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	MHL059-071	A. BUILDING: _____ B. WING _____	C 07/17/2019

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WEST MARION GROUP HOME	145 LUKIN STREET MARION, NC 28752

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V 000	INITIAL COMMENTS A complaint survey was completed on July 17, 2019. The complaint was unsubstantiated (intake #NC 00153507). A deficiency was cited. A sister facility is identified in this report. Sister facility staff will be identified using the letter of the facility and numerical identifier. The sister facility will be identified as sister facility A. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000	ff	
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	V 367	Due to the following deficiency, this organization implements the following systems for reviewing analyzing trends,potential risks, and sentinel events including allegations of abuse,neglect, mistreatment and exploitation,and injuries of unknown origin and death. Retraining staff in Incident reports are scheduled immediately ,all incident reports are to be discussed during staff meetings to help identify trends and address the importance of reporting any and all incidents. Disciplinary action was given to the former imployee of three days suspended without pay on july 3rd, due to failure to report an incident, however the employee did not show back up for duty and was released.	

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V 367	Continued From page 1 (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; (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:	V 367	House Managers and Qualified persons [Q] will moniter,review and report all incidents as needed to comply with policy and procedures.	

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V 367	Continued From page 2 (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. This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to notify the Local Management Entity (LME) of Level II and Level III incident reports within 72 hours. The findings are: Review on 7/17/19 of Former Client (FC #3)'s record revealed: Date of admission: 11/17/17 Date of discharge: 7/3/19 Diagnoses: Behavior Dysregulation, Severe Intellectual Developmental Disability (IDD), Mood Disorder, Cerebral Palsy, Hypothyroidism, Epilepsy, Dysphagia, Nocturnal Enuresis Behaviors: Recurrent agitation, physical aggression toward others and especially female staff, self-injurious (hits and kicks), property destruction, elopement, non-compliance with staff prompts and instructions; -6/28/19 at 9:47 pm, a written note of FC #3's physical aggression (throwing objects, kicking	V 367		

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and biting) toward Former Staff (FS #2) and an attempted elopement from the facility;
-The Owner/Manager came to the facility at the request of FS #2 and FC #3's physician was contacted with a request to change FC #3's medication to address FC #3's aggressive behaviors;
-FC #3's physician increased his Klonopin administration doses to three times daily;
-FC #3 was administered the Klonopin by FS #2 and the Owner/Manager stayed with and attempted to calm FC #3 with FC #3 having had no additional behaviors overnight;
-6/30/19 at 9:46 pm, a written note by Staff #1 that FC #3 refused to gather his personal items for showering and began to yell, hit the walls and hit himself in the head;
-FC #3 "lunged" at Staff #1 and "struck" her in the chest with both fists as she turned the water on in his shower;
-The Owner/Manager came to the facility at the request of Staff #1 and FC #3 showered, had a snack and went to bed without further behaviors overnight;
-7/1/19 at 3:42 pm, a written medical note electronically signed by a nurse practitioner that FC #3 had scratches on his face and a scratch or contusion to his left periorbital area (consisting of the eyelids and including the eyebrows, bony eye socket and rims) that appeared "self-inflicted."
-This note had that FC #3 did not wish to harm himself or others, and he acknowledged he struck himself when angry;
-7/1/19, a written and signed medication order to change FC #3's Klonopin from 0.5 milligrams (mg) to 1 mg three times daily for agitation and anxiety, and a prescribed order for Vyvanse 30 mg once daily.

Review on 7/17/19 of requested written facility

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incident reports that pertained to FC #3 from 5/1/19 through 7/16/19 revealed:
-7 Level 1 incident reports that varied from medication refusals on 6/17/19, 6/18/19, 6/21/19, and skin abrasions from slips and falls on 5/29/19 and 7/3/19 that was addressed by first aid methods to a right leg bruise on 6/29/19 from his attempt to climb over a door.

