STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411187	A. BUILDING: _____ B. WING _____	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARTER'S HOUSE	1606-H PINECROFT ROAD GREENSBORO, NC 27407

(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 survey was completed on 10/3/24. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 3 and has a current census of 3. 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 cause of the incident; and (6) other individuals or authorities notified	V 367		

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V 367	Continued From page 1	V 367		

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 include summary information as follows:
(1) medication errors that do not meet the

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V 367	Continued From page 2 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 report all Level III incidents to the Local Management Entity (LME)/Managed Care Organization (MCO) responsible for the catchment area where services were provided within 72 hours of becoming aware of the incident. The findings are: Review on 10/3/24 of the North Carolina Incident Response Improvement System (IRIS) revealed: - No IRIS report had been submitted regarding client #1 being restrained on 9/16/24. Review on 10/3/24 of the "Internal Incident Report" dated 9/17/24 revealed: - Date of incident: 9/16/24 - Reporter: Staff #2	V 367		

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V 367	Continued From page 3	V 367		

- "Interventions Implemented: Therapeutic hold...held hands."
- "She started throwing stuff and hitting me...I held her hands until QP (Qualified Professional #1/Licensee) pulled up. QP came and she hurried to sit on bed as if nothing happened."
- Signed by the QP #1/Licensee

Interview on 10/2/24 with client #1 revealed:
- She did not want to talk about the restraint.

Interview on 10/2/24 with client #2 revealed:
- She was in her bedroom and did not see the 9/16/24 restraint.

Interview on 10/2/24 with client #3 revealed:
- She was in her bedroom and did not see the 9/16/24 restraint.

Interview on 10/3/24 with staff #2 revealed:
- Client #1 was upset sometime in September 2024 because her doctor had changed her medication and she wanted to talk to the QP #1/Licensee who was not available when client #1 wanted to talk to her.
- Client #1 started doing property destruction in her bedroom and was close to the window.
- She held client #1's hands and guided her to the bed where client #1 sat down.
- Client #1 calmed down when QP #1/Licensee and QP #2 arrived at the facility.

Interview on 10/3/24 with the QP #1/Licensee revealed:
- The restraint that staff #2 did on client #1 occurred sometime in September 2024.
- She did not complete a level II IRIS incident report about the restraint.