STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL008-045	A. BUILDING: _____ B. WING _____	C 08/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 000	INITIAL COMMENTS A complaint survey was completed on August 13, 2019. The complaints were unsubstantiated Intake #NC00154028 & NC00153587. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000	The attached Administrative Policy & Procedure: Critical Incident Reporting addresses SFF, Inc. procedures for compliance with Rule 27G .0604 Incident Reporting Requirements. SFF, Inc's obligation as provider is to responsibly investigate and report occurrences based on evidence and not conjecture. SFF, Inc will only rely on objective facts and not subjective opinions or contradictions in the information given. SFF, Inc. will continue utilizing the interview as our main tool for gathering information. The interview will be limited to those who actually witnessed the incident in order to avoid gathering conflicting or false information. All necessary information as stated in the policy description will be elicited from witnesses during the interview to determine what happened and why. The Supervisor/Administrator will monitor the situation daily throughout the course of completion and reporting.	
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 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 and interview the facility failed to ensure a consistent description of a level II incident report was submitted to the MCO/LME (managed care organization/local management entity). The findings are: Review on 7/25/19 of a medical diagnostic exam dated 6/25/19 for client #2 revealed: "Trauma...nondisplaced fracture of the fourth metatarsal carpal..." Review on 7/23/19 of an incident report dated 6/25/19 revealed: "...as a result of this incident occurring our agency's Qualified Professional (QP) began gathering details of the cause of the incident...one staff member reported hearing a noise coming from his bedroom she found [client #2] leaning against the door frame of his bedroom. At our prom (6/21/19) he was very active from excitement, he wheeled himself in his wheelchair during the evening. Considering this activity it could be suspected his finger was injured while rolling himself in the wheelchair and	V 367		

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V 367	Continued From page 3 symptoms did not occur instantly. The QP interviewed [client #2]...although he cannot communicate words, he will gesture and nod to indicate yes or no...the QP asked [client #2] if he fell and he nodded yes. Agency does not suspect staff abuse as a cause of incident. Agency could conclude "fall" as a cause; however, there were no witnesses to confirm the actual cause..." Review on 7/23/19 of the QP's investigation dated 6/24/19 revealed: "...[staff #2] contacted the QP on 6/24/19 and informed her client #2's hand was hurting. QP asked staff #2 to examine client #2's hand for any bruising and swelling and if he could move his hand. There was no brusing or swelling at that time...QP interviewed staff #1 and asked her if client #2 had fallen during her shift...staff #1 stated client #2 had not fallen during her shift...she was gathering the trash to take the trash out, she heard a noise from client #2's bedroom...informed QP that when she went to go check on client #2 he was leaning against the door frame of his bedroom...staff #1 assisted client #2 with sitting down...staff #7 informed the QP she was in the kitchen preparing lunches for the next day and did not hear or see client #2 fall on 6/24/19...client #1 did not see client #2 fall and that she was not sure what happened..." Observation on 7/19/19 at 1:32pm revealed: - client #2 in a wheelchair with gait belt around the waist - last two fingers on left hand bandaged - he was nonverbal During an attempted interview on 7/19/19 client #2: - he smiled as he attempted to say something when asked what happened to his hand	V 367		

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V 367	Continued From page 4 During interview on 7/19/19 client #1 reported: - she was in the living room on the day of the incident (6/24/19) - client #2 came out of his bedroom with his walker - when she looked again he was on the floor in the hallway - staff #1 & #7 were there - he went to the doctor the next day During interview on 8/13/19 client #3 reported: - when asked what happened to client #2's hand... "fell" - when asked who helped him up... "[staff #1]" During interview on 7/19/19 & 8/13/19 staff #1 reported: - she picked the clients up in the morning to take to day support and then dropped them off in the afternoon - she ran the groups at day support - on the morning of 6/24/19 she was in the laundry room & staff #7 was in the kitchen...she walked past client #2's bedroom and said "come on we getting ready to go"...normally when she say that he knew to turn his television off and wait for staff's assistance. Client #2's balance was unstable and staff assisted him by holding onto his gaitbelt as he walked...that morning he got up and attempted to walk out the bedroom without staff's assistance...she heard a loud noise while she was in the laundry room (across from client #2's bedroom)...she looked and client #2 was leaned up against the side of his bedroom door with his walker...he "never" hit the floor...she assisted him to the kitchen area and looked him over...there was no swelling or bruising...the QP contacted her on the night of 6/24/19 around 9pm and asked if anything happened on her shift because client #2's hand was red and swollen	V 367		

