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	MHL091-060	A. BUILDING: _____ B. WING _____	R-C 12/22/2020

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed December 22, 2020. The complaint was unsubstantiated Intake #NC00171156. 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 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal	V 366		

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regulations in 42 CFR Part 483 Subpart I.
(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:
(1) immediately securing the client record by:
(A) obtaining the client record;
(B) making a photocopy;
(C) certifying the copy's completeness; and
(D) transferring the copy to an internal review team;
(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:
(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;
(B) gather other information needed;
(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and
(D) issue a final written report signed by the owner within three months of the incident. The

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V 366	Continued From page 2 final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interview the facility failed to implement their policy for one of two audited clients (#5). The findings are: Review on 12/22/20 of the facility's Incident Reporting Policy revealed "...in determining	V 366		

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V 366	Continued From page 3 whether an incident was handled in a responsible manner, the following questionings should be asked: - was good clinical practice exercised? - were any rights of the individual violated or was a violation alleged? - was the situation handled as well as possible? - was safety an issue? Types of incidents to report...individual injury or threat of harm or injury...allegation of abuse, neglect...Procedures...The Residential Manager will...review the report carefully...the person who completed the report make revisions or redo the form entirely...should an incident require further investigation or follow up..." Review on 12/16/20 of client #5 record revealed: - admitted 1/7/11 - diagnoses of Moderate Intellectual Developmental Disability, Depression with psychosis and Seizure Disorder Review of an incident report dated 10/24/20 for client #5 revealed: - "stuffed plastic bag down her throat and paper. Disoriented, unable to identify simple items/objects, lethargic...asked about wanting to see her mom as she often does...said her stomach hurt..started spitting up. Picking up things she normally would not touch. Layer on clothes then get naked, walking around in her room put on one item and pull it off...tried to leave her room naked...continuously getting on her knees...room in disarray..." - no further investigation after information was received that alleged client #4 inappropriately touched client #5 Review on 12/16/20 of a medical discharge for	V 366		

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V 366	Continued From page 4 client #5 revealed: - "10/25/20...chief complaint: abnormal behavior...patient is continually grabbing and rubbing her crotch... you have been diagnosed with Gardnerella vaginitis...this is an infection caused by bacteria. Some symptoms are vaginal itching or pain, painful urination and abnormal vaginal discharge that sometimes smell bad..." During interview on 12/10/20 all verbal clients denied being inappropriately touched while at the facility with the exception of client #5, who had been discharged. Client #4's mental health status made it difficult for her to be interviewed During interview on 12/10/20 the House Manager (HM) reported: - client #5 had a behavior in October 2020 - this was the first time since she was admitted to the facility - she thought it was due to the pandemic - client #5 had not seen her mother - the program was closed and clients could not get out like they used to - client #5 took a nap on 10/24/20 and when she awoke didn't know anyone - she contacted client #5's mom who took her to the hospital - mom contacted her and informed her there were no findings - no clients have complained to her about being inappropriately touched - clients are not allowed to go in each other bedrooms During interview on 12/15/20 the Executive Director reported: - client #5 had a behavior episode on October 24 - she tried to put a sock over her head...tried to	V 366		

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swallow plastic
- she was taken to the hospital for medication adjustment
- the next day her behaviors did not improve and she was taken to the hospital
- client #5's mom was contacted
- client #5's mother told the HM client #5 alleged client #4 inappropriately touched her
- mom said client #5 had a sexually transmitted disease
- she promised to meet the HM to show her the medical documentation
- client #5's mom did not show up
- she did not complete an internal investigation
- the HM might have completed an investigation
- she will send the incident report with documentation

During an attempted interview on 12/21/20 with client #5 revealed:
- client #5 was excited about a movie she watched
- she attempted to explain the movie
- she said she took her medicine...no seizures

During interview on 12/21/20 client #5's mother reported:
- on Oct 24, 2020 she received a call from the facility that client #5 had a behavior
- client #5 repeated the months October, November and December
- she didn't know her name, birthdate and didn't know her (mother)
- she took her to the hospital & then home with her
- on October 25, 2020 she got up and tore up the bathroom and her brother's bedroom.
- client #5 would put her hands down her pants and call client #4's name

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V 366	Continued From page 6 - She called and spoke with HM about client #5's allegations - she also explained to HM the physician had concerns about proper hygiene for client #5 - the HM said she could not speak for other staff but client #5 was bathed and cared for when in her care	V 366		