Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-405	A. BUILDING: ______ B. WING ______	C 03/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW YORK HOMES RESIDENTIAL CARE CEN'	644 OLIVETTE ROAD ASHEVILLE, NC 28804

(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 survey was completed on 3/19/19. The complaint was unsubstantiated (Intake #NC148267). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Individuals of all Disability Groups/Alternative Family Living.	V 000		
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	V 367		

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V 367	Continued From page 1 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; (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	V 367		

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V 367	Continued From page 2	V 367		

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.

This Rule is not met as evidenced by:
Based on record reviews and staff interviews, the facility failed to report a Level II incident to the Local Managing Entity/Managed Care Organization (LME/MCO) within 72 hours of when 1 of 3 sampled clients (Client #1) presented self-injurious, aggressive and destructive behaviors. The findings are:

Record review on 3/19/19 of Incident Response Improvement System (IRIS) reports revealed:
-Report submitted 1/3/19 regarding incident dated 12/29/18 (5 days) revealed:
Client #1 eloped out of his bedroom window. Staff found him outside walking toward the church and refused to return. He began destroying church property, cutting himself and became physically aggressive with staff. He continued to tear gutters from the church building when a neighbor, the pastor and police showed up. Client #1 was eventually able to calm down and return home and have cuts cleaned up.
-Report submitted 1/21/19 regarding incident dated 1/17/19 (4 days) revealed:

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V 367	Continued From page 3 While staff was engaged with another client, Client #1 exited the facility with no shoes, socks or shirt. Client refused staff's request to come back in and continued to walk across the street. Staff followed until they were able to calm Client #1 enough to sit down. They talked for about 45 minutes and then returned to the house. Client #1 was administered PRN but continued to pace for hours. -Report submitted 1/21/19 regarding incident dated 1/18/19 revealed: After pacing anxiously in the living room, Client #1 went to his bedroom and shut himself in his closet refusing to come out. Client #1 opened the closet door to reveal bleeding arms that he had been cutting with glass from a broken light bulb. He reluctantly gave the glass to staff and followed them to the bathroom to clean his wounds. He returned to his bedroom and tried to jump out of his bedroom window but staff stopped him. He then accompanied staff into the living room where he slept for the night. -Report submitted 1/21/19 regarding incident dated 1/20/19 revealed: Client #1 eloped out of his bedroom window before dinner on 1/20/19. Reported he wanted to kill several staff members as well as himself. 911 was called-police transported client to the hospital. -Report submitted 3/19/19 regarding incident dated 3/15/19 (4 days) revealed: Client #1 eloped from the home and was found wandering around outside. He refused to come back inside. He became physically aggressive with staff as he was attempting to lay down in the main road saying he wanted to kill himself. Police were called and escorted Client #1 home. After he refused to get out of the car, the police transported him to the hospital due to his aggression and suicidal threats.	V 367		

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V 367	Continued From page 4 Record review on 3/18/19 for Client #1 revealed: -Admission date of 10/29/17. -Diagnoses- Attention Deficit Hyperactivity Disorder, Moderate Intellectual Disability, Disruptive Mood Dysregulation Disorder and Persistent Disinhibition and Social Engagement. -History of self-harm, property destruction and severe aggression. Client #1 was unavailable for interview. Interview with Guardian for Client #1 revealed: -Client #1 had always been this way-"he can control every bit of this. He needs not to be cuddled but to have significant consequences when he does damage to others property. He just wants all the attention all the time." -He was working on something with the church to hold Client #1 accountable for his behaviors. Interview on 3/18/19 with Staff #1 (Alternative Family Living primary caregiver) revealed: -Client #1's behaviors would become uncontrollable when staff attention would be directed toward someone else in the home or if he could not have something he wanted. -Have tried changing medications. Client #1 had seen his psychiatrist 11 times in the past 12 months. -Client #1 had a behavior support plan and the psychologist would see Client #1 weekly. Interview on 3/19/19 with the Qualified Professional (QP) revealed: -Client #1's behaviors were normally up and down. -She was aware of the incident reports in their electronic medical record (EMR) system entered by Staff #1. -She was responsible for entering that information	V 367		

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V 367	Continued From page 5 into IRIS (Incident Response Improvement System) notifying the LME. -She reviewed their EMR for incident reports every day and entered the information into IRIS as soon as she could. -She was not aware that her IRIS reports were submitted late or within the required 72 hours.	V 367		