STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL069-001	A. BUILDING: _____ B. WING _____	R 09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAMLICO COUNTY GROUP HOME	554 HIGHWAY 306 NORTH GRANTSBORO, NC 28529

(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 29, 2023. The complaint was unsubstantiated (intake #NC00207402). 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 5 and has a census of 5. 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 ensure an incident report was submitted to the Local Management Entity (LME)/Managed Care Organization (MCO) within 72 hours as required. The findings are: Review on 09/7/23 of the North Carolina Incident Response Improvement System (IRIS) for September 1, 2023 thru September 29, 2023 revealed no level II report submitted by the facility. Review on 09/27/23 of client #3's record revealed: - 18 year old male.	V 367		

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V 367	Continued From page 3 - Admission date of 06/08/2023. - Diagnoses of Disruptive Dysregulation Disorder, Autism Spectrum Disorder, Mild Intellectual Developmental Disability, Attention Deficit Hyperactivity Disorder-Combined Type and Unspecified Anxiety Disorder. Review on 09/27/23 of a local sheriff office report for client #3 revealed: - "On September 11, 2023, at approximately 11:53 pm [Sergeant Name] was dispatched to 554 NC Hwy (highway) 306 North residence of Mr. [Client #3]. The call was in reference to a citizen assist. [Sergeant Name] was driving his marked patrol vehicle, wearing his issued uniform, and equipped with his watchguard body worn camera. Camera was active during this call for service. [Sergeant Name] arrived on scene and met with Mr. [Client #3's Father]. [Client #3's Father] informed [Sergeant Name] that his son Mr. [Client #3] who lives at 554 NC 306 North group home. Mr. [Client #3's Father] informed [Sergeant Name] that his son Mr. [Client #3] lives there due to him being diagnosed with Autism and him and his wife were speaking with him earlier and he informed them that he was given a firearm by a Mr. [Client at Day Program] at one of his day sites in [local town]. [Sergeant Name] had Mr. [Client #3's Father] to call his son and met him outside the residence and he asked Mr. [Client #3] where the firearm was located. [Client #3] informed he father that it was in his room behind the dresser. [Sergeant Name] went with [Client #3's Father] and located the firearm where Mr. [Client #3] said it would be. [Sergeant Name] picked up the firearm, examined it and recognized it to be a BB gun..." Review on 09/29/23 of an unsigned Incident Investigation for client #3 revealed:	V 367		

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V 367	Continued From page 4 - "Incident Investigation Pamlico Group Home 9/11/2023 I. Introduction: On 9/11/2023 [Residential Manager], Residential Manager contacted the mother of [Client #3] to discuss an incident in which [Client #3] had a lighter in his lunch bag. She indicated she would call him later and talk to him. [Residential Manager] received a call around midnight stating that the lighter in his lunch bag was a loaded gun. She was crying and stated that his father was 20 minutes away and had the police meeting him at the residence. [Residential Manager] attempted to call staff to no avail and was enroute to the group home. Police found the alleged gun and determined that it was a BB gun. When [Residential Manager] arrived, the police were gathering a statement from [Client #3]..." - "Person Supported Involved: Name: [Client #3] Diagnoses: Mild Intellectual Disabilities, Disruptive Mood Dysregulation Disorder, Unspecified Intellectual Disability, Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder combined presentation, Unspecified anxiety disorder...[Client #3] was admitted into Pamlico Group Home on June 8, 2023. [Client #3] has a history of physical aggression and difficulty utilizing coping skills when upset. [Client #3] was last IVC'd (Involuntary Committed) in May 2023 following a stay a month prior at [Psychiatric Hospital]. [Client #3]'s mother reports "outbursts" approximately twice per month. [Client #3] attends therapy and medication management. Per his psychological evaluation [Client #3] does not react well to unexpected changes and transitions, dependent on others to form schedule, and tends to become overwhelmed easily..." - "II. Timeline/Details [Qualified Professional (QP)] contacted Incident and Complaint Specialist for further direction regarding the incident.	V 367		

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V 367	Continued From page 5 Incident and Complaint Specialist indicated that it was a Level 1 report at this time..Per [Client #3]: [Client #3] stated he received the BB gun last week from [Client at Day Program] who had it in his backpack. He states [Client at Day Program] asked him if he wanted it. He stated the plan was to go to a strip club and they wanted protection because people shoot at a strip club. [Client #3] stated that [Client at Day Program] gave it to him in the bathroom and [Client #3] put the BB gun in his lunch box. [Client #3] says that [Client at Day Program] has another gun that he showed [Client #3] on a video gun (some type of shotgun)..." Interview on 09/25/23 staff #1 stated: - She recalled the incident on 09/11/23 with client #3. - Client #3's father came to the facility with a local policeman. - Client #3 had called his father about a gun. - Client #3 let his father and the police in the facility. - The police had searched client #3's bedroom for the BB gun and found it. Interview on 09/27/23 the QP stated: - About 2 weeks ago a BB gun was found in client #3's room. - The police had been to the facility and found the BB gun. - An IRIS report had been started but "not finished." - She had reviewed the information with the Incident and Complaint Specialist. Interview on 09/29/23 the Residential Director stated: - The incident on 09/11/23 with client #3 and law enforcement involvement was a Level II incident and required an IRIS report.	V 367		

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V 367	Continued From page 6 - There was an ongoing investigation. - She would work with the QP to ensure the report was completed in the timeframe as required.	V 367		