STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _			
		MHL059-094	B. WING		O9/03/2	2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PEOPLE I	HELPING PEOPLE	252 NC 120 NEBO, NC				
0.0.1=	CLIMMADY CT			DDOVIDED'S DI AN OF CORDECTION	vi .	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE ((X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	A complaint survey w The complaint was su #NC00219665). Defi	,				
	•	d for the following service 27G .5400 Day Activity for bility Groups.				
	This facility has a current census of 26. The survey sample consisted of an audit of 1 current client.					
V 366	27G .0603 Incident R	esponse Requirements	V 366			
	implement written pol response to level I, II shall require the prov (1) attending to of individuals involved (2) determining (3) developing measures according timeframes not to exc (4) developing to prevent similar inci specified timeframes (5) assigning p for implementation of preventive measures (6) adhering to set forth in G.S. 75, A 42 CFR Parts 2 and 3 164; and (7) maintaining	REMENTS FOR B PROVIDERS B providers shall develop and icies governing their or III incidents. The policies ider to respond by: The health and safety needs in the incident; The cause of the incident; The cause o				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

PRINTED: 09/04/2024 FORM APPROVED

Division of	<u>of Health Service Regu</u>	lation	_		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			B. WING		C
		MHL059-094	D. WING		09/03/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		252 NC 120	5		
PEOPLE H	HELPING PEOPLE	NEBO, NC			
040.15	CLIMMADY CT	ATEMENT OF DEFICIENCIES		DROVIDER'S DI AN OF CORRECTION	1 0/5
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
V 366	Continued From page	. 1	V 366		
V 300	Continued From page	- 1	1 300		
	(b) In addition to the	requirements set forth in			
	Paragraph (a) of this	Rule, ICF/MR providers			
	shall address incident	ts as required by the federal			
	regulations in 42 CFF	R Part 483 Subpart I.			
	(c) In addition to the	requirements set forth in			
	Paragraph (a) of this	Rule, Category A and B			
	providers, excluding I	CF/MR providers, shall			
	develop and impleme	ent written policies governing			
		vel III incident that occurs			
	while the provider is o	delivering a billable service			
	or while the client is o	on the provider's premises.			
	The policies shall req	uire the provider to respond			
	by:				
		securing the client record			
	by:	-			
		e client record;			
	(B) making a pl	hotocopy;			
	(C) certifying th	ne copy's completeness; and			
	(D) transferring	the copy to an internal			
	review team;				
	(2) convening a	a meeting of an internal			
	review team within 24	hours of the incident. The			
	internal review team s	shall consist of individuals			
	who were not involve	d in the incident and who			
	were not responsible	for the client's direct care or			
	with direct profession	al oversight of the client's			
	services at the time o	f the incident. The internal			
	review team shall con	nplete all of the activities as			
	follows:				
	(A) review the c	opy of the client record to			
	determine the facts a	nd causes of the incident			
	and make recommen	dations for minimizing the			
	occurrence of future i	ncidents;			
	(B) gather othe	r information needed;			
		n preliminary findings of fact			
	• •	rys of the incident. The			
	_	f fact shall be sent to the			
		nent area the provider is			
		IF where the client resides			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		IED
		MUU 050 004	B. WING		C	
		MHL059-094	D. 111110		09/0	3/2024
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
PEOPLE I	HELPING PEOPLE	252 NC 12 NEBO, NO				
	CHMMADV CT	·		DROVIDER'S DI AN OF CORRECTI	ON	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 366	Continued From page	e 2	V 366			
	if different; and (D) issue a final owner within three me final report shall be so catchment area the p LME where the client final written report shall dentified by the interninclude all public doctincident, and shall ma minimizing the occurr all documents needed available within three LME may give the prothere months to subm (3) immediately (A) the LME resarea where the service Rule .0604; (B) the LME while different; (C) the provide for maintaining and untreatment plan, if different provider; (D) the Departm (E) the client's applicable; and	written report signed by the conths of the incident. The ent to the LME in whose rovider is located and to the resides, if different. The all address the issues nal review team, shall uments pertinent to the ake recommendations for rence of future incidents. If d for the report are not months of the incident, the evider an extension of up to nit the final report; and a notifying the following: sponsible for the catchment rese are provided pursuant to the regent the client resides, if agency with responsibility pdating the client's erent from the reporting				
	failed to implement w	as evidenced by: ew and interview, the facility ritten policies governing rel I, II or III incidents. The				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		MHL059-094	B. WING		0.9	C 9/03/2024
NAME OF D		•	DDDEGG GITY GTATE	710.0005	1 00	77072024
NAME OF P	ROVIDER OR SUPPLIER	252 NC -	ADDRESS, CITY, STATE	, ZIP CODE		
PEOPLE I	HELPING PEOPLE		126 NC 28761			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 366	-admission date 5/13 -diagnoses of Modern Developmental Disalt Mellitus, Hyperthyroid Attention-Deficit Hyperthyroid Attenti	f Client #1's record revealed: //13. ate Intellectual bility, Dementia, Diabetes dism, Anxiety, eractivity Disorder, and an internal incident report ed: a other clients, were traveling I reached their destination tly laid down in the van seat of the van upon arrival). Staff ound 9:30 a.m., staff went to van and found client (Client Client was checked and he no visible signs of distress or	V 366	DEL IOIENC	.,	
	-staff did not know th	e time frame exactly, felt it 15 minutes" Client #1 was				

