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 |
|---|---|---|---|
| | MHL023012 | A. BUILDING: _____ B. WING _____ | C 06/30/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LADELL LANE GROUP HOME | 1116 LADELL LANE SHELBY, NC 28152 |

| (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 |
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| V 000 | INITIAL COMMENTS<br><br>A complaint survey was completed on June 30, 2023. The complaint was substantiated (Intake #NC00202819). A deficiency was cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.<br><br>This facility is licensed for 6 and currently has a census of 5. The survey sample consisted of audits of 1 current client. | V 000 | | |
| V 367 | 27G .0604 Incident Reporting Requirements<br><br>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS<br>(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:<br>(1) reporting provider contact and identification information;<br>(2) client identification information;<br>(3) type of incident;<br>(4) description of incident;<br>(5) status of the effort to determine the cause of the incident; and | V 367 | V367 27G Incident Reporting Requirements<br>Regional Director will ensure:<br>1) Currently the Regional Director and Consumer Advocate are providing QP supervision of Ladell Home until a new QP has been hired.<br>The Regional Director will train the staff on Incident Reporting Requirements to ensure that staff have knowledge of the standard. This training was completed shortly after 5/16/23 when the Regional Director was informed of the incident. | 5/24/23 |

RECEIVED
By Laura Bryant at 4:03 pm, Jul 20, 2023

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Barbra Massey TITLE Regional Director (X6) DATE 7/18/23

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| V 367 | Continued From page 1<br>(6) other individuals or authorities notified or responding.<br>(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:<br>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or<br>(2) the provider obtains information required on the incident form that was previously unavailable.<br>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:<br>(1) hospital records including confidential information;<br>(2) reports by other authorities; and<br>(3) the provider's response to the incident.<br>(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).<br>(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 | 2) When a new supervising "Q" is hired the "Q" will receive training regarding submission of Incident Reports and training on the Levels (I, II, III) of incidents.<br>3) All level II and III incidents will be reported to the CEO to ensure an Internal Investigation is completed regarding the incident. | On hire of the new "Q"<br>6/30/23 |

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| V 367 | Continued From page 2<br>(1) medication errors that do not meet the definition of a level II or level III incident;<br>(2) restrictive interventions that do not meet the definition of a level II or level III incident;<br>(3) searches of a client or his living area;<br>(4) seizures of client property or property in the possession of a client;<br>(5) the total number of level II and level III incidents that occurred; and<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure incidents were reported to the Local Management Entity (LME) for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are:<br><br>Review on 6-29-23 of the North Carolina Incident Response Improvement System (IRIS) revealed:<br>-Facility became aware of incident on 4-9-23.<br>-IRIS report was not completed until 5-16-23.<br><br>Review on 6-29-23 and 6-30-23 of the facility's internal documentation revealed:<br>-Staff #1 completed an internal "T-log" daily summary note on 4-9-23 of the incident. | V 367 | | |

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| V 367 | Continued From page 3<br>-The Qualified Professional (QP) was made aware of the incident that day.<br><br>Interview on 6-29-23 with Staff #1 revealed:<br>-Her immediate supervisor, the QP, had been contacted immediately.<br>-Completed electronic internal "T-log" summary note of incident.<br>-Completing IRIS reports were not a part of her responsibilities.<br>-Would have reported to the Regional Director had she known the QP had not reported it, even though that was outside the scope of her job responsibilities.<br><br>Interview on 6-29-23 with the Regional Director revealed:<br>-Had not been made aware of the incident until 5-16-23.<br>-The QP was responsible for completing the IRIS report.<br>-The QP "...didn't do an incident report..." nor had she made anyone else aware of the incident.<br>-Did not learn about the incident until after the QP had been let go from her employment. | V 367 | | |