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
	MHL017-027	A. BUILDING: ______ B. WING ______	10/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAITHFUL COMPANION GROUP HOME	**3848 CHERRY GROVE ROAD ELON, NC 27244**

(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 An annual and complaint survey was completed on October 4, 2023. The complaints were substantiated (intake #NC00207538 and intake #NC00207609). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and currently has a census of 4. The survey sample consisted of audits of 2 current clients and 1 deceased client.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to develop and implement goals and strategies to address the needs of 1 of 1 Deceased Client (DC #1). The findings are:

Review on 9/27/23 of DC #1's record revealed:
-An admission date of 2/24/21
-Diagnoses of Schizoaffective Disorder, Paranoid Disorder and Hypertension
-Age: 64
-Date of death 9/3/23
-No goals or strategies to address additional DC #1's falls
-A Physician Discharge Summary from a local Emergency Department (ED) dated 3/23/23 "Principal Problem: Falls ...the patient was brought to the ED via EMS (Emergency Medical Services) ...with multiple falls today ..."
-A Physician Discharge Summary from a local ED dated 6/1/23 " ...diagnosis: fall ..."

Review on 9/28/23 of a written statement dated 5/20/23 by staff #2 revealed:
-"[DC #1] fell on May 20 (2023) at about noon (1:00pm). I asked her if she wanted me to call EMS (Emergency Medical Services). She said 'no', she was 'ok'. Put a band-aid on her chin. She said, 'thank you'. I am 'ok'."

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Review on 10/2/23 of the facility's internal incident report dated 9/5/23 and written by Administrator #1/Qualified Professional/Licensee (A #1/QP/L) revealed:
-"On Sunday September 3, 2023, at approximately 10:45am, [DC #1] left the front porch after smoking a cigarette to go to her bedroom with no complaints. [Staff #1] went into [DC #1]'s bedroom at approximately 10:48 am to check on her because [staff #1] thought she heard a loud noise. [Staff #1] found [DC #1] laid across the bed unresponsive. [Staff #1] immediately called 911 and then started CPR (Cardiopulmonary Resuscitation), while 911 was on the phone with [staff #1] until EMS (Emergency Medical Services) arrived at approximately 11:05am. [Staff #1] called 911 at 10:45am. EMS arrived at the facility at approximately 11:05am and work with [DC #1] for approximately 30 minutes after which [DC #1] was pronounced deceased."

Review on 9/27/23 of DC #1's death certificate, dated 9/3/23, revealed:
-"Immediate cause of the death was Blunt Force Injuries to the Head
-Manner of Death: Accident
-Describe how the injury occurred: fell and struck head that resulted in cardiac arrest."

Interviews on 9/27/23 with clients #2, #3, #4 and #5 revealed:
-Had seen DC #1 fall in the facility

Interview on 9/28/23 with Staff #2 revealed:
-DC #1 had fallen several times at the facility
-Those dates were 3/23/23, 5/20/23, 6/1/23, and 9/3/23
-Administrator #1/Qualified Professional/Licensee (A #1/QP/L) was responsible for the clients'

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treatment plans

Interview on 9/27/23 with the Supervisor In Charge (SIC) revealed:
-DC #1 had fallen in the facility on more than one occasion
-A #1/QP/L was responsible for the clients' treatment plans
-Was not sure if there were goals and strategies in DC #1's treatment plan to address falls

Interview on 9/28/23 with Administrator #2 (A #2) revealed:
-DC #1 had fallen two times at the facility
-Treatment plans for the clients were written by A #1/QP/L

Interview on 10/2/23 with Administrator #3 (A #3) revealed:
-DC #1 had fallen on more than one occasion at the facility
-Treatment plans were the responsibility of A #1/QP/L
-Was not sure if there were goals and strategies in DC #1's treatment plan to address falls

Interview on 10/2/23 with DC #1's physician revealed:
-"With [DC #1], given her age she would be considered a fall risk ..."

Interview on 10/4/23 with A #1/QP/L revealed:
-Was responsible for writing the clients' treatment plans
-"I wrote her (DC #1's) plan, and the ACTT (Assertive Community Treatment Team) and Peer Support workers wrote her short-term goals."
-Was not aware DC #1 had fallen on 5/20/23 and 6/1/23
-Had not developed or implemented goals and

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strategies to address DC #1's falls
-"I was only made aware of the falls on the day she died (9/3/23)."

