STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-158	A. BUILDING: _____ B. WING _____	C 06/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING WAY 104	104 CARING WAY SHELBY, NC 28150

(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 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.	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	V 367	RECEIVED JUN 24 2022 DHSR-MH Licensure Sect	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Edna Depp QP/Director TITLE: 6-20-22 (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CARING WAY 104	104 CARING WAY SHELBY, NC 28150

(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 367	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 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:	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING WAY 104	104 CARING WAY SHELBY, NC 28150

(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 367	Continued From page 2 (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 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: The facility failed to report a level II incident during the provision of services. The findings are: 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. Review on 6-2-22 of North Carolina Incident Response Improvement System (IRIS) revealed:	V 367		

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V 367	Continued From page 3 -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.	V 367		

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: [redacted] **Director of Operations**

COVID NOTIFICATION: In the event a COVID positive case is identified within 48 hours of a DHSR survey – the provider or DHSR should notify the other entity to prevent possible continued exposures.

Rule Violation/Tag #/Citation Level: **10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers/V367/Standard**

Rule Violation/Tag #/Citation Level: _____

Rule Violation/Tag #/Citation Level: _____

Rule Violation/Tag #/Citation Level: _____

Rule Violation/Tag #/Citation Level: _____

Client & Staff Identifier List
(Indicate staff title or number beside each name)

Deceased Client #1 [redacted]
Client #4 [redacted]

Staff #1 [redacted]
Staff #Qualified Professional (QP) [redacted]
Staff #Director of Operations [redacted]

CITATION LEVEL: Number of days from survey exit for citation correction
Standard = 60 days **Recite** – standard = 30 days **Type A** = 23 days **Type B** = 45 days
Uncorrected Type A or Type B Imposed = provider should provide written notification of intended correction date

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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.

- 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 original 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