STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL042-076	A. BUILDING: _____ B. WING _____	08/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMECARE MANAGEMENT CORPORATION	1165 GREGORY DRIVE, SUITE A ROANOKE RAPIDS, NC 27870

(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 An annual and complaint survey was completed on August 13, 2021. The complaints were substantiated (intake #NC00180027) and unsubstantiated (intake #NC00179578). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5400 Day Activity for Individuals of all Disability Groups.	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.	V 367		

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V 367	Continued From page 1 (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 (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;	V 367		

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V 367	Continued From page 2 (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: Based on record review and interview, the facility failed to ensure a Level II incident report was completed within 72 hours affecting one of three audited clients (#1). The findings are: Record review on 8/3/21 of Client #1's record revealed: - Admission date of 7/5/20. - Diagnoses: Attention-Deficit Hyperactivity Disorder, Moderate Intellectual Disabilities, Seizure Disorder, Lennox-Gastaut Syndrome, intractable without statuepile epilepticus, SLE (Systemic Lupus Erythematosus) and Vitamin D Deficiency -No documentation of bruises or incident reporting to the Incident Response Information System (IRIS)	V 367		

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V 367	Continued From page 3 Record review on 8/3/21 of facility records revealed: - No documentation of bruises or incident reporting to the Incident Response Information System (IRIS) Review on 8/13/21 of handwritten notes provided by the Staff #1/Clincal Supervisor/Qualified Professional (Staff #1/CS/QP) revealed: - The facility had two handwritten pages of notes of documented bruises observed on Client #1 - "May 13, 2021 Staff [#3] called [Staff #1/CS/QP] into restroom due to observing a purple bruise on client's [initials of Client #1] right leg. Staff stated she noticed while assisting client with toileting. [Staff #1/CS/QP] interviewed client in the office. Client is not completely verbal but state in phrases that '[Person #1] hit her' and 'pushed me on the bed'. [Person #1] is another client who resides in Alternatative Family Living (AFL) home." - Separate entry with no date: "Day Support staff observed purple bruise on client left arm (lower) that was covered by one gold bracelet. [Staff #1/CS/QP] spoke with client private, but was not able to determine the cause of the bruise." - "6/22/21 [Staff #1/CS/QP] was called into restroom due to Day Support Staff noticing a purple bruise on client's buttocks and leg. Bruise was discovered as staff was assisting client with toileting at the day program. [Staff #1/CS/QP] was not able to determine from client the cause of the bruises. Staff expressed concern. [Staff #1/CS/QP] informed staff that bruises are being documented and [Staff #1/CS/QP] will continue to monitor and document further bruises or changes."	V 367		

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V 367	Continued From page 4 Interview on 8/13/21 the Staff #1/CS/QP reported: - She did not complete an incident report for Client #1's suspected abuse - She was responsible for submitting the IRIS report - She hesitated to report without investigating the cause of the bruises Interview on 8/13/21 the Department of Social Services Social Worker reported: - An Adult Protective Services investigation was conducted regarding bruises found on Client #1 - "[Person #1] was not identified as a client" in the Alternative Family Living Home	V 367		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy	V 500		

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V 500	Continued From page 5 that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention.	V 500		

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V 500	Continued From page 6	V 500		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the governing body failed to report an allegation of abuse to the Department of Social Services (DSS) affecting one of three audited clients (#1). The findings are:

Review on 8/3/21 of Client #1's record revealed:
- Admission date of 7/5/20.
- Diagnoses of Attention-Deficit Hyperactivity Disorder, Moderate Intellectual Disabilities, Seizure Disorder, Lennox-Gastaut Syndrome, intractable without statuepile epileptics, SLE (Systemic Lupus Erythematosus) and Vitamin D Deficiency
- There was no documentation that the facility had reported the allegations of abuse to DSS.

Review on 8/3/21 of Staff #1/Clinical Supervisor/Qualified Professional (Staff #1/CS/QP)'s personnel file revealed:
- Hired: 2/24/20

Review on 8/13/21 of handwritten notes provided by the Staff #1/CS/QP revealed:
- The facility had two handwritten pages of notes of documented bruises observed on Client #1
- "May 13, 2021 Staff [#3] called [Staff #1/CS/QP] into restroom due to observing a purple bruise on client's [initals of Client #1] right leg. Staff stated she noticed while assisting client with toileting. [Staff #1/CS/QP] interviewed client in the office. Client is not completely verbal but state in phrases that '[Person #1] hit her' and 'pushed me on the bed'. [Person #1] is another client who resides in the Adult Family Living (AFL)

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V 500	Continued From page 7 home." - Separate entry with no date: "Day Support staff observed purple bruise on client left arm (lower) that was covered by one gold bracelet. [Staff #1/CS/QP] spoke with client private, but was not able to determine the cause of the bruise." - "6/22/21 [Staff #1/CS/QP] was called into restroom due to Day Support Staff noticing a purple bruise on client's buttocks and leg. Bruise was discovered as staff was assisting client with toileting at the day program. [Staff #1/CS/QP] was not able to determine from client the cause of the bruises. Staff expressed concern. [Staff #1/CS/QP] informed staff that bruises are being documented and [Staff #1/CS/QP] will continue to monitor and document further bruises or changes." Interview on 8/13/21 the DSS Social Worker reported: - An Adult Protective Services investigation was conducted regarding bruises found on Client #1 - "[Person #1] was not identified as a client" in the Alternative Family Living Home Interview on 8/13/21 the Staff #1/CS/QP reported: - She was keeping a handwritten log of observed bruises on Client #1 to investigate herself - She confirmed the agency failed to report the allegations of abuse to DSS.	V 500		