STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-643	A. BUILDING: _____ B. WING _____	R 06/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R E S T GROUP HOME #5	250 PRINCE CHARLES DRIVE FAYETTEVILLE, NC 28311

(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 was completed on June 6, 2018. The complaint was unsubstantiated (Intake #NC00139614). Deficiencies were cited. This facility is licensed for the following category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
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. 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	V 132		

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V 132	Continued From page 1 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 reviews and interviews, the facility failed to report an allegation of abuse to the Health Care Personnel Registry (HCPR). The findings are: See Tag V367 for specifics. Review on 06/06/18 of facility records revealed no documentation the HCPR was notified of the 06/03/18 allegation staff #1 abused client #2. Interview on 06/06/18 the Director of Residential Services stated she understood the HCPR was required to be notified of all allegations of abuse against staff.	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	V 367		

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V 367	Continued From page 2 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 information;	V 367		

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V 367	Continued From page 3 (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		

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V 367	Continued From page 4 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure a critical incident report was submitted to the Local Management Entity (LME) within 72 hours as required. The findings are. Review on 06/06/18 of the North Carolina Incident Response Improvement System (IRIS) revealed no Level II incident reports had been submitted for June 3, 2018. Review on 06/06/18 of a Level I incident report completed by the Director of Residential Services and dated 06/03/18 revealed: - "Staff was using the restroom when the door chimes rang. Staff asked who went out or who came in-no one replied. Staff immediately checked consumer rooms and found [Client #2] to be missing and not in the group home. Staff immediately grabbed nearest phone to call group home manager and went outside to see if [Client #2] was around the side of the house-he was not. Staff called his name there was no answer but staff did catch a glimpse of [Client #2] behind the slightly wooded area on the side of the group home. [Group Home Manager] was called. Staff was instructed to call [Director of Residential Services] and follow what she says to do. [Director of Residential Services] was called and she instructed staff to call 911. 911 was called and while on the phone with the 911 operator a woman (staff thought to be the neighbor) and started saying ugly accusatory things to staff. Staff replied to the best of ability as the 911 operator was still on the line. 911 instructed staff to not listen to the woman and to please notify them if there were any changes, they were sending an officer out. [Director of Residential	V 367		

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V 367	Continued From page 5	V 367		

Services] came and took other consumers to another group home and staff made a report to the police officer who arrived as she was leaving." -Typed statement by the Director of Residential Services revealed: "On Sunday June 3rd at 1:11pm I [Director of Residential Services] received a call from [Staff #1] informing me that a consumer had left the premises. I informed her to call 911 and give a description of the consumer and the directions in which he went. I received a call back at 1:36 that I should come to the house immediately as the consumer was in the care of the neighbors and they had refused to return him to the group home. The staff sounded upset and I informed her that I was on my way. Before I left for the group home I made arrangement for him and the other consumers to be picked up and transported to another site. Upon arrival, I noticed the consumer sitting in a chair in the neighbor driveway surrounded by two individuals. I pulled into the driveway of the neighbor's house and introduced myself as the Director of the residential services and showed my ID badge to the two people. The woman introduced herself as [Neighbor] and her son. I acknowledged the consumer and asked if he was okay. The consumer informed me that he was fine, but he was afraid to return to the group home. [Neighbor] informed me that the consumer was fine, but she wanted to file a complaint. I provided her with the name and number of the organizations Executive Director. [Neighbor] also informed me that the consumer has stated the staff has hit him. I stayed with the consumer until the replacement staff arrived with the additional transportation. Once the consumer was with the other staff, I went to the home and spoke to [Staff #1]. [Staff #1] was visible upset, she was crying and on the phone. I asked if she was okay and she informed me that she was afraid off losing

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V 367	Continued From page 6 her job. I mentioned to her that she needed to complete an incident report, and the police office showed up. I introduced myself and directed all questions to [Staff #1]. I excuse myself and went to the other site to check on the consumers. End of Statement." Interview on 06/06/18 the Director of Residential Services revealed a Level II had not been completed but she and the Executive Director were unsure if the incident was a Level II. The staff was not reported to the Health Care Personal Registry.	V 367		