This deficiency is cross referenced into 10A NCAC 27G .5603 OPERATIONS (V291) for a Type A1 rule violation and must be corrected within 23 days.

V 291 | 27G .5603 Supervised Living - Operations | V 291

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.
(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

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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 reviews and interviews, the facility failed to ensure service coordination was maintained with other professionals responsible for treatment affecting 1 of 1 Deceased Client (DC #1). The findings are:

Cross Reference:10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (V112). Based on record reviews and interviews, the facility failed to develop and implement goals and strategies to address the needs of 1 of 1 Deceased Client (DC #1).

Cross Reference: 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS (V366). Based on record reviews and interview, the facility failed to implement written policies governing their response to incidents as required.

Cross Reference: 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS (V367). Based on record reviews and interviews, the facility failed to submit a level II incident report within 72 hours of becoming aware of the incident.

Finding #1
Review on 9/27/23 of DC #1's Physician Discharge Summary from a local Emergency Department (ED) dated 3/23/23 revealed:
-An admission date of 3/22/23
-A discharge date of 3/23/23

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V 291	Continued From page 6 -"Recommendations at discharge: 1. Follow up with PCP (Primary Care Physician) within 1 to 2 weeks and follow up with neurology if warranted and have an outpatient work-up for dizziness including MRI (Magnetic Resonance Imaging) of the brain. -Discharge Diagnoses: Principal Problem: Falls, Active Programs: Uncontrolled Hypertension (High Blood Pressure), Psychosis (a mental disorder characterized by a disconnection from reality), Hypokalemia (low level of potassium) and Hyponatremia (low concentration of sodium in the blood). -[DC #1] is a 60-year-old female with medical history significant for hypertension, schizophrenia, psychosis. The patient was brought to the ED via EMS (Emergency Medical Services), reports of generalized weakness with multiple falls today ...she reports some mild dizziness. Patient fell onto her knees. -BP (Blood Pressure) elevated to 194/138, IV (Intravenous therapy) Labetalol (used to treat high blood pressure) 20 mgs (milligrams) given with improvement. Attempted ambulating patient to the ED, the patient was weak, and relying heavily on ED staff. The patient was rehydrated with normal saline, and fluid resuscitation and improved. She ambulated with physical therapy, and they recommended no follow up given that she was back to her baseline. Patient denied any dizziness and feels that she tripped over her feet causing her to lose her balance. She is advised that if she felt dizzy again that she would need further neurological work-up and recommended that she see a neurologist in outpatient setting, however she appears to be at her baseline now and she is deemed medically stable to be discharged at this time. -Assessment and Plan: *Falls: Generalized weakness, falls, reports some dizziness but is	V 291		

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improved. Etiology (cause or manner of) at this time not determined but could have been a mechanical (force or an object) fall in the setting of volume depletion from her Hydrochlorothiazide. Patient has improved and was back to her baseline and was recommended to have outpatient neurological workup if she continues to be dizzy and has recurrent falls, however this fall was felt to be mechanical fall in the setting of her tripping over her feet with generalized weakness in the setting of volume depletion.
-Procedures performed: Head CT (Computed Tomography).
-Result Date 3/22/23: No acute intracranial findings are seen.
-Result date: 3/22/23: No fracture or dislocation is seen in the left knee."

Review on 9/28/23 of DC #1's after visit summary dated 6/1/23 from a local emergency room revealed:
-"Reason for visit: altered mental status, diagnosis: fall, initial encounter, abrasion (a cut or scrape on your skin) on right knee, initial encounter.
-There were no serious injuries found. She has an abrasion of her right knee that needs to be cleaned with soap and water daily and apply a band aid until it heals ..."

Interview on 9/28/23 with staff #2 revealed:
-"With me ...she fell about 3 times. The first time I tried to get her to let me call them (the ambulance) and she said 'no'. The second time she was checked out and the third time she said she was 'okay', and she refused to let me call them. We usually have EMS come out and check them (clients)."
-Was not aware of the recommendation for DC #1 to be seen by a neurologist if she fell again.

