Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601529 05/01/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7239 WALDEN PARK LANE DIGSBY HOME CHARLOTTE, NC 28214 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual and complaint survey was completed on 5-1-24. The complaint was unsubstantiated (Intake # NC00215914). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 5600F Supervised Living for Alternative Family Living. This facility is licensed for two and currently has a census of one. The survey sample consisted of audits of one current client. V 132 G.S. 131E-256(G) HCPR-Notification, V 132 Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (q) 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

Division of Health Service Regulation

LABORATORY DIRECTOR OF PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED MHL0601529 B. WING 05/01/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7239 WALDEN PARK LANE DIGSBY HOME CHARLOTTE, NC 28214 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 132 Continued From page 1 V 132 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. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to report allegations against health care personnel to the Health Care Personnel Registry for 1 of 1 Alternative Family Living (AFL) Provider. The findings are: Review on 4-22-24 and 4-29-24 of the North Carolina Incident Response Improvement System (IRIS) report submitted by the Clinical Director dated 4-23-24 and updated on 4-26-24 revealed: -No documentation of an allegation that the Alternative Family Living (AFL) Provider had hit Client #1 or knocked her down. Interview on 4-26-24 with Client #1 revealed:

her down on several occasions (dates unknown). Division of Health Service Regulation

-The AFL Provider had hit her and knocked

6WNP11

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: _ COMPLETED MHL0601529 B. WING_ 05/01/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7239 WALDEN PARK LANE DIGSBY HOME CHARLOTTE, NC 28214 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5)PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 132 Continued From page 2 V 132 -The AFL Provider had also had forgotten to feed her. -She thought that she would go back with her family when she left the hospital. -She did not like the AFL Provider and did not want to go back to her house. Interview on 5-1-24 with the Clinical Director revealed: -They learned about the allegation (that the AFL Provider had hit Client #1) from Client #1's Department of Social Services Guardian. -The report just "fell through the cracks." (not reported) -Either she or the Qualified Professional should have reported the allegation in the IRIS report. V 318 13O .0102 HCPR - 24 Hour Reporting V 318 10A NCAC 130 .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).

Division	of Health Service Regu	ulation			FORM APPROVE
STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL0601529	B. WING		05/01/2024
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE	1 05/01/2024
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Біооді	TIOME	CHARL	OTTE, NC 28214		
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V 318	Continued From page	3	V 318		
	allegations against he 24 hours of the health aware of the allegatio care facility's investigathe Department. The fill the Department. The fill the Department. The fill the Department on 4-26-24 vertically a series of the AFL Provide her down on several of the AFL Provide her. She thought that family when she left the She did not like the want to go back to her literview on 4-23-24 vertically a series of the provided in the she was a series of the series of t	the facility failed to report all salth care personnel within a care facility becoming in. The results of the health ation shall be submitted to findings are: with Client #1 revealed: In had hit her and knocked accasions (dates unknown). In had also forgotten to feed she would go back with her be hospital. In he AFL Provider and did not shouse. With the AFL Provider and aware of the allegation in had hit Client #1 by the Services guardian for Client the the Clinical Director ut the allegation (that the lient #1) from Client #1's services Guardian. Ill through the cracks." (not Qualified Professional in eallegation in the IRIS		All callegation towards staff he reported in the PR se done. Climical is that she was a that she was a that the Porvider forged her. Go forward any allegation multiple reported in the reported and any will be reported any omplete a the	schill will into will in the contract of the c
V 367	27G .0604 Incident Rep	porting Requirements	V 367	eviewed by	
vision of Heal	th Service Regulation				

	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE ((X2) MULTIPLE CONSTRUCTION		
LAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
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OF PROVIDER OR SUPPLIER	STREET	ADDRESS CITY STATE	= ZIR CODE	1 08	0/01/2024
BY HOME	DER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7239 WALDEN PARK LANE CHARLOTTE, NC 28214 SUMMAP STATEMENT OF DEPOIDNCIES (CHARLOTTE, NC 28214) SUMMAP STATEMENT OF D				
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IX (EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE THE APPROPRIATE	COMPLETE
367 Continued From page	e 4	V 367			
10A NCAC 27G .060. REPORTING REQUIT CATEGORY A AND E (a) Category A and E level II incidents, except the provision of billab consumer is on the princidents and level II to whom the provider 90 days prior to the in responsible for the caservices are provided becoming aware of the besubmitted on a form Secretary. The report in person, facsimile or means. The report shinformation: (1) reporting providentification informatication	REMENTS FOR B PROVIDERS B providers shall report all ept deaths, that occur during le services or while the roviders premises or level III deaths involving the clients rendered any service within recident to the LME atchment area where within 72 hours of the incident. The report shall me provided by the that may be submitted via mail, the encrypted electronic hall include the following the provider contact and con; the finding that is a contact and contact and con; the finding that is a contact and con	V 367			

		OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE COMP	SURVEY
ŀ			MHL0601529	B. WING		05/	/01/2024
	NAME OF P	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
	DIGSBY	HOME		LDEN PARK LANE OTTE, NC 28214			
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
		upon request by the Li obtained regarding the (1) hospital reco information; (2) reports by ot (3) the provider's (4) Category A and B of all level III incident responsible to the providers shall send a incidents involving a click that the client death within several becoming aware of the providers shall send a incidents involving a click that the provider shall be soming aware of the client death within several becoming aware of the providers shall send a incident shall be several becoming aware of the client death within several becoming aware of the providers shall send a incident shall be served a limitation of a level II or (2) restrictive intention of a level II or (3) searches of a level II or (4) seizures of client becoming aware of the providers and II or (5) the total number of the client death within several becoming aware of the providers and II or (5) the total number of the client death within several becoming aware of the providers and II or (6) a statement in the providers and II or (7) and II or (8) and II or (8) and II or (9) and II or (1) an	ME, other information a incident, including: ords including confidential ther authorities; and a response to the incident. providers shall send a copy eports to the Division of pmental Disabilities and vices within 72 hours of a incident. Category A copy of all level III itent death to the Division of a incident. In cases of an days of use of seclusion are shall report the death and by 10A NCAC 26C 27E .0104(e)(18). Providers shall send a lamb a lamb a lamb a services are provided. The services are provided and to a form provided and to a sollows: The rors that do not meet the level III incident; are the level III incident; and the level III incident; and the level III and level III and dicating that there have dents whenever no during the quarter that as set forth in Paragraphs	V 367			

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601529 05/01/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7239 WALDEN PARK LANE DIGSBY HOME CHARLOTTE, NC 28214 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRFFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 367 Continued From page 6 V 367 through (4) of this Paragraph. This Rule is not met as evidenced by: All reports requiring an IRIs report will be done 6-1-24 within 72 hrs. Based on record reviews and interviews, the facility failed to report all Level 2 incidents to the Local Management Entity (LME) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident. The findings are: Review on 4-29-24 of North Carolina Incident Response Improvement System (IRIS) revealed: -Incident dated 4-11-24 entered on 4-23-24 and updated on 4-26-24. -Client #1 was eating with her Alternative Family Living (AFL) Provider and soda spilled on her accidentally. Client #1 became extremely upset aggressive. When the AFL Provider attempted to take Client #1 home Client #1 started saying she was going to kill herself. The AFL Provider took Client #1 to the local emergency room, police were called. When the police arrived Client #1 pulled out a disposable shaver to attack the AFL Provider, Police handcuffed Client #1 and she was admitted to a local behavioral health unit. reviewed by Interview on 4-26-24 with Client #1 revealed: -Client #1 would not talk about trying to attack

revealed:

her AFL Provider with a disposable razor.

Interview on 5-1-24 with the Clinical Director

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PRINTED: 05/17/2024 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL0601529 05/01/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7239 WALDEN PARK LANE DIGSBY HOME CHARLOTTE, NC 28214 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 367 Continued From page 7 V 367 All IRIS reports will be made within 72 hrs Ofincident 6-1-24 -The report "fell through the cracks." (not reported) -The report should have been filed in a timely manner, as soon as they knew that police were involved. reviewed bu

PRINTED: 05/17/2024 Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: MHL0601529 05/01/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7239 WALDEN PARK LANE **DIGSBY HOME** CHARLOTTE, NC 28214 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual and complaint survey was completed on 5-1-24. The complaint was unsubstantiated (Intake # NC00215914). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 5600F Supervised Living for Alternative Family Living. This facility is licensed for two and currently has a census of one. The survey sample consisted of audits of one current client V 132 G.S. 131E-256(G) HCPR-Notification, V 132 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

Division of Health Service Regulation

are being provided.

healthcare facility.

a patient or client for whom the employee is LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

c. Misappropriation of the property of a

facility or to a patient or client.

