STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL012-019	A. BUILDING: _____ B. WING _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCI-EMERGENT NEED RESPITE CENTER	101 POPLAR STREET MORGANTON, NC 28655

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V 000	INITIAL COMMENTS A complaint survey was completed on March 9, 2023. The complaint was substantiated (intake #NC00199245). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5100 Community Respite Services for Individuals of all Disability Groups. This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 1 current 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	V 367		

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V 367	Continued From page 1	V 367		

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
(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

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V 367	Continued From page 2 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 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. The findings are: Review on 3-8-23 of Client #1's record revealed: -Date of Admission: 11-30-2022. -Diagnoses: Autism Spectrum Disorder, Moderate Intellectual Developmental Disability, Intermittent Explosive Disorder, Anxiety Disorder, Major Depressive Disorder. Review on 3-8-23 of Facility Incident Report dated 2-27-23 revealed: -Client #1 was IVC'd on 2-26-23 due to self-injurious behaviors.	V 367		

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V 367	Continued From page 3 -Completed by Qualified Professional (QP) #1. Review on 3-7-23 of Incident Response Improvement System (IRIS) revealed: -Incident on 2-26-23 where Client #1 became upset and physically aggressive towards former staff #3 (FS #3). FS #3 was physically aggressive toward Client #1 in return. -Allegations of FS #3 were reported to Health Care Personnel Registry. -No information documented in IRIS regarding Client #1 being taken to the hospital and been involuntarily committed (IVC). Review on 3-9-23 of IRIS revealed: -New report had been entered on 3-9-23 for incident on 2-26-23 regarding Client #1's self-harm threatening behaviors and transport to the hospital resulting in the IVC. Interview on 3-8-23 with the Facility Administrator revealed: -Was aware that Client #1 had an incident on 2-26-23 where she got upset and assaulted FS #3. FS #3 assaulted Client #1 in return. -Was aware that Client #1 had been IVC'd. -In regards to IRIS reporting for the incident on 2-26-23, had a conversation with QP #1 and " ...I remember him saying the on-call QP needed to do something." Interview on 3-8-23 with the Qualified Professional #1 revealed: -Completed IRIS specifically for the staff assault against Client #1. -Client #1 was IVC'd on 2-26-23. -QP #2 was responsible for completing IRIS for the IVC. "I asked my boss." Interview on 3-8-23 with Staff #2 revealed:	V 367		

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V 367	Continued From page 4 -On 2-26-23 Client #1 became upset and broke a window. -Client #1 was threatening to harm herself. -After convincing Client #1 to give staff the piece of glass, Client #1 eloped from the facility and crossed the street before returning moments later. -Client #1 continued to make threats of self-harm. -Mobile Crisis was called but due to an extended time before they could respond, the police and EMS were called. -Client #1 went with EMS to the hospital. -It was not her responsibility to complete IRIS. Interview on 3-9-23 with the QP #2 revealed: -Was the on-call QP for the incident that occurred on 2-26-23. -The incident at the home had already occurred when contacted. -"EMS arrived when I was on the phone." (with the facility) -Client #1 was not initially going to be involuntarily committed. She was going to be kept overnight for evaluation. "We sat and talked for hours ...when they (nursing staff) came with scrubs, she declined and refused ...she became combative. They (hospital staff) decided to IVC her and I left at that point." -"I was not aware that I needed to do that (submit IRIS report). I am a newer QP." -"I did submit an email letting my supervisor and [QP #1] know what had happened. Since the next on-call QP would take over on Monday (the next day)." -"We did do a late entry IRIS report and that was submitted today (3-9-23)." Interview on 3-9-23 with the Quality Manager revealed: -The IRIS report on 2-26-23 should have had	V 367		

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V 367	Continued From page 5 more information. It really was one continuous event. -"It wasn't ideal. There were multiple people involved. It should have all been reported together. He (QP #1) only reported what he was a part of." -QP #1 didn't know much about the IVC. -A new IRIS report was completed today and it was referenced as additional information to the events of 2-26-23.	V 367		