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-It was Administrator #3 (A #3)'s responsibility to review clients' discharge paperwork from appointments

Interview on 9/27/23 with the Supervisor In Charge (SIC) revealed:
-"One time she (DC #1) stumbled, but she had a UTI (Urinary Tract Infection), and we sent her out (to the hospital) ..."
-"She fell about 3 times to my knowledge."
-Was not aware of the recommendation for DC #1 to be seen by a neurologist if she fell again.
-It was A #3's responsibility to review clients' discharge paperwork from appointments

Interview on 9/28/23 with Administrator #2 (A #2) revealed:
-"To my knowledge, she (DC #1) has fallen two times that I know about. She was at therapy (day program) and fell. They called me and I said to send her out (to the hospital). She fell in the facility also. [The SIC] called me and I told her to send her out (call EMS) ...[DC #1] was very head strong and if she did not want to go, you could not make her."
-Was not aware of the recommendation for DC #1 to be seen by a neurologist if she fell again.
-It was A #3's responsibility to review clients' discharge paperwork from appointments

Interview on 10/2/23 with A #3 revealed:
-"I think the doctor would be responsible for ensuring things were in place to assist her (DC #1) with walking and falls."
-"I am pretty sure someone told me about her falling. Once at [a restaurant]. She was taken to the hospital then. I am not sure what ever happened to her. Someone told me she fell and hit her chin ..."
-Was not aware of the recommendation for DC

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#1 to be seen by a neurologist if she fell again.
-It was his responsibility to review clients' discharge paperwork from appointments

Interview on 10/2/23 with DC #1's Primary Care Physician (PCP) revealed:
-Took over as the physician for DC #1 in May 2023 or June 2023
-"All of the residents at the facility are considered fall risks due to the medications they receive. That would include psych (psychiatric) medications and blood pressure medications. With [DC #1], given her age she would be considered a fall risk ..."
-Was not aware DC #1 was seen in the Emergency Room on 3/23/23
-Was not aware DC #1 had fallen on 5/20/23, 6/1/23 and 9/3/23
-No one had communicated to her DC #1 was to see a Neurologist if she fell again

Interview on 10/4/23 with A #1/QP/L revealed:
-DC #1 had fallen on 3/23/23 and was seen at the Emergency Room
-"Actually, I did not know about all the falls that she had. When I spoke to her PCP, she was unaware as well."
-Was not aware of the recommendation for DC #1 to be seen by a neurologist if she fell again.
-"Appointments for the clients are done by my son (A #3)."
-Was unable to recall who went with DC #1 to the hospital on 3/23/23
-"I have another system in place now and should have had it in place previously. Staff are to send the discharge paperwork to me. Then I will notify their physicians and we will go from there."

Finding #2
Review on 9/27/23 of DC #1's record revealed:

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-An admission date of 2/24/21
-Diagnoses of Schizoaffective Disorder, Paranoid Disorder and Hypertension
-Age: 64
-Date of death 9/3/23
-No documentation of dental care within the last 12 months

Review on 9/29/23 of photos of DC #1 while in the morgue, taken by her family, revealed:
-Photograph #3 showed DC #1's upper teeth were broken, decayed and two teeth appeared to be missing
-Photograph #4 showed a different angle of DC #1's mouth and lower teeth were missing

Review on 10/4/23 of the facility's Refusal of Care Form revealed:
-"Service refused: 7/7/23, [DC #1] refused to go to [a local dentist's office], her legal guardian was contacted and [the LG] still didn't respond to the situation."

Review on 9/28/23 of the facility's Quarterly Review of Residents Form for DC #1 revealed:
-No documentation of rescheduled dental appointments

Interview on 9/28/23 with Staff #2 revealed:
-"[DC #1] had no dental appointments that I know of. She has been here for over two years ... I saw her brush her teeth during my shifts ...she never complained about her teeth hurting ..."

Interview on 9/27/23 with the Supervisor In Charge (SIC) revealed:
-"[DC #1] went to [the local dentist]'s office, but it has been awhile ... she could be in a little pain and not tell you. She did not like hospitals so she would not tell us if she was hurting ...she told me

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she would go to the dentist if I went with her ..."
-Administrator #3 (A #3) was responsible for taking the clients to medical appointments
-Thought the last time DC #1 went to the dentist was in May (2022)
-"She had an appointment scheduled in July (2023), but she refused to go to that appointment ..."

Interview on 9/28/23 with Administrator #2 (A #2) revealed:
-"If she (DC #1) had any appointments, it was [A #3]'s responsibility to ensure she went. He started being responsible for all the clients' appointments in the last year or two. You will have to ask him about appointments."

