NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
OF CONTLOTION	IDENTIFICATION NOWIDER.					
	MHL065-221	B. WING			⋜ 21/2023	
PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
OUSE			401			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETE DATE	
INITIAL COMMEN	TS	V 000				
category: 10A NCA	AC 27G .5600C Supervised					
census of 5. The s	survey sample consisted of					
27G .0604 Incident	Reporting Requirements	V 367				
REPORTING REQ CATEGORY A AND (a) Category A and level II incidents, exthe provision of bills consumer is on the incidents and level to whom the provid 90 days prior to the responsible for the services are provid becoming aware of be submitted on a fixed Secretary. The repin person, facsimile means. The report information: (1) reporting identification inform (2) client iden (3) type of ind (4)	UIREMENTS FOR D B PROVIDERS I B providers shall report all accept deaths, that occur during able services or while the providers premises or level III II deaths involving the clients or rendered any service within a incident to the LME catchment area where ed within 72 hours of the incident. The report shall form provided by the port may be submitted via mail, a or encrypted electronic a shall include the following provider contact and nation; antification information; cident; on of incident;					
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETTE DUSE) INITIAL COMMENTA An annual, complain completed on Septimas cited. This facility is license category: 10A NCA Living for Adults with the services are provided to whom the provision of billiconsumer is on the incidents and level to whom the provided you days prior to the responsible for the services are provided becoming aware of the services are provided becoming a service and the services are provided	MHL065-221 PROVIDER OR SUPPLIER STREET AD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An annual, complaint, and follow up survey was completed on September 21, 2023. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 6 and currently has a census of 5. The survey sample consisted of audits of 3 current clients. 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	MHL065-221 B. WING	OF CORRECTION MHL065-221 B. WING	OF CORRECTION DENTIFICATION NUMBER: B. WING	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

	of Health Service Re		1		1	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
					,	۲
MHL065-221		B. WING			21/2023	
		WITTE003-22 T			03/2	1/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
KEDD III	21105	514 OLIVI	E STREET			
KERR H	JUSE	WILMING	TON, NC 28	401		
(X4) ID	SHMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
				DEFICIENCY)		
V 367	Continued From pa	ge 1	V 367			
	(6) other indiv	viduals or authorities notified				
	or responding.	riduals of additionales floatified				
		B providers shall explain any				
		ete information. The provider				
		ated report to all required				
		the end of the next business				
	day whenever:	the end of the flext business				
		er has reason to believe that				
		d 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.	dent form that was previously				
		B providers shall submit,				
		E LME, other information				
		the incident, including:				
		ecords including confidential				
	information;	Journal Indiading Commonition				
		other authorities; and				
		er'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					
		elopmental Disabilities and				
		Services within 72 hours of				
		the incident. Category A				
	O	d a copy of all level III				
		a client death to the Division of				
	•	ulation within 72 hours of				
		the incident. In cases of				
		even days of use of seclusion				
		vider shall report the death				
		uired by 10A NCAC 26C				
		AC 27E .0104(e)(18).				
		B providers shall send a				
		he LME responsible for the				
		ere services are provided.				
		submitted on a form provided				
		electronic means and shall				
		formation as follows:				

Division of Health Service Regulation STATE FORM

ORM P8UP11 If continuation sheet 2 of 4

STATEMENT OF DEFICIENCIES (X'AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		MHL065-221	B. WING		09/2	1/2023
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KERR HOUSE 514 OLIVE ST WILMINGTON				401		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 367	definition of a level (2) restrictive the definition of a le (3) searches (4) seizures of the possession of a (5) the total r incidents that occur (6) a statement been no reportable incidents have occur meet any of the crit	on errors that do not meet the II or level III incident; interventions that do not meet evel II or level III incident; of a client or his living area; of client property or property in a client; number of level II and level III rred; and ent indicating that there have incidents whenever no curred during the quarter that eria as set forth in Paragraphs calle and Subparagraphs (1)	V 367			
	failed to ensure crit submitted to the Lo within 72 hours as a Review on 9/20/23 Response Improve the following incide required timeDate of Incident: 8 8/31/23Health Care Perso Allegation Informati was reported by a fand stated that [formatical content of the content of	et as evidenced by: views and interview the facility ical incident reports were cal Management Entity (LME) required. The findings are. of the North Carolina Incident ment System (IRIS) revealed nt was not reported within the //19/23 - Date Submitted: onnel Registry (HCPR) Facility ion - Allegation Description: "It former/prn staff who called 911 mer staff #4] was working at n 8/19/23. Former worker/PRN				

Division of Health Service Regulation

STATE FORM P8UP11 If continuation sheet 3 of 4

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL065-221	B. WING			R 21/2023
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
KERR H	KERR HOUSE 514 OLIVE STREET WILMINGTON, NC 28401					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
V 367	[former staff #5]call [former staff #4] wa and that she also be has come to work a multiple times while -HCPR Facility Alleg reported to Local D on 8/20/23. Interview on 9/20/23 Administrator stated -Due to the completed iscussions about here.	ed 911 and expressed that is intoxicated while on Duty elieves that [former staff #4] at the RHA group home e under the influence." gation Information - Incident epartment of Social Services 3 and 9/21/23 the	V 367			

Division of Health Service Regulation

STATE FORM P8UP11 If continuation sheet 4 of 4