STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL024-105	A. BUILDING: _____ B. WING _____	12/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS AVENUE GROUP HOME	711 DAVIS AVENUE WHITEVILLE, NC 28472

(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 December 18, 2019. The complaint was unsubstantiated (Intake #NC00158793). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Developmentally Disabled Minors.	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 to protect residents from harm while the	V 132		

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V 132	Continued From page 1 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: Review on 12/18/19 of facility records revealed no documentation the HCPR was notified of an allegation of abuse against staff #1 on 11/25/19. See Tag V367 for specifics. During interview on 12/18/19 the Qualified Professional revealed: -He did not report staff #1 to the HCPR because client #3 stated he had lied about the incident.	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 2 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	V 367		

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V 367	Continued From page 3 (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 4 Based on record reviews and interview the facility failed to ensure critical incident reports were submitted to the Local Management Entity (LME) within 72 hours as required. The findings are. Review on 12/18/19 of the North Carolina Incident Response Improvement System (IRIS) revealed: -An incident dated 11/25/19 of an allegation of abuse from staff but was not submitted to the LME until 12/03/19. -LME representative responded to the report and revealed, "For future reporting, please note that incidents must be reported and submitted in IRIS within 72 hours of notification. [LME] does track timely submission of incident reports." Review on 12/18/19 of the North Carolina Incident Response Improvement report dated 12/18/19 revealed: -"Client (client #3) went to school on Monday morning and reported to his teacher that he was hit by staff at the group home with a belt. The school contacted the office to speak with staff concerning the incident. When interviewed client reported that staff hit him with the belt. Then he changed his story and said 'He put the bruises on himself by balding his fist up and started hitting and punching himself in the back of the leg, because he was upset that worker took his cookies from him.' He demonstrated how he bald his fist up and how he was beating the back of his leg with his fist. The worker was brought in the office to give his statement about the accusation. QP (Qualified Professional) asked worker to give his side of the story worker stated 'that he had client to clean his room because it was dirty and it was time to clean client's room. Worker took apart clients bed so he can get the trash under his bed, he also had client to fold his clothes and put the clothes back in his drawers. Worker also	V 367		

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V 367	Continued From page 5 found a bag it was full of cookies client had stolen. Worker asked client why did he steal the cookies he stated he didn't know. So the worker instructed client to finish cleaning his room. Client did not inform the other worker that he was hit with a belt by staff. Group home manager stated that she was not aware of what took place because client did not report it to her. The next morning while client was getting dressed for school group home manager saw client hitting and kicking himself in the back of the legs before going to school when he thought no one was watching. Other staff at the group home also reported that they have witnessed client hitting himself (kicking and punching himself) when he doesn't get his way or when he gets caught lying or stealing. Client has a history of self inflicted behaviors." During interview on 12/18/19 client #3 revealed: -He made the story up because he was mad. -He missed staff #1. -All the staff at the facility were nice to him. -He hit himself with his hands. During interview on 12/18/19 the Regional Manager revealed: -She completed the incident reports and internal investigations. -The incident report had not been completed and finalized.	V 367		