STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-156	A. BUILDING: _____ B. WING _____	09/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HINKLE HOUSE AT BETHABARA	2030 CLYDE HAYES DRIVE WINSTON SALEM, NC 27106

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 9/21/21. The complaint was substantiated (intake #NC00181118). Deficiencies were 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 regulations in 42 CFR Part 483 Subpart I.	V 366		

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V 366	Continued From page 1 (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 final report shall be sent to the LME in whose	V 366		

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V 366	Continued From page 2 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 reviews and interviews the facility failed to implement written policies governing their response to level 1 incidents. The findings are: Interview on 9/15/21 with client #4 revealed: - She fell out of her bed around 4:00 am on	V 366		

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V 366	Continued From page 3	V 366		

9/1/21.
- After she fell out of bed, she sat in her rocking chair and then went back to bed.
- She did not call out for help when she fell out of bed.
- On 9/1/21, Staff #1 was on shift and she did not tell staff #1 that she fell out of bed until later in the morning. She told staff #1 her upper and lower back hurt and was given her PRN (as needed) pain medication.
- She was taken to the doctor and the doctor reported she had no injuries.
- "Now I have rails on my bed and now I feel safer."

Interview on 9/16/21 with staff #1 revealed:
- Client #4 told her on 9/1/21 at around 5:30 am that she fell out of the bed during the night.
- Client #4 told her the fall scared her, but she was not hurting.
- When client #4 returned from her day program on 9/3/21 client #4 reported her shoulder hurt and asked for her ibuprofen. On 9/3/21 client 4's primary care physician's (PCP) office was contacted, and an appointment was made for 9/8/21
- Client #4's PCP reported that client #4 had no injuries.
- She was unable to provide an incident report.

Review on 9/15/21 of Level 1 incident reports revealed:
- There was not an incident report regarding client #4 falling out of her bed.

Interview on 9/16/21 with the Qualified Professional revealed:
- Staff had not completed an incident report regarding client #4 falling out of her bed.
- An incident report was not completed because

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V 366	Continued From page 4 she was not sure client #4 fell out of the bed.	V 366		
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 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	V 367		

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V 367	Continued From page 5 (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; (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	V 367		

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V 367	Continued From page 6 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 interviews the facility failed to report all Level II incidents that occurred during the provision of billable services to the LME (Local Management Entity) within 72 hours of becoming aware of the incident. The findings are: Review on 9/15/21 of Level 1 incident reports revealed: - "Entered by: [The Qualified Professional] on 3/11/21 4:26 pm." - "Event date: 3/10/2021" - "Describe what happened before the event: Resident (client #2) had finished folding her clothes. After putting them away, she went to sit on the edge of the bed. She was trying to reach across the bed and fell backwards. Hitting her head on her dresser." - "Summary: [Client #4 was taken to the hospital. During the visit she stated that many area were hurting. 3 sets of xrays was taken during the visit. The doctor stated the only thing he saw was congestion in her chest. He asked that a follow up appointment be made with her primary doctor." Review on 9/15/21 of "After Visit Summary"	V 367		

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V 367	Continued From page 7 revealed: - Patient: "[Client #2]" - Date: 3/11/21 - "Today's Visit: You saw [Physician Assistant] on Thursday March 11, 2021. The following issue was addressed: Closed displaced fracture of body of right scapula, initial encounter." Review on 9/21/21 of the Incident Response Improvement System (IRIS) revealed: - There was no IRIS report of the 3/10/21 incident that pertained to client #2's fall. Interview on 9/21/21 with the Qualified Professional revealed: - She was unable to provide a completed IRIS report regarding client #2's fall on 3/10/21. - She thought the IRIS report regarding client #2's fall on 3/10/21 was in IRIS.	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to be maintained in a safe, clean, attractive, and orderly manner. The findings are: Observations from approximately 2:50 pm- 3:32	V 736		

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V 736	Continued From page 8 pm on 9/21/22 of the facility revealed: - An outlet in the middle of the den floor did not have a cover. The outlet was covered with cardboard box material that was taped down to the floor. - The inside of the microwave had rust. - The lights above the sink in the hall bathroom (right side) did not work. When the switch was turned on the lights would flash and then go out. Interview on 9/21/21 with the Qualified Professional revealed: - She had reported the lights did not work in the bathroom to the maintenance worker. The maintenance worker told her that it was due to a switch on the wall. - The den had cardboard taped over an outlet in the middle of the floor because "it is missing an outlet cover." - The microwave did not work, and the group home only used the lights and fan on the microwave.	V 736		
V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit. This Rule is not met as evidenced by: Based on observations and interviews, the facility	V 752		

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V 752	Continued From page 9 failed to maintain the hot water temperature between 100-116 degrees Fahrenheit. The findings are: Observations from approximately 2:50 pm- 3:32 pm on 9/21/22 of the facility revealed: - The kitchen sink water temperature was approximately 95. - The bathroom sinks had a water temperature of approximately 94 degrees. Interview on 9/21/21 with the Qualified Professional revealed: - She checked the kitchen sink temperature, and she reported a water temperature of 95.5. - She checked the water temperature of the bathrooms and the temperature ranged from 95-95.9 degrees. - She had checked the water temperature last week and it was 95 degrees.	V 752		