STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on March 8, 2024. The complaint was unsubstantiated (intake #NC00213765). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. The survey sample consisted of audits of 1 former 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		

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V 112	Continued From page 1	V 112		

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 needs for 1 of 1 audited former clients (FC)(#1). The findings are:

Review on 3/6/24 - 3/8/24 of FC #1's record revealed:
-52 year old female.
-Admission date: 12/13/07.
-Date of death: 2/20/24.
-Diagnoses of Severe Mental Retardation, Schizophrenia, History of Seizures, and Edema (leg).
-No strategies developed to address concerns with FC #1's unsteady gait.

Review on 3/6/24 of FC #1's Behavior Data Sheet revealed:
-2/16/24: "Consumer bumping into walls going to the bathroom."
-2/15/24: "Staff reported consumer fell running to van after appointment at doctor's office. Small scratches noted on palms of hands, both knees and arm. Consumer unsteady on feet bumped into door and kitchen table at dinner."
-1/20/24: "Consumer jumped out chair to go to bathroom and tripped and hit shoulder on on chair."

Interview on 3/6/24 client #2 stated:

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V 112	Continued From page 2 -He had witnessed FC #1 fall down multiple times. -FC #1 would bump into walls, doors and furniture multiple times per week. Interview on 3/6/24 client #3 stated: -He had witnessed FC #1 fall down multiple times. -FC #1 would bump into walls, doors and furniture multiple times per week. Interview on 3/6/24 client #4 stated he had witnessed FC #1 fall down or run into objects "probably everyday." Interview on 3/7/24 staff #1 stated: -FC #1 had always been unsteady on her feet. -FC #1 would frequently walk into walls and furniture. -Incidents occurred frequently. Interview on 3/6/24 staff #2 stated: -FC #1 had been unsteady on her feet. -FC #1 would frequently stumble or trip trying to walk too fast. -FC #1 would often run into furniture and walls. Interview on 3/6/24 the Licensee stated: -FC #1 had an unsteady gait and was unstable on her feet. -FC #1 would frequently walk into chairs, tables, and walls. -FC #1 would sometimes fall. -Incidents involving running into furniture or tripping happened on a weekly basis and occurred "all the time." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 112		

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V 114	Continued From page 3	V 114		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview the facility failed to have fire and disaster drills held at least quarterly and repeated on each shift. The findings are: Review on 3/6/24 of facility records from 10/1/23 - 12/31/23 revealed no fire or disaster drills documented on the 2nd shift. Interview on 3/6/24 the Licensee stated: -There were 2 shifts throughout the week. -1st shift was approximately 7am - 6-7pm. -2nd shift was approximately 6-7pm - 7am. -Moving forward, she would ensure that all shifts were completed.	V 114		

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V 114	Continued From page 4 This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department.	V 132		

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V 132	Continued From page 5	V 132		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure the Health Care Personnel Registry (HCPR) was notified of all allegations against health care personnel and failed to ensure all alleged acts were investigated. The findings are:

Review on 3/6/24 of the North Carolina Incident Response Improvement System (IRIS) for December 2023 - February 2024 revealed no level II reports submitted to HCPR by the facility to include 24 hour notification of allegations of abuse towards former client (FC) #1. Also no subsequent facility documentation of investigations had been submitted to HCPR within 5 business days as required by rule.

Interview on 3/6/24 the Licensee stated:
-FC #1 passed suddenly on 2/20/24.
-She was notified by a supervisor from the Department of Social Services (DSS) that there had been concerns about bruising found on FC #1's body when FC #1 arrived at the hospital.
-She confirmed that there was brusing present, as FC #1 had an unsteady gait and frequently walked into walls, tables and often fell to the floor.

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V 132	Continued From page 6 -On 2/21/24 members of DSS arrived at the facility to interview other clients and stated there had been an allegation of abuse made due to the bruises found on FC #1. -She had interviewed her clients and staff about the allegation, but did not document it. -She hadn't thought of completing HCPR notification, as she knew where the bruising came from and that the allegation was false.	V 132		
V 366	27G .0603 Incident Response Requirements 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	V 366		

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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 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

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V 366	Continued From page 8 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 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 interviews, the facility failed to document their response to level I and level II incidents. The findings are: Review on 3/6/24 - 3/8/24 of former clients (FC)	V 366		

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#1's record revealed:
-52 year old female.
-Admission date: 12/13/07.
-Date of death: 2/20/24.
-Diagnoses of Severe Intellectual Disability, Schizophrenia, History of Seizures, and Edema (leg).