Interview on 10/2/23 with A #3 revealed:
-Worked at the residential facility in the capacity of an Administrator
-Duties included transportation (for dental and foot care) and scheduling (of the residents' medical appointments)
-"I believe I did take her (DC #1) to the dentist if I am not mistaken. There are so many residents, if one (dental appointment) was missed, it was because they refused ..."
-Appointments to the dentist would be documented in the clients' records.
-"It should also be documented of her refusal of care form if she refused to go to the dentist ..."

Interview on 10/4/23 with Administrator #1/Qualified Professional/Licensee revealed:
-A #3 was responsible for ensuring the clients went to all dental and medical appointments
-"It appears she (DC #1) refused to go in the earlier part of the year. That is another issue I will address. We have a new process to follow now. Because residents do refuse their medical

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appointments, we want to ensure we reschedule them."
-"My recourse will be retraining the staff, reviewing the policy on coordination of care and ensuring that I am made aware of their appointments. I will talk directly to the residents and see if I can go with them."
-"I have a good relationship with the residents and will barter with them to get them to cooperate with me. You would be surprised how far offering the clients a cold drink, cigarettes or a hair appointment will go."

Review on 10/4/23 of the facility's plan of protection, dated 10/4/23 and written by A #2, revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care? Immediately, Oct. 4, 2023, the facility will develop and implement communication between the facility staff, upper management and any outside agencies who are involved with the care of the residents. The treatment plans will immediately (10/4/23) be reassessed by the Administrator (A #1/QP/L) to meet the individual needs of the consumers and update as needed. Facility staff will be responsible for writing incidents and the Administrator (A #1/QP/L) will review it, enter it into IRIS (Incident Response Improvement System) and ensure outside agencies are aware of the incident.
-Describe your plans to make sure the above happens. The Administrator (A #1/QP/L) will be responsible for reviewing all clients' medical records from all outside agencies. I, [Administrator #2] will be responsible for reviewing the treatment plans, incident reports to ensure coordination of care for all consumers."

The facility was licensed as a Supervised Living

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FAITHFUL COMPANION GROUP HOME	3848 CHERRY GROVE ROAD ELON, NC 27244

(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 291	Continued From page 13 for Adults with Mental Illness and served 5 adult females who had diagnoses that included Schizoaffective Disorder, Paranoid Disorder, Seizure Disorder, Intellectual Disability Disorder, Moderate, Cardiomyopathy with Pacemaker, Hyperthyroidism and Hypertension. Deceased Client #1 (DC #1) was admitted to the facility on 3/1/21 and died on 9/3/23. DC #1's upper and lower teeth were decayed and broken. Documentation for DC #1 showed she refused dental appointments. There was no documentation that the dental appointments had been rescheduled. On 3/23/23, DC #1 was seen at the emergency room due to multiple falls that day. The discharge paperwork recommended if she fell again, she should be seen by a Neurologist. DC #1 had subsequent falls at the facility on 5/20/23 and 6/1/23, but she was not taken to a Neurologist for an evaluation. DC #1 fell again on 9/3/23, the day of her death. The cause of DC #1's death was determined to be blunt force trauma to the head from a fall that resulted in cardiac arrest. Administrator #1/Qualified Professional/Licensee (A #1/QP/L) was aware of the fall on 3/23/23. The facility staff failed to notify Administrator #1/QP/L of the subsequent falls. There was no communication with DC #1's Primary Care Physician about her initial fall on 3/23/23, her additional falls, or the ER recommendation of a follow up with Neurology. Furthermore, DC #1's treatment plan was not updated to include goals and intervention strategies to address her frequent falls. Also, the facility failed to report and respond to DC #1's death as required by not determining the cause of the incident and failed to assign a person to be responsible for making recommendations for minimizing the occurrence of future incidents. These failures constitute a Type A1 rule violation for serious neglect and harm and must be	V 291		

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V 291	Continued From page 14 corrected within 23 days. An administrative penalty of $8,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 291		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in	V 366		

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V 366	Continued From page 15	V 366		

Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:
(1) immediately securing the client record by:
(A) obtaining the client record;
(B) making a photocopy;
(C) certifying the copy's completeness; and
(D) transferring the copy to an internal review team;
(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:
(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;
(B) gather other information needed;
(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and
(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the

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LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and

(3) immediately notifying the following:

(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;

(B) the LME where the client resides, if different;

(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;

(D) the Department;

(E) the client's legal guardian, as applicable; and

(F) any other authorities required by law.

