

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL023-158	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/03/2022
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NAME OF PROVIDER OR SUPPLIER CARING WAY 104	STREET ADDRESS, CITY, STATE, ZIP CODE 104 CARING WAY SHELBY, NC 28150
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(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	<p>INITIAL COMMENTS</p> <p>A complaint survey was completed on June 3, 2022. The complaint was unsubstantiated (Intake #NC 00187495). Deficiencies were cited.</p> <p>The facility is licensed for the following service category: 10A NCAC 27G 5600C Supervised Living for Adults with Developmental Disability.</p> <p>The facility is licensed for 4 and currently has a census of 3. The survey sample consisted of audits of 1 deceased client.</p>	V 000		
V 367	<p>27G .0604 Incident Reporting Requirements</p> <p>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(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:</p> <ol style="list-style-type: none"> (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 	V 367		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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V 367	<p>Continued From page 1</p> <p>(6) other individuals or authorities notified or responding.</p> <p>(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:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(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).</p> <p>(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:</p>	V 367		

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V 367	<p>Continued From page 2</p> <p>(1) medication errors that do not meet the definition of a level II or level III incident;</p> <p>(2) restrictive interventions that do not meet the definition of a level II or level III incident;</p> <p>(3) searches of a client or his living area;</p> <p>(4) seizures of client property or property in the possession of a client;</p> <p>(5) the total number of level II and level III incidents that occurred; and</p> <p>(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.</p> <p>This Rule is not met as evidenced by: The facility failed to report a level II incident during the provision of services. The findings are:</p> <p>Review on 6-2-22 of Deceased Client #1's(DC #1) record revealed: -DC #1 was transported via Emergency Medical Services (EMS) and admitted to the hospital on 8-7-21 due to a choking incident. -DC #1 was treated at the hospital for an occluded airway and seizure. -DC #1 was discharged from the hospital on 8-12-21. -Date of Death for DC#1 was 3-24-22.</p> <p>Review on 6-2-22 of North Carolina Incident Response Improvement System (IRIS) revealed:</p>	V 367		

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V 367	<p>Continued From page 3</p> <p>-No incident reports for DC #1 from his hospitalization in August 2021.</p> <p>Interview on 6-2-22 the Qualified Professional (QP) revealed:</p> <ul style="list-style-type: none"> -The Director of Operations was ultimately responsible for completing incident reports. -"I usually do all the IRIS reports." -"I thought we would have done one when he went to the Emergency Room, but we always debated." <p>Interview on 6-2-22 with the Director of Operations revealed:</p> <ul style="list-style-type: none"> -Felt that an IRIS report should have been done for DC #1's hospital visit in August 2021. -"We go back and forth with the different level incidents." -Either himself or the QP were responsible for submitting IRIS reports. -"Coordinator of Human Rights Committee, QP, and myself talk about the incident and determine if it is a level." -Was not sure if an IRIS report had been completed but knew an internal incident report had been done for DC #1's August 2021 hospital admittance. 	V 367		