Review on 7/17/19 of the North Carolina Incident Response Improvement System (IRIS) revealed no Level II or Level III incident reports that pertained to FC #3 between 5/1/19 and 7/17/19.

Observation on 7/17/19 at 1:20 pm of FC #3 revealed:
-His verbal communication appeared limited to 1-2-word sentences;
-He appeared neatly dressed and well-groomed;
-He wore a short-sleeved t-shirt and beige shorts;
-No visible marks or bruises were observed on his face, neck, arms or legs;
-He appeared calm in his behaviors with his private caregiver.

Interview on 7/17/19 with the Owner/Manager revealed:
-On or about 6/29/19, FC #3 and his housemates were playing basketball at sister facility A and FC #3 attempted to jump through a half-door;
-FC #3 "was not behaving," in that, he did not want to listen to staff instructions;
-He was contacted by Staff A1 to come to sister facility A to help address FC #3's escalated behaviors of yelling and hitting himself;
-He arrived at sister facility A at approximately 11:00 am on 6/29/19, and he took FC #3 into the medicine room where FC #3 yelled and continued to hit himself;
-He realized when he brought FC #3 into the

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medicine room to help calm him down that FC #3 had a cut on his nose which he believed FC #3 scratched with his fingernails;
-FC #3 calmed down after talking with him but he was still somewhat agitated because he did not like being told by staff what he could and could not do;
-On 7/3/19, FC #3 attended a July 4th picnic where FC #3 became angry at the Owner/Manager when he (FC #3) was directed to go into the bathroom when he masturbated;
-FC #3 was returned to the facility by Former Staff (FS #2) due to his anger and noncompliance with staff instructions;
-Back at the facility, FC #3 physically attacked Staff #1, who was pregnant, and 911 was called which led FC #3 to be taken to a local hospital for an assessment of his behaviors;
-He received a telephone call from a local Adult Protective Services (APS) social worker and was informed of an allegation that an unidentified staff said he had hit FC #3;
-FC #3 was interviewed by the APS social worker and a local child advocacy and local law enforcement investigated the allegation of physical assault as well;
-He did not know the outcomes of these investigations;
-He was surprised at the allegation because he believed he had a good relationship with FC #3 even though FC #3 got verbally angry when he was told he could not do something he wanted to do;
-FC #3 had recent medication changes for the purpose of addressing his behaviors and the medications were supposed to have addressed FC #3's urges to masturbate;
-FC #3 was admitted to a local hospital from 7/3/19 to 7/16/19;
-FC #3 was to have been discharged from the

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hospital to a local group respite facility on 7/16/19 but the respite facility decided not to admit him and FC #3 was placed in a private home by his legal guardian to be cared for.

Interview on 7/17/19 with the Owner/Director revealed:
-FC #3 was taken to his physician on or about 7/1/19 because of his self-injurious behaviors that included hitting himself;
-She did not recall whether he had any injuries;
-She had not completed incident reports regarding FC #3's escalated behaviors but the incidents were documented in FC #3's record;
-She was responsible for completing and entering Level II and Level III IRIS reports;
-She took full responsibility for not having completed an IRIS incident report for FC #3 with local APS and local law enforcement involvement in the allegation of physical abuse of FC #3;
-She and the Owner/Manager had never faced this type of allegation in the past.

Interview on 7/17/19 with a local APS supervisor revealed:
-He confirmed APS involvement with FC #3 that pertained to the alleged physical abuse of FC #3 on or about 6/29/19;
-There was no evidence found of caretaker physical abuse of FC #3.

Interview on 7/17/19 with a local law enforcement detective revealed:
-Local law enforcement investigated the 6/29/19 allegation of physical abuse of FC #3 by staff and found no evidence that FC #3's injuries resulted from the Owner/Manager;
-FC #3 had a long history of self-injurious behaviors;
-They had no concerns about the care of FC #3

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V 367	Continued From page 7 and other residents at the facility.	V 367	Director of Operation NCORGH Ray Patrick	08/27/19