Division of Health Service Regulation

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		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Helen D. Judd TITLE CEO/OWNER (X6) DATE 06/24/2020

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GUARDIAN CARE 2	**510 CRISSY DRIVE** **JACKSONVILLE, NC 28541**

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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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V 367	Continued From page 3	V 367		

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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V 367	Continued From page 4 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.	V 367		

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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		

123 HENDERSON DRIVE JACKSONVILLE, NC 28540 PH: 910-939-4663 FAX: 910-939-5079

Response to Complaint Survey completed June 09, 2020

Guardian Care 2, 510 Crissy Drive, Jacksonville, NC 28541

MHL #067-157

Email Address: spiritofexcellence.nc@gmail.com

Intake #NC 00164348

Re-cited standard level deficiencies.

(1) 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 deputy's car. [Client #1] advised the [local law enforcement]. 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]."
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-Date of incident: 5/14/20 - Date submitted: 05/18/20.

(2)-"[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 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.

(3)-"[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 (Continued From page 4 V 367) street to ensure his safety. Staff pulled up next to [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."
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-"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 [Client #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 remainder 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. Continued From page 5 V 367. 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 06/08/20, the Administrator revealed: -Incident reports were being completed but she did not realize they had not been finalized until after the 72-hour period has passed.

-She would ensure the IRIS reports were completed as required moving forward,
completed as required.

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RESPONSE

[This deficiency constitutes a re-cited deficiency and must be corrected within 30 Days]

Spirit of Excellence Community Outreach, Inc. Response to Complaint Survey completed on June 09, 2020.

1. Re-cited standard level deficiency will be corrected within 30 days from the exit of the survey which is July 09, 2020 in the following ways:

A.) Assistant Director and Administrative staff will ensure all Residential Level IV, IDD Staff, Innovations Staff, and anyone providing Direct Care Services receives an Incident Reporting Training Refresher. This refresher will be facilitated by the Qualified Professional. Each participant will receive a copy of the current IRIS Technical Manual from the North Carolina Incident Response Improvement System from (irisdhhs.state.nc.us).

B.)The Agency Incident Reporting policy will also be reviewed Annually and as often as there are changes to the Policy and Procedures, and NC Administrative rules and codes.

C.) Assistant Director and Office Manager will ensure that all Level II and Level III Incident reports are entered into the North Carolina Incident Response Improvement System prior to the 72-hour deadline of them becoming aware of the incident. Staff training will continue bi-annually to ensure all staff is aware on how to effectively enter an Incident Report in IRIS to include the individual entering the incident report being able to navigate through all of the tabs, to include the Supervisor Actions, and effectively finishing the incident report. The Residential IV staff will also monitor the entries of the Level II and III IN iris to ensure they entered prior to the 72-hour time frame.

D.) The accuracy of the monitoring of the Level II and Level III will take place as frequently as the Incident Reports occur.

E.) The Incident Reporting Policy and Procedure will be reviewed Quarterly by the Office Manager to ensure there were not any updates to any **NC Health and**

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Human Services Rules, or Administrative Rules that have been redacted that were missed from being added to our agency Policy and Procedures.

F.) All Policy and Procedure checks will be added as scheduled updates on our agency calendar so they will remain on schedule and not be forgotten. Any new information will be provided to our staff, consumers, and stakeholders in the form of a training in a classroom setting, or virtually via Zoom.

G.) Those scheduled updates will also be emailed to essential staff so they will Be aware of the upcoming dates as well.

H.) Updated information for training will be searched for on a Quarterly basis by our Quality Management Team and Office Manager.

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

June 15, 2020

Tomeica Taylor, Administrator
Spirit of Excellence Community Outreach, Inc.
123 Henderson Drive
Jacksonville, NC 28540

Re: Complaint Survey completed June 9, 2020
Guardian Care 2, 510 Crissy Drive, Jacksonville, NC 28451
MHL # 067-157
E-mail Address: spiritofexcellence.nc@gmail.com
Intake #NC00164348

Dear Ms. Taylor:

Thank you for the cooperation and courtesy extended during the complaint survey completed June 9, 2020. The complaint was unsubstantiated.

Additional deficiencies were cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Re-cited standard level deficiency.

Time Frames for Compliance

- Re-cited standard level deficiency must be ***corrected*** within 30 days from the exit of the survey, which is July 9, 2020.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records.
Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.