(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

d. Diversion of drugs belonging to a health care

e. Fraud against a health care facility or against

TITLE

(X6) DATE

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED MHL0601529 B. WING 05/01/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7239 WALDEN PARK LANE DIGSBY HOME CHARLOTTE, NC 28214 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 132 Continued From page 1 V 132 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. All allegations
will he reported
a the HCPR will 6-1-24
ne completed as This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to report allegations against health care personnel to the Health Care Personnel Registry for 1 of 1 Alternative Family Living (AFL) Provider. The findings are: Review on 4-22-24 and 4-29-24 of the North Carolina Incident Response Improvement System (IRIS) report submitted by the Clinical Director

her down on several occasions (dates unknown). Division of Health Service Regulation

dated 4-23-24 and updated on 4-26-24 revealed: -No documentation of an allegation that the Alternative Family Living (AFL) Provider had hit

Interview on 4-26-24 with Client #1 revealed: -The AFL Provider had hit her and knocked

Client #1 or knocked her down.

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED
			A. BUILDING	:	CON	PELED
		MHL0601529	B. WING		0:	5/01/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
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/Y4\\ID	SLIMMADVSTA	ATEMENT OF DEFICIENCIES	TE, NC 2821			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 132	Continued From page	2	V 132			
V 0.40	feed her. -She thought that family when she left th -She did not like to want to go back to her interview on 5-1-24 with revealed: -They learned about AFL Provider had hit of Department of Social Streported) -Either she or the should have reported to report.	the AFL Provider and did not house. the Clinical Director but the allegation (that the client #1) from Client #1's Services Guardian. ell through the cracks." (not Qualified Professional the allegation in the IRIS				
	personnel as defined in including injuries of unk done within 24 hours of becoming aware of the the health care facility's	INVESTIGATING AND CARE PERSONNEL care facilities to the ations against health care G.S. 131E-256 (a)(1), known source, shall be the health care facility allegation. The results of	V 318			

Division	of Health Service Regu	ulation			FORM APPROVED
STATEME	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		MHL0601529	B. WING		05/01/2024
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	TE. ZIP CODE	1 00/01/2027
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DIGGET	HOME	CHARL	OTTE, NC 28214		
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V 318	Continued From page	3	V 318		
	allegations against he 24 hours of the health aware of the allegatio care facility's investigathe Department. The 1 health aware of the allegatio care facility's investigation that the Department. The 1 health aware on 4-26-24 was also as a second of the 1 health aware of the 1 health	the facility failed to report all calth care personnel within a care facility becoming in. The results of the health ation shall be submitted to findings are: with Client #1 revealed: with A hit her and knocked accasions (dates unknown). In had also forgotten to feed she would go back with her are hospital. The AFL Provider and did not shouse. with the AFL Provider ade aware of the allegation are had hit Client #1 by the Services guardian for Client		Any allegation made towards Staff will he reported immediately will be completed a teamed neces	dictely. I also
	AFL Provider had hit C Department of Social S -The report just "fe reported) -Either she or the 6 should have reported th report and done an inter-	out the allegation (that the lient #1) from Client #1's Services Guardian. If through the cracks." (not Qualified Professional ne allegation in the IRIS ernal investigation.		Reviewed 104,	
V 367	27G .0604 Incident Rep	porting Requirements	V 367		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		TE SURVEY MPLETED
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NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
DIGSBY I	НОМЕ	7239 WALE	DEN PARK L	ANE		
		CHARLOT	TE, NC 2821	4		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
	level II incidents, exce the provision of billable consumer is on the pro- incidents and level II d to whom the provider r 90 days prior to the incresponsible for the cate services are provided to becoming aware of the be submitted on a form Secretary. The report in person, facsimile or means. The report sha information:	REMENTS FOR PROVIDERS providers shall report all pt deaths, that occur during e services or while the oviders premises or level III eaths involving the clients endered any service within cident to the LME chment area where within 72 hours of incident. The report shall in provided by the may be submitted via mail, encrypted electronic				
	identification informatio (2) client identific (3) type of incide (4) description of (5) status of the e cause of the incident; a (6) other individual or responding. (b) Category A and B p missing or incomplete in shall submit an updated report recipients by the day whenever: (1) the provider h information provided in e erroneous, misleading of (2) the provider of	ration information; Int; Incident; Incident; Incident to determine the Indicated als or authorities notified Incoviders shall explain any Information. The provider Incorrect to all required Incorrect				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPE	E CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAI	N OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			IPLETED
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		MHL0601529	B. WING			
		WHL0001529	B. W. (C		05	5/01/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
DIGSBY	HOME	7239 WAI	LDEN PARK LA	NE		
D.00D1		CHARLO	TTE, NC 28214	1		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	E CORRECTION	
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO	THE APPROPRIATE	DATE
				DEFICIEN	CY)	
V 367	Continued From page	5	V 367			
	Upon request by the I	NATE -41				
	upon request by the L	ivie, other information				
	obtained regarding the					
	(1) hospital reco	ords including confidential				
		her authorities; and				
	(3) the provider's	s response to the incident.				
	(d) Category A and B	providers shall send a copy				
	of all level III incident r	eports to the Division of				
	Substance Al Develo	pmental Disabilities and				
		rices within 72 hours of				
	becoming aware of the	incident. Category A				
	providers shall send a	copy of all level III				
	Health Carrier Devel	ient death to the Division of				
	Health Service Regular	tion within 72 hours of				
	becoming aware of the	incident. In cases of				
	client death within seve	en days of use of seclusion				
	or restraint, the provide	er shall report the death				
	immediately, as require	ed by 10A NCAC 26C				
	.0300 and 10A NCAC 2	27E .0104(e)(18).				
	(e) Category A and B p	providers shall send a				
	report quarterly to the L	.ME responsible for the				
	catchment area where	services are provided.				
	The report shall be sub	mitted on a form provided				
	by the Secretary via ele	ectronic means and shall				
	include summary inform	nation as follows:				1
	(1) medication er	rors that do not meet the				
	definition of a level II or					
	(2) restrictive inte	rventions that do not meet				
	the definition of a level I					
	(3) searches of a	client or his living area;				
	(4) seizures of clie	ent property or property in				
	the possession of a clie					
	(5) the total numb	er of level II and level III				
	incidents that occurred;					
	(6) a statement in	dicating that there have				
	been no reportable incid	lents whenever no				i
	incidents have occurred	during the quarter that				- 1
	meet any of the criteria a	as set forth in Paragraphs				1
	(a) and (d) of this Rule a	ind Subparagraphs (1)				- 1
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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED MHL0601529 B. WING 05/01/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7239 WALDEN PARK LANE DIGSBY HOME CHARLOTTE, NC 28214 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 367 Continued From page 6 V 367 through (4) of this Paragraph. All Level 2 incidences Will he reported within Mahrs & This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all Level 2 incidents to the Local Management Entity (LME) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident. The findings are: Review on 4-29-24 of North Carolina Incident Response Improvement System (IRIS) revealed: -Incident dated 4-11-24 entered on 4-23-24 and updated on 4-26-24. -Client #1 was eating with her Alternative Family Living (AFL) Provider and soda spilled on her accidentally. Client #1 became extremely upset aggressive. When the AFL Provider attempted to take Client #1 home Client #1 started saying she was going to kill herself. The AFL Provider took Client #1 to the local emergency room, police were called. When the police arrived Client #1 pulled out a disposable shaver to attack the AFL Provider. Police handcuffed Client #1 and she was admitted to a local behavioral health unit.