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V 367	Continued From page 5 During interview on 7/23/19 staff #2 reported: - on 6/24/19 she went to get client #2 up to use the restroom around 8:30pm/9p...he said no...no...ma...ma..hurt and pointed to his hand. His left ring finger near the pinky was swollen...she asked client #2 what happened and he said "fell" called "[staff #1]'s" name...she immediately contacted the QP. She explained to the QP client #2's hand was swollen... During interview on 7/23/19 an anonymous staff reported: - they were informed client #2 fell coming down the hallway - staff #1 pulled a chair to client #2 from the kitchen table and took it down the hallway - staff #1 told client #2 to pull himself up on the chair because he was not going to hurt her back - staff #1 & staff #7 assisted him up During interview on 8/13/19 staff #7 reported: - she was in the kitchen preparing lunch for the clients - she did not see what happened - she did help staff #1 pick client #2 up off the floor During interview on 8/13/19 the QP reported: - the information provided in the 6/25/19 incident report and investigation was reported to her - she was not aware of any swelling to client #2's hand until the morning of 6/25/19 - he was taken to his primary physician at that time During interview on 8/13/19 the Licensee reported: - she questioned staff about the 6/24/19	V 367		

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V 367	Continued From page 6 incident - she was informed client #2 did not fall to the floor - she was unsure if the injury had occurred at the client's prom held a few days earlier (6/21/19)	V 367		

Definition

Critical Incident is defined as a stress experienced by a client, employee, or stakeholder due to an event, which overwhelms the individual's normal coping mechanism, rendering the person ineffectual. Some examples of critical incidents include abuse and neglect, death of a client, attempted suicide or suicide, injury/illness, sexual assault, mental health crisis, drug/alcohol overdose, medication errors, use of seclusion and restraint, aggressive/violent behaviors, sentinel events, use or possession of weapons, elopement or wandering, vehicular accidents, biohazard accidents, use or possession of illicit or licit substances, fire/explosion with injuries or significant damage, natural disasters, infectious diseases/control, communicable diseases, and any other designated emergencies.

PROCEDURE:

1. When the incident occurs, the individual discovering the incident will:

   a. Notify the Supervisor/Administrator immediately with observations or identification of the incident.

   b. Follow-up with client and/or client's physician if indicated by the Supervisor/Administrator.

   c. Maintain the confidentiality of the information.

   d. Completion of an incident report form by the staff involved in the incident within twenty-four (24) hours of the incident.

The procedure/form will be completed as follows:

a. Complete date and time of Incident

b. Indicate name of clients(s) involved

c. Indicate type of Incident with check mark

d. Location of Incident

e. Description of Incident/Injury in narrative form

f. Witnesses to Incident

g. Medication taken within the last eight (8) hours

h. Nature of injury to employee (if applicable)

i. Nature of injury to client (if applicable)

j. Was employee or client seen by a Physician

k. Person(s) notified, time of notification and by whom

l. Follow-up notification requested

m. Reporting Individual will sign and date report

n. Parent, guardian, next of kin, and Bureau of Licensing will be notified immediately

o. The client will be protected from staff member(s) if incident includes suspect of agency staff members.

2. The Supervisor/Administrator and the reporting staff member will review and sign the Incident Report Form and follow-up with the client or his or her legal representative for a debriefing within (48) hours. Remedial education may be required to prevent repeated incidents.

3. The Supervisor/Administrator shall file the Incident Report in the QA binder and forward the incident and any other information to the Administrator or Board of Directors.

4. The Administrator will review the Incident Reports and conduct follow-up as indicated.

5. A summary of the Incident Reports should go to the Owners who will review the report recommendations and make any adjustments necessary to prevent the issue from recurring in the future.

6. An annual Quality Assurance report regarding Critical Incidents will be written to address: causes, trends, actions taken, performance improvements, education and training of personnel, prevention recurrence, and internal and external reporting requirements.

REFERENCES: