STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL012-152	A. BUILDING: _____ B. WING _____	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STATES HOME	4320 BELMONT DRIVE MORGANTON, NC 28655

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on March 8, 2024. The complaint was substantiated (intake #NC00213838). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600F Supervised Living for Alternative Family Living. The facility is licensed for 2 and currently has a census of 1. The survey sample consisted of audits of 1 current client and 1 former client.	V 000		
V 318	13O .0102 HCPR - 24 Hour Reporting 10A NCAC 13O .0102 INVESTIGATING AND REPORTING HEALTH CARE PERSONNEL The reporting by health care facilities to the Department of all allegations against health care personnel as defined in G.S. 131E-256 (a)(1), including injuries of unknown source, shall be done within 24 hours of the health care facility becoming aware of the allegation. The results of the health care facility's investigation shall be submitted to the Department in accordance with G.S. 131E-256(g). This Rule is not met as evidenced by: Based on record review and interview, the facility failed to notify the Health Care Personnel Registry (HCPR) of allegations against a health	V 318		

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V 318	Continued From page 1	V 318		

care personnel within 24 hours of the facility becoming aware of the allegation. The findings are:

Review on 3/6/24 of Former Client (FC) #2's record revealed:
-admission date 9/20/19.
-diagnoses of Mild Intellectual Developmental Disability, Schizophrenia, Post-Traumatic Stress Disorder, Diabetes Mellitus Type II, Depression, Hypothyroidism, Hyperlipidemia, Hypertension, Depression, Esophagitis, and Gastroesophageal Reflux Disease.

Review on 3/6/24 of IRIS reports submitted by the facility revealed:
-a level III physical abuse allegation on 1/8/24 involving the AFL provider and FC #2.
-date licensee learned of incident 1/9/24.
-date licensee initiated incident report 1/22/24.
-licensee comment 1/24/24 "...Member (FC #2) claimed after incident report submission that staff (AFL provider) pushed her into the kitchen/living area."
-1/24/24 comment by Local Management Entity/Managed Care Organization comment "2...Please complete the HCPR section completely..."
-1/24/24 licensee completed the HCPR portion.

Interview and record review on 3/7/24 with the Qualified Professional revealed:
-the AFL provider called her the next morning, 1/9/24, after the incident.
-it was reported that FC #2 "attacked" and pushed the AFL provider.
-on 1/9/24 she interviewed and typed a statement from FC #2 who stated the AFL provider pushed her and she fell to the ground.
-"Carrie's statement...When [FC #2] said she got

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V 318	Continued From page 2 angry and started yelling. [AFL provider] then pushed her putting her hands on her throat...[AFL provider] began pushing her to her room causing [FC #2] to fall..." Interview and record review on 3/7/24 with the Quality Manager revealed: -he conducted and typed the interviews found on the "Guardian team Contacts" as part of the internal investigation. -on 1/9/24 during interviews with FC #2 it was determined this was more than a client behavior incident. -as typed on 1/9/24 - FC #2's guardian stated "...[AFL provider] put her hands around her (FC #2's) throat...I called [FC #2]..."She (AFL provider) grabbed my neck...(AFL provider) started pushing me (FC #2) and shoving me to my room and that is when I fell." -he "...chose to wait to talk to (AFL provider)..." before submitting the IRIS report, "that's on me."	V 318		
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,	V 367		

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V 367	Continued From page 3	V 367		

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 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

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V 367	Continued From page 4 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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report a level III incident in the Incident Response Improvement System (IRIS) within 72 hours of becoming aware of the incident. The findings are:	V 367		

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V 367	Continued From page 5 Review on 3/6/24 of Former Client (FC) #2's record revealed: -admission date 9/20/19. -diagnoses of Mild Intellectual Developmental Disability, Schizophrenia, Post-Traumatic Stress Disorder, Diabetes Mellitus Type II, Depression, Hypothyroidism, Hyperlipidemia, Hypertension, Depression, Esophagitis, and Gastroesophageal Reflux Disease. Review on 3/6/24 of IRIS reports submitted by the facility revealed: -a level III physical abuse allegation on 1/8/24 involving the AFL provider and FC #2. -date licensee learned of incident 1/9/24. -date licensee initiated incident report 1/22/24. -licensee comment 1/24/24 "...Member (FC #2) claimed after incident report submission that staff (AFL provider) pushed her into the kitchen/living area." Interview and record review on 3/7/24 with the Qualified Professional revealed: -the AFL provider called her the next morning, 1/9/24, after the incident. -it was reported that FC #2 "attacked" and pushed the AFL provider. -on 1/9/24 she interviewed and typed a statement from FC #2 who stated the AFL provider pushed her and she fell to the ground. -"Carrie's statement...When [FC #2] said she got angry and started yelling. [AFL provider] then pushed her putting her hands on her throat...[AFL provider] began pushing her to her room causing [FC #2] to fall..." Interview and record review on 3/7/24 with the Quality Manager revealed: -he conducted and typed the interviews found on the "Guardian team Contacts" as part of the	V 367		

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V 367	Continued From page 6 internal investigation. -on 1/9/24 during interviews with FC #2 it was determined this was more than a client behavior incident. -as typed on 1/9/24 - FC #2's guardian stated "... [AFL provider] put her hands around her (FC #2's) throat...I called [FC #2]..."She (AFL provider) grabbed my neck...(AFL provider) started pushing me (FC #2) and shoving me to my room and that is when I fell." -he "...chose to wait to talk to (AFL provider)..." before submitting the IRIS report, "that's on me."	V 367		