revealed:

Interview on 4-26-24 with Client #1 revealed:

her AFL Provider with a disposable razor.

Interview on 5-1-24 with the Clinical Director

-Client #1 would not talk about trying to attack

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ MHL0601529 B. WING_ 05/01/2024

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V 367 Continued From page 7 -The report "fell through reported) -The report should have manner, as soon as they kn involved.	V 367 the cracks." (not be been filed in a timely	G CROSS-REFERENCEI	O TO THE APPROPRIATE DAT

PLAN OF CORRECTION

DIGSBY HOME

ALL DEFICIENCIES WILL BE CORRECTED BY OR BEFORE 6-30-24. IRIS REPORTS WILL BE DONE WITHIN 72HRS OF THE INCIDENT. ALL ALLEGATIONS THAT ARE MADE BY A CONSUMER WILL BE REPORTED AND A HCPR WILL BE COMPLETED IMMEDIATELY WHEN THE IRIS IS DONE.

(CLINICAL DIRECTOR) WILL ENSURE ALL INCIDENT REPORTS ARE REVIEWED AND DISCUSSED WITH THE ASSIGNED QUALIFIED PROFESSIONAL. THE INCIDENT WILL BE DETERMINED IF AN IRIS REPORT WILL NEED TO BE DONE OR AN HCPR.

WILL COMPLETE A TRAINING FOR ALL QP'S ON INCIDENT REPORTING AND COMPLETION OF AN IRIS REPORT TO ENSURE IT IS BEING DONE CORRECTLY AND IN THE APPROPRIATE TIME FRAME.

WILL MONITOR EACH INCIDENT AS THEY OCCUR.

IRIS TRAINING WILL BE DONE BY 7-1-24
HCPR TRAINING WILL BE DONE BY 7-1-24