This Rule is not met as evidenced by:
Based on record reviews and interview, the facility failed to implement written policies governing their response to incidents as required. The findings are:

Review on 9/27/23 of Deceased Client #1 (DC #1)'s record revealed:
-An admission date of 2/24/21

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-Diagnoses of Schizoaffective Disorder, Paranoid Disorder and Hypertension
-Age: 64
-Date of death 9/3/23

Review on 10/2/23 of the facility's internal incident report dated 9/5/23 and written by Administrator #1/Qualified Professional/Licensee (A #1/QP/L) revealed:
-"On Sunday September 3, 2023, at approximately 10:45am, [DC #1] left the front porch after smoking a cigarette to go to her bedroom with no complaints. [Staff #1] went into [DC #1]'s bedroom at approximately 10:48 am to check on her because [staff #1] thought she heard a loud noise. [Staff #1] found [DC #1] laid across the bed unresponsive. [Staff #1] immediately called 911 and then started CPR (Cardiopulmonary Resuscitation), while 911 was on the phone with [staff #1] until EMS (Emergency Medical Services) arrived at approximately 11:05am. [Staff #1] called 911 at 10:45am. EMS arrived at the facility at approximately 11:05am and work with [DC #1] for approximately 30 minutes after which [DC #1] was pronounced deceased."

Further review on 10/2/23 of the facility's incident report dated 9/5/23 and written by A #1/QP/L revealed the following:
-No documentation of the cause of the incident, or recommendations for minimizing the occurrence of future incidents
-No evidence that written preliminary findings had been sent to the Local Management Entity (LME)

Interview on 10/4/23 with the A #1/QP/L revealed:
-Had completed an internal incident report on 9/5/23 for DC #1
-"It was a natural death, and I did not know about

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V 366	Continued From page 18 the falls and did not see any harm to the other clients." -Had not determined the cause of the incident -"The people I spoke with felt like it (DC #1's death) was a natural cause. I am comfortable with that decision ..." -Had not made recommendations for minimizing the occurrence of future incidents -"The only thing that I put in place was that I felt I needed to be made aware when they (the clients) go to the hospital and then I need to review the discharge paperwork." -"Everyone was satisfied with the level of care we provided her (DC #1) with." -Had not assigned persons to be responsible for implementation of the corrections and preventative measures -"[Administrator #2], [Administrator #3] and I will be responsible for checks and balances." -Had not notified the Local Management Entity of the incident as required by law -"I did notify the supervisor at the Department of Social Services, her guardian and her family." This deficiency is cross referenced into 10A NCAC 27G .5603 OPERATIONS (V291) for a Type A1 rule violation and must be corrected within 23 days.	V 366		
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	V 367		

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V 367	Continued From page 19 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 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	V 367		

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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 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.

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to submit a level II incident report within 72 hours of becoming aware of the incident. The findings are:

Review on 9/27/23 of Deceased Client (DC #1)'s record revealed:
-An admission date of 2/24/21
-Diagnoses of Schizoaffective Disorder, Paranoid Disorder and Hypertension
-Age: 64
-Date of death 9/3/23

Review on 9/27/23 of DC #1's death certificate dated 9/3/23 revealed:
-"Immediate cause of the death was Blunt Force Injuries to the Head
-Manner of Death: Accident
-Describe how the injury occurred: fell and struck head that resulted in cardiac arrest."

Reviews on 9/28/23, 9/29/23, 10/2/23, 10/3/23 and 10/4/23 of the North Carolina Incident Response Improvement System (IRIS) revealed:
-No incident report was submitted for DC #1's death

Interview on 9/27/23 with the Supervisor In Charge (SIC) revealed:
-Administrator #1/Qualified Professional/Licensee (A #1/QP/L) was responsible for submitting incident reports

Interview on 9/28/23 with Administrator #2 (A #2) revealed:
-A#1/QP/L was responsible for submitting incident reports
-"I am sure he completed a level III incident report

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V 367	Continued From page 22 on [DC #1] ...he won't be back until next week (10/2/23). You will have to ask him about it." Interview on 10/4/23 with A#1/QP/L revealed: -Had not submitted an IRIS report for DC #1's death on 9/3/23 -"I have bad internet connection and we had a storm that knocked it out. I plan to go back and ensure it (the incident report) was entered into IRIS." This deficiency is cross referenced into 10A NCAC 27G .5603 OPERATIONS (V291) for a Type A1 rule violation and must be corrected within 23 days.	V 367		