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STATE FORM 4DEI11 If continuation sheet 4 of 8

DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
ORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
				С	
	MHL059-094	B. WING		09/03/2024	
INER OR SLIPPLIER	STREET ADI	DESS CITY STA	TE ZIR CODE		
IDEN ON SUFFLIER		, ,	TE, ZIF GODE		
PING PEOPLE					
	·	20701			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
ontinued From page	e 4	V 366			
ft alone in the van. It was early still and otcould have been ot." Then Client #1 return egistered Nurse/Qua kamined him and he Client #1's legal guar terview on 9/3/24 w everything that was of cident had been reco	cool that morningwasn't a different outcome if it was need to the facility the alified Professional (RN/QP) was "fine." rdian was not contacted. ith the RN/QP revealed: completed regarding the served.				
DA NCAC 27G .0604 EPORTING REQUIL ATEGORY A AND B) Category A and B vel II incidents, exce e provision of billable onsumer is on the precidents and level II of whom the provider didays prior to the in esponsible for the cate ervices are provided ecoming aware of the esubmitted on a form ecretary. The report person, facsimile of eans. The report st formation:) reporting pre- entification informat	A INCIDENT 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 acident to the LME atchment area where within 72 hours of the incident. The report shall m provided by the t may be submitted via mail, r encrypted electronic hall include the following ovider contact and ion;	V 367			
	DIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENCY REGULATORY OR IT Ontinued From page of alone in the van. It was early still and obt could have been obt." When Client #1 return registered Nurse/Questamined him and he client #1's legal guar and terview on 9/3/24 we verything that was obticed in the incident was not one incident reporting the incident was not of a could be provided by the provider of the pro	IDENTIFICATION NUMBER: MHL059-094 IDER OR SUPPLIER STREET ADI 252 NC 12 NEBO, NO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Dontinued From page 4 fit alone in the van. It was early still and cool that morningwasn't bitcould have been a different outcome if it was bit." When Client #1 returned to the facility the egistered Nurse/Qualified Professional (RN/QP) training that was completed regarding the cident had been received. Ilevel one incident report was completed. In evel one incident Reporting Requirements DA NCAC 27G .0604 INCIDENT EPORTING REQUIREMENTS FOR ATEGORY A AND B PROVIDERS O Category A and B providers shall report all vel II incidents, except deaths, that occur during the provision of billable services or while the ensumer is on the providers premises or level III cidents and level II deaths involving the clients whom the provider rendered any service within the provider rendered any service within the provider of the incident. The report shall ensumer is on the incident area where the provider of the incident. The report shall ensumited on a form provided by the ensure are provided within 72 hours of the incident. The report shall ensumited on a form provided by the encretary. The report may be submitted via mail, person, facsimile or encrypted electronic teans. The report shall include the following formation: In reporting provider contact and tentification information; In client identification information; In client identification information;	IDER OR SUPPLIER STREET ADDRESS, CITY, STA 252 NC 126 NEBO, NC 28761 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) To antinued From page 4 fit alone in the van. It was early still and cool that morningwasn't butcould have been a different outcome if it was but." Then Client #1 returned to the facility the egistered Nurse/Qualified Professional (RN/QP) tamined him and he was "fine." Idient #1's legal guardian was not contacted. Iterview on 9/3/24 with the RN/QP revealed: verything that was completed regarding the cident had been received. Ievel one incident report was completed. Ie incident was not submitted to the LME. IO .0604 Incident Reporting Requirements IO ANCAC 27G .0604 INCIDENT EPORTING REQUIREMENTS FOR ATEGORY A AND B PROVIDERS IO Category A and B providers shall report all vel II incidents, except deaths, that occur during e provision of billable services or while the submitted on a form provided by the correctory. The report may be submitted via mail, person, facsimile or encrypted electronic eans. The report shall include the following formation: In client identification information; ID CIENTAL ADDRESS AND STREET ADDRESS. IO Category Of the catchment area where envices are provided within 72 hours of excending aware of the incident. The report shall excending aware of the incident. The report shall excending aware of the incident. The report shall excending aware of the incident of the LME excending aware of the incident of the catchment area where envices are provided within 72 hours of excending aware of the incident to the LME excending aware of the incident of the LME excending aware of the incident of the LME excending aware of the incident of	IDENTIFICATION NUMBER: MHL059-094	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			00 22.23
MHL059-094	B. WING		C 09/03/2024
NAME OF PROVIDER OR SUPPLIER STREET A	ADDRESS, CITY, STATE	E, ZIP CODE	
252 NC	126		
PEOPLE HELPING PEOPLE NEBO, N	NC 28761		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
(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 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.	V 367		

