STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-157	A. BUILDING: _____ B. WING _____	C 06/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE 2	510 CRISSY DRIVE JACKSONVILLE, NC 28541

(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 June 9, 2020. The complaint was unsubstantiated (Intake #NC00164348). 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		
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 missing or incomplete information. The provider	V 367		

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V 367	Continued From page 1 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 the definition of a level II or level III incident;	V 367		

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V 367	Continued From page 2 (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 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 5/30/20 of the North Carolina Incident Response Improvement System (IRIS) revealed the following incidents that were reported after the 72- hour time frame: -Date of Incident: 05/19/20 - Date Submitted: 05/24/20. -"[Client #1] arrived at the [local] gas station the attendant saw him and called 911. Staff was outside with [Client #1] constantly encouraging him to get in the vehicle with staff or to walk back home. [Client #1] declined repeatedly to return back home. At this point 10 [local law enforcement] deputies arrived and surrounded the store. The deputies attempted to reason with [Client #1] to return home with staff or he would go downtown in the back of the deputies car. [Client #1] advised the [local law enforcement]	V 367		

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that he was going to kill himself. The [local law enforcement] called for an EMS. EMS arrived and got all of [Client #1's] information and contact information from the staff. The EMS advised that staff was unable to accompany [Client #1] to the hospital due to Covid policies in place to protect all. [Client #1] was transported to [community hospital]."
-Notes from LME - "For future reporting, please note that incidents must be reported and submitted in IRIS within 72 hours of notification, as [LME] does track timely submission of Incident Reports in accordance with the NC Administrative Code."

-Date of incident: 5/14/20 - Date submitted: 05/18/20.
-"[Client #1] then went out the front door and began walking down the street with his pants halfway on. Staff 1 followed [Client #1] contacting staff 3 advising of the situation ...Staff 3 walked alongside [Client #1] demonstrating the appropriate way to walk in the grass for his safety ...Staff 3 then went to the next parking lot [local gas station] to wait on [Client #1]. While waiting there [local law enforcement] pulled into the parking lot to approach [Client #1] due to him walking in the traffic ...The [local law enforcement] explained that he only had two options going in the back of his car with him or to the group home. [Client #1] got into the car with staff 3 and returned to the group home."

-Date of incident: 3/27/20 - Date submitted: 4/01/20.
-"[Client #1] became upset and eloped from the Residential Facility. Staff #1 attempted to follow [Client #1] and encourage him to return but he yelled 'f-k no' and continued to walk down the street. Staff #2 then began to walk down the

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street to ensure his safety. Staff pulled up next yo [Client #1] pleading with him to return back to the home and [Client #1] said 'no'. While staff #2 continued encouraging [Client #1] to return home, he began to masturbate walking towards the staff's car in the middle of the street. Staff explained to [Client #1] that his actions will bring consequences being out in public performing such acts."
-Notes from LME - "For future reporting, please note that incidents must be reported and submitted in IRIS within 72 hours of notification, as [LME] does track timely submission of Incident Reports in accordance with the NC Administrative Code."

-Date of incident: 10/25/20 - Date submitted: 10/30/20.
-"Staff #1 heard [Client #1] moaning and went into [Client #1's] room during his fifteen-minute check and noticed that [Client #1] was calling Staff #2's name. When Staff #1 entered [Client #1's] room he discovered [Client #1] had mucus coming from his nose. Staff #1 thoroughly cleaned [Clint #1's] face and then contacted the on-call supervisor to inform them of the situation at hand. Once Staff #1 cleaned [Client #1's] face he began to awake and inquired the location of staff #2. Staff #2 arrived at the Residential facility around 7:15am. Upon arrival of Staff #2 [Client #1] was showing signs that he was not feeling well. [Client #1] complained that he was having pain in his legs. Staff #3 arrived to assist Staff #2 with the completion of [Client #1's] Personal Care. At this point Staff noticed [Client #1's] breathing was becoming erratic, and his eyes began to glare over as staff was speaking to him. Staff #3 contacted Emergency Personnel. Staff #2 began to gather all pertinent information needed for Emergency Medical Services prior to their arrival.

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V 367	Continued From page 5 Staff #3 contacted the agency on call supervisor to notify her that Emergency Medical Services (EMS) was contacted to come to the Residential Facility to provide medical attention to [Client #1]. The agency On-call supervisor advised [Client #1's] guardian, [Client #1 parent] that EMS was contacted for [Client #1] to receive additional medical assistance as he was complaining of pain and as staff could see his breathing was labored, and his eyes were glared. Emergency Medical Services arrived at the Residential Facility at 8:50am and questioned Staff #2 and #3 regarding [Client #1's] medical history while three other EMS personnel checked [Client #1's] vital signs. They reported that his vital signs were good. EMS and The Fire Department Personnel proceeded to hoist [Client #1] up on the gurney and took him out of the home and loaded him onto the EMS vehicle." During interview on 6/08/20 the Administrator revealed: -Incident reports were being completed but she did not realize they had not been finalized until after the 72-hour period had past. -She would ensure the IRIS reports were completed as required. [This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.]	V 367		