STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-202	A. BUILDING: _____ B. WING _____	R 03/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A CARING HEART INDEPENDENCE CENTER-J	603 NEW BRIDGE STREET JACKSONVILLE, NC 28540

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on March 12, 2024. The complaint was substantiated (intake #NC00213960). A deficiency was cited. This facility is licensed for the following service category: NCAC 27G .5400 Day Activity for Individuals of all Disability Groups. This facility has a current census of 13. The survey sample consisted of audits of 3 current clients.	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 interview, the facility failed to report a critical incident to the home and host Local Management Entity (LME) within 72 hours as required. The findings are: Review on 3/12/24 of client #1's record revealed: - 76 year old female. - Admission date of 11/1/23. - Diagnoses of Major Depressive Disorder and Intellectual Disability - Moderate. Review on 3/12/24 of a North Carolina Incident Response Improvement System (IRIS) report for client #1 revealed: - Date of Incident: 2/16/24.	V 367		

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V 367	Continued From page 3 - Date Provider Learned of Incident: 2/16/24 - Date IRIS report submitted to the LME: 2/22/24. - Provider Comments: 2/22/24 - "Consumer reported to QP (Qualified Professional) on 02/16/2024 about concerns with her provider. In addition to this report QP also received a call from the Guardian/DSS (Department of Social Services) worker Friday at 4:40 pm asking to meet with QP on 02/19/2024 at 2:30pm. QP was told by both consumer and her Guardian that her provider took the consumer to her cousin ' s house not sure what day or how many times this had happened, consumer also reported that its times that she wants to go to the stores to shop or just look around which is something that the consumer enjoys doing however her provider takes the consumer over to her cousin ' s house instead. Consumer stated that she had wanted to talk to QP about these issues that she was having. When the QP was asked to pick consumer up for the dance on 2/16/2024 the consumer got an opportunity to tell the QP. QP was told by the Guardian/DSS worker that the consumer reported to her that the staff took her to a car dealership with her cousin and another consumer that her cousin was providing services for. QP was told by the Guardian/DSS worker that the consumer reported to her that the staff and the cousin went on base because the cousin had to do something for her husband. QP was told by the Guardian/DSS worker that the consumer reported to her that the provider was late getting the consumer home so the provider asked the consumer to lie for the provider by telling the AFL worker that they were late due to having to attend a meeting but the reason they were late is because the provider was at an appointment with the cousin somewhere in Morehead City. The Guardian asked the consumer why did she not tell the truth and the consumer said that the	V 367		

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V 367	Continued From page 4 provider would not allow her to use her tobacco which is something the consumer likes to do. On 2/19/2024 the Guardian/DSS worker stated that the consumer told her that they did not go to volunteer with the group instead they went to the cousin ' s house then they went somewhere else that involved a situation with the cousin and the child's father not paying for something but it had nothing to do with child support. QP reached out to day program manager to ask her did she see the provider and the consumer while volunteering with the group. Day program manager responded that she did not see the provider or the consumer at all." Interview on 3/12/24 the QP stated: - She was aware the IRIS report was submitted late. - There were problems with the IRIS system when she initially tried to submit the report.	V 367		