STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-336	A. BUILDING: _____ B. WING _____	R-C 09/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME CARE SOLUTIONS AT INLAND DRIVE	719 INLAND DRIVE KERNERSVILLE, NC 27284

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 9/25/19. The complaint was unsubstantiated (intake #NC00153890). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults whose Primary Diagnosis is a Developmental Disability.	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 notify the Health Care Personnel Registry (HCPR) of an allegation of abuse against health care personnel and conduct an internal investigation, affecting 1 of 3 clients (former client (FC) #3). The findings are: Reviews on 7/24/19 and 9/24/19 of facility records revealed no documentation that HCPR was notified of allegations of abuse. Interviews on 7/24/19 and 7/26/19 with FC #3 revealed: -The day program he attended and the facility where he resided were owned by the same individuals; -He had informed his 1 on 1 worker at the day program he attended on 7/24/19 that he had been sexually abused by a staff member; -His 1 on 1 worker was present with him when he discussed the allegation with law enforcement; -He had not been asked by anyone at the facility to provide details of the abuse.	V 132		

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V 132	Continued From page 2 Interviews on 7/24/19, 9/24/19 and 9/25/19 with the Qualified Professional (QP) revealed: -She had not notified the HCPR of the allegation of abuse or conducted an internal investigation; -She was made aware on 7/24/19 by the Chief Operating Officer (COO) that law enforcement had talked with FC #3 regarding some allegations but she wasn't provided with details. Interviews on 7/24/19, 7/26/19 and 9/25/19 with the COO revealed: -He was made aware by law enforcement on 7/24/19 that FC #3 had alleged that staff #1 sexually abused him; -Staff #1 was still employed but was out on medical leave; -"[Staff #1] was one of our better workers;" -The detective that interviewed FC #3 on 7/24/19 had informed him that the allegation was going to be unsubstantiated; -"[FC #3] has a strong history of not telling the truth;" -"[Staff #1] is not a homosexual type of person;" -He was not aware that the HCPR was not notified of the allegation and that an internal investigation had not been completed; -It was the responsibility of the QP to notify HCPR of all allegations and to complete internal investigations; -He had notified the QP of the allegations.	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 level II incidents, except deaths, that occur during	V 367		

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V 367	Continued From page 3	V 367		

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;
(2) reports by other authorities; and

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V 367	Continued From page 4 (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. This Rule is not met as evidenced by:	V 367		

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V 367	Continued From page 5 Based on record reviews and interviews the facility failed to ensure critical incident reports were submitted to the Local Management Entity (LME) within 72 hours as required. The findings are. Reviews on 7/24/19 and 9/24/19 of the Incident Response Improvement System for the facility revealed no reports submitted regarding an allegation of staff #1 abusing former client (FC) #3. Interviews on 7/24/19 and 7/26/19 with FC #3 revealed: -The day program he attended and the facility where he resided were owned by the same individuals; -He had informed his 1 on 1 worker at the day program he attended on 7/24/19 that he had been sexually abused by a staff member at the facility; -His 1 on 1 worker was present with him when he discussed the allegation with law enforcement; -He had not been asked by anyone at the facility to provide details of the abuse. Interviews on 7/24/19, 9/24/19 and 9/25/19 with the Qualified Professional (QP) revealed: -She had not submitted an incident report regarding the allegation of abuse; -She was made aware on 7/24/19 by the Chief Operating Officer (COO) that law enforcement had talked with FC #3 regarding some allegations but she wasn't provided with details. Interviews on 7/24/19, 7/26/19 and 9/25/19 with the COO revealed: -He was made aware by law enforcement on 7/24/19 that FC #3 had alleged that staff #1 sexually abused him; -Staff #1 was still employed but was out on	V 367		

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V 367	Continued From page 6 medical leave; -"[Staff #1] was one of our better workers;" -The detective that interviewed FC #3 on 7/24/19 had informed him that the allegation was going to be unsubstantiated; -"[FC #3] has a strong history of not telling the truth;" -"[Staff #1] is not a homosexual type of person;" -He was not aware that an incident report was not submitted regarding the allegation; -It was the responsibility of the QP to submit incident reports; -He had notified the QP of the allegations.	V 367		