STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL040-006	A. BUILDING: _____ B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPEWELL	292 DOGWOOD LANE SNOW HILL, NC 28580

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on August 27, 2024. The complaint was unsubstantiated (intake #NC00221037). A deficiency was 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 6 and has a current census of 5. The survey sample consisted of audits of 3 current clients.	V 000		
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	V 367		

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V 367	Continued From page 1	V 367		

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. The report shall be submitted on a form provided by the Secretary via electronic means and shall

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V 367	Continued From page 2 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 interviews, the facility failed to submit incident reports to the Incident Response Improvement System (IRIS) and to Local Management Entity/Managed Care Organization (LME/MCO) responsible for the catchment area where services are provided within 72 hours of becoming aware of the incidents. The findings are: Review on 8/26/24 and 8/26/24 of the IRIS system from July 2024 thru August 27, 2024 revealed: -No documentation of an incident report for 8/8/24 for client #1 due to police and emergency services involvement.	V 367		

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-No documentation that an incident report for 8/8/24 for client #1 was submitted to the Local Management Entity/Managed Care Organization (LME/MCO) responsible for the catchment area where services are provided within 72 hours of becoming aware of the incidents.

Review on 08/27/24 of 2 facility incident reporting forms for client #1 dated 8/8/24 revealed:
- Report completed by Group Home Leader- "Description of the incident including facts only: On 8/8/24 @ 11:55pm [client #1] walked through the living and out the from door. He proceed to run once he got out the door...I yelled for him to come back but he would not listen...called 911... [client #1 was gone for a little less than an hour...we found him at 12:45am in the field across from the house...EMS took him to [local hospital] in [nearby city]...I followed the EMS to the hospital..."

- Report completed by staff #1; "On 8/8/24 [client #1] came out of his room around 11:55pm, walks from his room to the living room and straight out the front door...myself and other staff member goes out behind him. He starts to speed walking while the other staff is still trying to get him to back...the other staff member looses sight of [client #1] but states that he knows the vicinity of where he was headed...he calls 911. When police arrived the looked for him around the wooded area first...They searched the baseline of the woods...they did find in the field across from the house...it was 12:45am when they found him. The other staff member followed the [EMS] to the hospital..."

Interview on 8/26/24 the Group Home Leader stated
- He called 911 when client #1 had not responded

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V 367	Continued From page 4 to redirection and he could no longer see him. - Client #1 was gone for less than an hour and he knew the area he was in. - He has completed an incident reporting form. During interview on 08/27/24 and the Qualified Professional revealed: - Staff had completed the internal incident reporting form and he had reviewed it. - He had not submitted a report for client #1 to the IRIS system or to the LME/MCO. - He understood the reporting requirements and would ensure a report was entered for the incident involving client #1 on 8/8/24.	V 367		