STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-417	A. BUILDING: ______ B. WING ______	R-C **09/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG HOME	**25 PINE KNOLL STREET ASHEVILLE, NC 28806**

(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 and follow up survey was completed on September 21, 2023. The complaint was substantiated (NC# 00205594). Deficiencies were cited. This facility is licensed for the following service category 10A NCAC 27G .5600F Supervised Living for Individuals of all Disability Groups/Alternate Family Living. This facility is licensed for 2 and currently has a census of 2. The survey sample consisted of an audit of 1 current client.	V 000		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals.	V 291		

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V 291	Continued From page 1 (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to coordinate medical care for 1 of 1 current client, #1. The findings are: Review on 9/20/23 of Client #1's record revealed: -Admission Date: 8/22/22. -Diagnoses: Spina Bifida, Chiari II Syndrome with R ventriculoperitoneal procedures, Epilepsy, Neurogenic GT and Bladder, Deaf in R ear, Vision Loss, R Hip Post-Op Dysplasia, Thermoregulatory Dysfunction, Syrinxes, Traumatic Brain Injury, Attention Deficit Hyperactivity Disorder (D/O), Intermittent Explosive D/O, Moderate Intellectual Developmental Disabilities, and Sensory Integration Dysfunction. -respite care: 6/30/23-7/9/23. Interview on 9/15/23 with Client #1's guardian revealed: -saw client 7/1/23 and 7/14/23; -took client to urgent care on 7/14/23 after she discovered blisters on client's feet (behind big toe) during a visit, "it looked like an open wound ...saw bloody discharge on her sock;" -Urgent Care wrapped her feet ...said they (feet) had been rubbed raw from shoes that don't fit well."	V 291		

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-Client #1 had been in respite care and was playing in a pool that had created a water blister.
-Client #1 doesn't have a lot of sensation in her feet and didn't complain.
-AFL staff didn't say anything to her about it and later reported the blisters happened at respite.

Interview on 9/20/23 with Client #1 revealed:
-the blisters have healed up on her feet.
-"they happened at [respite provider] home ...didn't know they were there till I looked down and saw them bleeding."
-feet were treated by the respite provider with band aids and medicine.
-guardian took her to the doctor and they wrapped her feet.

Interview on 9/20/23 with AFL Provider revealed:
-was gone from 6/29/23 to 7/9/23.
-when she came back from vacation, Client #1 had quarter size sores on her feet.
-put Neosporin and bandages on her feet to treat them.
-Client #1 walks on the sides of her feet and she wants to wear sandals.
-the guardian took Client #1 to Urgent Care and they gave her cream and bandages, "they weren't infected."
-did not complete an incident report.
-they (AFL providers) check Client #1's feet morning and evening now and log it in to the electronic record system.
-in the past had let Client #1 go out on the walkway in front of her house barefooted but has stopped doing this.

Interview on 9/21/23 with the Qualified Professional revealed:
-provided respite for Client #1 from 7/6/23-7/9/23;
-when Client #1 came to her house, she had the

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V 291	Continued From page 3 start of a blister on the top of her foot and a mark on the bottom of her foot that was healing; -after Client #1 played in a kiddie pool, it looked like the blister on her foot had popped; -she treated Client #1's blisters with bandages. -took Client #1 back to the AFL provider on 7/9/23 and told them to keep an eye on it. -the guardian took Client #1 to urgent care on 7/14/23 for medical treatment. -Urgent Care prescribed ointment. -in retrospect, she should have called the guardian regarding Client #1's feet. -the AFL provider is now checking Client #1's feet twice a day and logging it in the electronic record system.	V 291		
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;	V 367		

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(3) type of incident;
(4) description of incident;
(5) status of the effort to determine the 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

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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:
(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 review and interview, the facility failed to report all level II incidents within 72 hours as required to the Local Management Entity/Managed Care Organization as required.
The findings are:

Review on 9/15/23 of the North Carolina Incident Response Improvement System (IRIS) revealed:
-Level II incident dated 7/14/23 revealed: "client was taken to Urgent Care by her guardian upon her guardian noticing that the blisters on her feet were not healing appropriately ...She inspected

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the client's feet ...
Injury information: Blistering on top of both feet due to wearing shoes that do not fit correctly."
-date submitted: 7/31/23.

Interview on 9/15/23 with the guardian revealed:
-took client to urgent care on 7/14/23 for medical treatment after she discovered blisters on client's feet.
-Urgent Care wrapped her feet and prescribed ointment.

Interview on 9/20/23 with the AFL Provider revealed:
-was gone on vacation 6/29/23-7/9/23 and Client #1 was in respite.
-when she came back from vacation, Client #1 had "quarter size sores" on her feet.
-provided treatment for blisters with Neosporin and band aids.
-did not initially complete an incident report regarding Client #'s feet because it happened at respite.
-Client #1's guardian took her to urgent care, "she (guardian) was worried they were diabetic ulcers ...they were water blisters."
-"check her feet twice a day now."

Interview on 9/21/23 with the Qualified Professional revealed:
-provided respite from 7/6/23-7/9/23 and Client #1 developed blisters;
-took Client #1 back to the AFL on 7/9/23 and told them to keep an eye on it.
-didn't initially fill out an incident report regarding Client #1's blisters.
-Client #1 was taken for medical care by her guardian on 7/14/23 due to concern of how the blisters on her feet looked.
-they (Urgent Care) prescribed ointment.

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V 367	Continued From page 7 Review on 9/21/23 of facility's internal investigation revealed: -"late reporting for injuries to [Client #1]'s foot and delayed communication between AFL and Clinical supervisor." -"Systemic Measures: staff be reminded of requirement to report all injuries immediately ...and complete incident reports."	V 367		