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			SURVEY PLETED
		MHL059-094	B. WING		90	C 0/ 03/2024
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
DEOD! E	HELDING DEODLE	252 NC 1	26			
PEOPLE	HELPING PEOPLE	NEBO, N	C 28761			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 367	by the Secretary via e include summary info (1) medication definition of a level II (2) restrictive in the definition of a level (3) searches of (4) seizures of the possession of a control (5) the total numerical incidents that occurrence (6) a statement been no reportable in incidents have occurrence the any of the criter (1) medical incidents in the criter (2) includes the criter (3) includes the criter (4) incidents have occurrence (5) incidents have occurrence (6) incidents hav	ubmitted on a form provided electronic means and shall armation as follows: errors that do not meet the or level III incident; nterventions that do not meet el II or level III incident; f a client or his living area; client property or property in lient; mber of level II and level III ed; and at indicating that there have icidents whenever no eled during the quarter that in as set forth in Paragraphs e and Subparagraphs (1)	V 367			
	failed to report a leve Response Improveme	as evidenced by: ew and interview, the facility I II incident in the Incident ent System (IRIS) within 72 ware of the incident. The				
	-admission date 5/13, -diagnoses of Modera Developmental Disab Mellitus, Hyperthyroid	ate Intellectual vility, Dementia, Diabetes				

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DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
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		MHL059-094	B. WING		09/03/2024
NAME OF D	20/4050 00 011001150	OTDEET AS	DDEGG OITY OTA	TE 710 000E	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	I E, ZIP CODE	
DEOD! E I	IEI DING DEODI E	252 NC 12	26		
PEOPLE	IELPING PEOPLE	NEBO, N	28761		
	OLIMANA DV OT	· · · · · · · · · · · · · · · · · · ·		DDOV/DEDIO DI ANI OF CODDECTION	
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	()
PREFIX TAG	,	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
.,		,	1.7.0	DEFICIENCY)	
V 367	Continued From page	2 7	V 367		
	1 3				
	Review on 9/3/24 of a	a level I internal incident			
	report dated 4/18/24 r	revealed:			
	•	other clients, were traveling			
		reached their destination			
	-	reached their destination			
	"around 9:00 a.m."				
		ly laid down in the van seat			
	and did not get out (o	f the van upon arrival). Staff			
	did not noticeAt arc	ound 9:30 a.m., staff went to			
get a tent out of the van and found client (Client #1) sitting in the van. Client was checked and he					
		o visible signs of distress or			
		o visible signs of distress of			
	trauma"				
	Review on 9/3/24 of t	he DHSR IRIS system			
	revealed:				
	-there was no inciden	t report for Client #1			
	involving the 4/18/24	· ·			
	ge ., .e,= .				
	Intorvious on 9/20/24 s	with Client #1 revealed:			
		er his name, date of birth			
	and where he lived.				
		nswer questions about the			
	above incident.				
	Interview on 8/30/24 v	with the Vice President			
	revealed:				
	-he conducted the inv	estigation regarding the			
	incident on 4/18/24.	conganon rogarding the			
		to be a level Lineident			
	-uns was determined	to be a level I incident.			
		ith the RN/QP revealed:			
	-it was her responsibi	lity to ensure level II and III			
	incidents were entere				

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