithin 72 hours. The face of the Review on 04/09/18 of revealed: -36 year old male. -Admission date of 02 -Diagnoses of Schizo Unspecified Depressi Intellectual Functionin Disorder, Mild Neuroo TBI's (traumatic brain Review on 04/09/18 of Accident/Incident Reprevaled: "-Consumer/Staff/Dar Date of Incident/Accident Date Reported: March Location of accident/iii	and record reviews, the Level II critical incident anagement Entity (LME) indings are: of client #4's record 2/05/18. phrenia Paranoid Type, we Disorder, Borderline ag, Antisocial Personality cognitive Disorder due to injuries). of the facility's cort dated 03/27/18 mage/Other: [Client #4]. dent: March 27, 2018 Time:				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND FLAN OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMP	LETED	
	MHL054-173	B. WING		04	/09/2018	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
HARLEE MAC GROUP HOME	1752 ELIZ	ABETH DRIVE				
	KINSTON,	NC 28501				
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
when, why and h by staff, [Staff #1] [Staff #1] verbally running and retur loud verbal prom to [Staff #1's] pro faster. [Staff #1] unable to stop hi returned to the fa The licensee con Review on 04/09 Response Improve no Level II incide incident on 03/27 Interview was att #4 but he refused talk. During interview -He and client #4 breakClient #4 was ta voicesClient #4 took of house and he fol -He was unable to -He returned to the LicenseeThe Licensee con During interview -When client #4 gone for approxim -She immediately client #4She did not com	dent/incident: (what, where, ow): [Client #4] was observed running away from the facility. It prompted him loudly to stop in to the property. After several ots, [Client #4] was not receptive impts and continued to run pursued [Client #4], but was in from running. [Staff #1] cility and notified the licensee. It tacted the police." In the North Carolina Incident element System (IRIS) revealed in that been submitted for the limited and stated he did not want to the limited and stated he did not want to the limited and stated he did not want to the limited and was hearing in running on the side of the limited him. In the facility and contacted the limited limited limited the limited lin	V 367				

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A. BUILDING:	
MHL054-173 B. WING	04/09/2018
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
HARLEE MAC GROUP HOME -I 1752 ELIZABETH DRIVE KINSTON, NC 28501	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORR	R'S PLAN OF CORRECTION (X5) ECTIVE ACTION SHOULD BE COMPLETE ENCED TO THE APPROPRIATE DATE DEFICIENCY)
V 367 Continued From page 4 -She was unaware a Level II had to be completed if the police were contacted.	

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