Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ C B. WING MHL023-158 06/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 CARING WAY **CARING WAY 104** SHELBY, NC 28150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)**PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 A complaint survey was completed on June 3, 2022. The complaint was unsubstantiated (Intake #NC 00187495). Deficiencies were cited. The facility is licensed for the following service category: 10A NCAC 27G 5600C Supervised Living for Adults with Developmental Disability. The facility is licensed for 4 and currently has a census of 3. The survey sample consisted of audits of 1 deceased client. RECEIVED V 367 27G .0604 Incident Reporting Requirements V 367 JUN 2 4 2022 10A NCAC 27G .0604 INCIDENT **DHSR-MH Licensure Sect** 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: reporting provider contact and (1) 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

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

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Division of Health Service Regulation

MML023-158 MHL023-158 MHL023-158 MHL023-158 MHL023-158 STREET ADDRESS, CITY, STATE, ZIP CODE 104 CARING WAY 104 CARING WAY SHEBY, NC 28150 SUBMANY STATEMENT OF DEPCENCIES SHEBY, NC 28150 HERST TAG COntinued From page 1 (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 bas 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 submit and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incident reports to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. Casegory A providers shall send a copy of all level III incident reports to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. Casegory A providers shall send a copy of level min mediately, as required by 10 A NCAC 26C. 3300 and 10 A NCAC 27E. 0104(e)(8). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment are where services are provided. The report shall be submitted on a form provided by the Socretary wis electronic means and shall	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
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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		
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	definition of a level II of (2) restrictive in the definition of a level (3) searches of (4) seizures of of the possession of a cli (5) the total numincidents that occurred (6) a statement been no reportable incidents have occurred meet any of the criteria (a) and (d) of this Rule through (4) of this Para The facility failed to repduring the provision of Review on 6-2-22 of Defit (4) record revealed: -DC #1 was transported	errors that do not meet the or level III incident; terventions that do not meet I II or level III incident; a client or his living area; client property or property in ient; nber of level II and level III d; and indicating that there have cidents whenever no ed during the quarter that a as set forth in Paragraphs and Subparagraphs (1) agraph. See evidenced by: bort a level II incident services. The findings are: ecceased Client #1's(DC d via Emergency Medical limitted to the hospital on g incident. the hospital for an eizure.	V 367					
1	Review on 6-2-22 of No Response Improvemen	orth Carolina Incident t System (IRIS) revealed:						

Division of Health Service Regulation

STATE FORM

PRINTED: 06/16/2022 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ COMPLETED C B. WING MHL023-158 06/03/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 104 CARING WAY **CARING WAY 104** SHELBY, NC 28150 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 367 Continued From page 3 V 367 -No incident reports for DC #1 from his hospitalization in August 2021. Interview on 6-2-22 the Qualified Professional (QP) revealed: -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." Interview on 6-2-22 with the Director of Operations revealed: -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.

Division of Health Service Regulation

104 Caring Way

Shelby, NC

MHL #023-158

10A NCAC 27G .0604 Incident Reporting V367

Measures in place to correct the deficient area of practice: When an incident is reported QP/ Director will share the findings with management team and if it is determined based on Incident Reporting rules to be a Level 2 or 3 an IRIS report will be completed.

Measures in place to prevent the problem from occurring again: Each time an incident is reported QP's/ Director and management team will review report and determine what category the incident falls under per IRIS requirements. Any time a client receives treatment above first aid or is admitted to the hospital an IRIS report will be completed.

Who will monitor the situation to ensure it will not occur again?: Home Managers, QP, Director Management Team

How often will the monitoring take place?: As incidents are reported.

Division of Health Service Regulation Mental Health Licensure and Certification Section Rule Violation and Client/Staff Identifier List

Facility Name: Caring Way 105	MHL Number: 023-158
Exit Date:June 3, 2022	Surveyor(s): Benjamin Robinson and Maria Smith
EXIT PARTICIPANTS:_	Director of Operations
COVID NOTIFICATION: In the event a hours of a DHSR survey – the provider prevent possible continued exposures.	COVID positive case is identified within 48 or DHSR should notify the other entity to
Rule Violation/Tag #/Citation Level: 10A No Requirements for Category A and B Pro	CAC 27G .0604 Incident Reporting viders/V367/Standard
Rule Violation/Tag #/Citation Level:	
Client & Staff (Indicate staff title or num	Identifier List ber beside each name)
Deceased Client #1 Client #4	
Staff # <u>1</u> Staff # <u>Qualified Professional (OP)</u> Staff # <u>Director of Operations</u>	



ROY COOPER • Governor

KODY H. KINSLEY • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

June 17, 2022

Eddie Scruggs One on One Care Inc. 1137 East Marion Street, PMB 109 Shelby, NC 28150

Re: Complaint Survey completed June 3, 2022

Caring Way 104, 104 Caring Way, Shelby, NC 28150

MHL # 023-158

E-mail Address: escruggs@oneononecare.net

Intake #NC00187495

Dear Mr. Scruggs:

Thank you for the cooperation and courtesy extended during the Complaint survey completed June 3, 2022. The complaint was unsubstantiated.

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

All tags cited are standard level deficiencies.

Time Frames for Compliance

• Standard level deficiencies must be *corrected* within 60 days from the exit of the survey, which is August 2, 2022.

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.

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718
www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

June 17, 2022 Caring Way 104 One on One Care Inc.

- 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.*

Send the <u>original</u> completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section NC Division of Health Service Regulation 2718 Mail Service Center Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Lynn Grier at 336-247-1723.

Sincerely,

Benjamin Robinson

Benjamin Robinson

Facility Compliance Consultant I

Mental Health Licensure & Certification Section

Cc: QM@partnersbhm.org

Pam Pridgen, Administrative Supervisor