Review on 3/6/24 of the North Carolina Incident Response Improvement System (IRIS) website revealed:
- No level II incident report was created by the facility for the allegation of abuse related to FC #1.
- A level II incident report for the death of FC #1 was present at the facility but unable to be located within IRIS when reviewed.

Review on 3/6/24 - 3/8/24 of facility records from December, 2023 - present revealed:
-There were 5 level I incidents between January 1, 2024 - February 20, 2024 related to possible physical injuries.

Interview on 3/6/24 client #2 stated:
-He had witnessed FC #1 fall down multiple times.
-FC #1 would bump into walls, doors and furniture multiple times per week.

Interview on 3/6/24 client #3 stated:
-He had witnessed FC #1 fall down multiple times.
-FC #1 would bump into walls, doors and furniture multiple times per week.

Interview on 3/6/24 client #4 stated he had witnessed FC #1 fall down or run into objects "probably everyday."

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V 366	Continued From page 10 Interview on 3/7/24 staff #1 stated: -FC #1 had always been unsteady on her feet. -FC #1 would frequently walk into walls and furniture. -Incidents occurred frequently. Interview on 3/6/24 staff #2 stated: -FC #1 had been unsteady on her feet. -FC #1 would frequently stumble or trip trying to walk too fast. -FC #1 would often run into furniture and walls. Interview on 3/6/24 - 3/8/24 the Licensee stated: -FC #1 had an unsteady gait and was unstable on her feet. -FC #1 would frequently walk into chairs, tables, and walls. -FC #had fallen in the parking lot of her physician's office on 2/15/24 that left marks on her hand, knew a, and arm. -FC #1 also had a choking incident on 2/4/24 that required the Heimlich maneuver and left marks on her back and under her breast. -She was notified by a supervisor from the Department of Social Services (DSS) that there had been concerns about bruising found on FC #1's body when FC #1 arrived at the hospital on 2/20/24. -On 2/21/24 members of DSS arrived at the facility to interview other clients and stated there had been an allegation of abuse made due to the bruises found on FC #1. -She hadn't thought of completing an incident report for the allegation, as she knew where the bruising came from and that the allegation was false. -Moving forward, she would ensure level II's were completed following any allegations made and she wanted to implement new incident reports that created daily documentation of body checks.	V 366		

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V 366	Continued From page 11 -She was not certain as to why the incident report documenting the death of FC #1 was not appearing in IRIS (she presented copy of IRIS report at time of interview).	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 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:	V 367		

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(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 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;

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V 367	Continued From page 13 (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 a critical incident report was submitted to the Local Management Entity (LME) within 72 hours as required. The findings are. Review on 3/6/24 - 3/8/24 of former clients (FC) #1's record revealed: -52 year old female. -Admission date: 12/13/07. -Date of death: 2/20/24. -Diagnoses of Severe Intellectual Disability, Schizophrenia, History of Seizures, and Edema (leg). Review on 3/6/24 of the North Carolina Incident Response Improvement System (IRIS) website revealed: - No level II incident report was created by the facility for the allegation of abuse related to FC #1. - A level II incident report for the death of FC #1 was present at the facility but unable to be	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-723	A. BUILDING: _____ B. WING _____	R 03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHARPER IMAGES	1700 BRIDGER STREET FAYETTEVILLE, NC 28301

(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 367	Continued From page 14 located within IRIS when reviewed. Interview on 3/6/24 - 3/8/24 the Licensee stated: -She hadn't thought of completing an incident report for the allegation, as she knew where the bruising came from and that the allegation was false. -Moving forward, she would ensure level II's were completed following any allegations made and she wanted to implement new incident reports that created daily documentation of body checks. -She was not certain as to why the incident report documenting the death of FC #1 was not appearing in IRIS (she presented copy of IRIS report at time of interview).	V 367		