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
	MHL065-272	A. BUILDING: ______ B. WING ______	R 12/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON HOUSE GROUP HOME	28 BEAUREGARD DRIVE WILMINGTON, NC 28412

(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 December 22, 2023. The complaints were unsubstantiated (intake #NC00210535 and #NC00210325). Deficiencies were 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 4 and currently has a census of 4. The survey sample consisted of audits of 3 current clients.	V 000	Cape Fear Group Homes, Inc. will report all allegations against health care personnel to DHHS within 24 hours of becoming aware of the allegation, beginning 12/22/2023. The Quality Assurance Coordinator will be responsible for reporting. If the QA Coordinator is unavailable, the Executive Director (or designee) will be responsible for reporting. This will be monitored at least quarterly by the Executive Director and through the Quality Assurance/ Improvement committee.	
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 interviews, the facility failed to report to the Health Care Personnel Registry (HCPR) an allegation of	V 318	RECEIVED JAN 2 2 2024 DHSR-MH Licensure Sect	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ed Wall — TITLE: Executive Director — (X6) DATE: 1/19/24

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

Review on 12/20/23 of the North Carolina Incident Response Improvement System (IRIS) revealed the following incident was not reported within the required time.
- Date of Incident: 11/14/23.
- Date Provider Learned of Incident: 11/16/23.
- Date Submitted: 11/21/23.
- Provider Comments: "Camera footage shows that on 3rd shift, November 13,[former staff (FS) #2] brought a large box with a pack of wipes out of [client #2's] bedroom and placed it on the floor. She then proceeded to fill the box with a Costco pack of hamburger patties, loaf of bread, apple juice, eggs, cheese, toilet paper, and bottled water. She took the box to her car at 1:00 AM (Nov 14th), and left the premises. [FS #2] was the only one on shift that evening, so participants were left unattended until she returned at 3:00 AM along with another vehicle. They remained in the driveway for about 10-15 minutes before leaving again around 3:15 AM. [FS #2] did not return to the group home until almost 5:00 AM. Around 6:15 AM, another car pulled into the driveway, and [FS #2] met with someone on the front porch. [FS #2] went inside. She entered [client #2's] bedroom and retrieved a pair of black pants. She took the pants outside and gave them to the person on the porch. Also noted on the footage is possible drug use. [FS #2] can be seen in the med room, standing in front of the med cart, and holding a spoon with a clear liquid in it with one hand while using a lighter to heat it with the other hand. She is not seen on camera consuming the liquid. When asked, she stated she was taking Vitamin B. On the same night, video footage shows her standing in front of the

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V 318	Continued From page 2 washing machine, topless, presumably doing her own laundry." - Incident was reported to local Department of Social Services, local law enforcement, and client #2's guardians. Review on 12/21/23 of Complaint Intake and Health Care Personnel Investigations dated 11/22/23 revealed: - Date of incident: 11/14/23. - Date local law enforcement was notified: 11/17/23 - Investigation summary and accompanying documentation was completed on 11/17/23. - FS #2 was terminated on 11/17/23. - Documentation was completed and sent to HCPR on 11/22/23. Interview on 12/20/23 the Quality Assurance-Improvement Coordinator stated: - She was aware of the required timeframe for reporting incidents to HCPR. - There were initial problems with uploading the investigation information to the HCPR section in IRIS so a report was faxed over to HCPR on 11/22/23.	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	V 367	Cape Fear Group Homes, Inc. will report all allegations against health care personnel to the LME responsible for the catchment area, using the provided form, within 72 hours of becoming aware of the allegation, beginning 12/22/2023. The Quality Assurance Coordinator will be responsible for reporting. If the QA Coordinator is unavailable, the Executive Director (or designee) will be responsible for reporting. This will be monitored at least quarterly by the Executive Director and through the Quality Assurance/ Improvement committee.	

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V 367	Continued From page 3	V 367		

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 Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of

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V 367	Continued From page 4 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. This Rule is not met as evidenced by: Based on record reviews and interview the facility	V 367		

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V 367	Continued From page 5 failed to ensure critical incident reports were submitted to the Local Management Entity (LME) within 72 hours as required. The findings are. Finding #1: Review on 12/20/23 of the North Carolina Incident Response Improvement System (IRIS) revealed the following incident was not reported within the required time. - Date of Incident: 11/14/23. - Date Provider Learned of Incident: 11/16/23 - Date Submitted: 11/21/23. - Provider Comments: "Camera footage shows that on 3rd shift, November 13,[former staff (FS) #2] brought a large box with a pack of wipes out of [client #2's] bedroom and placed it on the floor. She then proceeded to fill the box with a Costco pack of hamburger patties, loaf of bread, apple juice, eggs, cheese, toilet paper, and bottled water. She took the box to her car at 1:00 AM (Nov 14th), and left the premises. [FS #2] was the only one on shift that evening, so participants were left unattended until she returned at 3:00 AM along with another vehicle. They remained in the driveway for about 10-15 minutes before leaving again around 3:15 AM. [FS #2] did not return to the group home until almost 5:00 AM. Around 6:15 AM, another car pulled into the driveway, and [FS #2] met with someone on the front porch. [FS #2] went inside. She entered [client #2's] bedroom and retrieved a pair of black pants. She took the pants outside and gave them to the person on the porch. Also noted on the footage is possible drug use. [FS #2] can be seen in the med room, standing in front of the med cart, and holding a spoon with a clear liquid in it with one hand while using a lighter to heat it with the other hand. She is not seen on camera consuming the liquid. When asked, she stated she was taking Vitamin B. On the same night,	V 367		

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video footage shows her standing in front of the washing machine, topless, presumably doing her own laundry."
- Incident was reported to local Department of Social Services, local law enforcement, and client #2's guardians.

Finding #2:
Review on 12/20/23 of the North Carolina Incident Response Improvement System (IRIS) revealed the following incident was not reported within the required time.
- Date of Incident: 11/13/23.
- Date Provider Learned of Incident: 11/13/23
- Date Submitted: 11/19/23.
- Provider Comments: [Client #1] began to fall while getting out of the shower/tub. He was attended by staff at the time, who reported he was shaky while getting out. She tried to break his fall. Once on the ground, he had a seizure. He was taken to the emergency room by EMS. An X-ray of his right femur indicated displaced distal femoral diaphyseal fracture."
- Incident was reported to client #1's guardians.

Interview on 12/20/23 the Quality Assurance-Improvement Coordinator stated:
- She was aware of the required timeframe for reporting incidents.
- She was out of town at the time of the incidents but completed documentation of the incidents within IRIS upon her return.