STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL090-163	A. BUILDING: _____ B. WING _____	R 06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHGATE GROUP HOME	818 GATE ROAD MONROE, NC 28110

(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 An annual and complaint survey was completed 6-17-24. The complaint was substantiated (#NC00216361). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 5600A Supervised Living for Adults with Mental Illness. This facility is licensed for five and currently has a census of four. The survey sample consisted of audits of three current clients.	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 reviews and interviews the facility failed to report allegations of abuse to the Health Care Personnel Registry within 24 hours of becoming aware of the incident. The findings	V 318		

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V 318	Continued From page 1 are: Review on 6-3-24 of the facility's Internal Investigation dated 5-24-24 revealed: -Residential Director was interviewing Client #1 on 4-18-24 when Client #1 made an allegation that Former Staff #1 had cursed at him. Review on 6-3-24 of North Carolina Incident Response Improvement System (IRIS) revealed: -Report to the Health Care Personnel Registry was not reported until 4-23-24. Interview on 6-17-24 with the Residential Director revealed: -He didn't know how he missed putting the report into the Health Care Personnel Registry on time. -He had been working on another allegation at the time, and it had just been overlooked. -He was aware that he had 24 hours to report allegations of abuse.	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	V 367		

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V 367	Continued From page 2 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 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	V 367		

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V 367	Continued From page 3 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 review and interview the facility failed to report a level II incident to the Local Management Entity (LME) within 72 hours of first learning of the incident. The findings are:	V 367		

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V 367	Continued From page 4 Review on 6-3-24 of the facility's Internal Investigation dated 5-24-24 revealed: -Residential Director was interviewing Client #1 on 4-18-24 when Client #1 made an allegation that Former Staff #1 had cursed at him. Review on 6-3-24 of North Carolina Incident Response Improvement System (IRIS) revealed: -Incident on 4-18-24 was not submitted to IRIS until 4-23-24. Interview on 6-17-24 with the Residential Director revealed: -He didn't know how he missed putting the report into IRIS on time. -He had been working on another allegation at the time, and it had just been overlooked. -He was aware that he had 72 hours to report allegations to IRIS.	V 367		