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	MHL0411161	A. BUILDING: _____ B. WING _____	R-C 12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANGING LIVES GROUP HOME IV, LLC	1404 CUSHING STREET GREENSBORO, NC 27405

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on December 4, 2024. The complaint was unsubstantiated (Intake #NC00223172). 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 4 and has a current census of 3. The survey sample consisted of audits of 1 current client.	V 000		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and	V 366		

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(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.
(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.
(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:
(1) immediately securing the client record by:
(A) obtaining the client record;
(B) making a photocopy;
(C) certifying the copy's completeness; and
(D) transferring the copy to an internal review team;
(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:
(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;
(B) gather other information needed;
(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the

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V 366	Continued From page 2 LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews, the	V 366		

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facility failed to implement policies governing their response to level II incidents. The findings are:

Review on 11/25/24 of client #1's record revealed:
-Date of Admission: 3/20/24;
-Diagnoses: Schizophrenia Disorder; other Psychotic Disorders, Atopic Dermatitis, and Gastroesophageal Reflux Disease (GERD);
-Hospitalization dated 9/13/24 for aggressive behavior.

Review on 11/26/24 of the facility's internal incident report dated 9/13/24 revealed:
-Client #1 came out of his bedroom into the livingroom and was cursing/yelling. Client #1 called staff #1 several racial slurs;
-Client #1 contacted law enforcement from his cellphone and alleged that staff #1 "smashed his hand" in the door. Client #1 was taken to the behavioral health hospital;
-Law enforcement and a social worker arrived at the facility and spoke with client #1;
-Law enforcement contacted client #1's guardian to confirm client #1's injury occurred at the day program.

Review on 12/4/24 of the North Carolina Incident Response Improvement System (IRIS) from September 9, 2024 to November 25, 2024 revealed:
-No report was submitted for the incident that occurred on 9/13/24.

Interview on 11/26/24 with client #1 revealed:
-He and staff #1, "got into it" (argument) because all he had to eat was fish sticks;
-On 9/13/24, "I called the police on myself and I told law enforcement that I needed to go to the hospital;"
-"[Staff #1] slammed the door on my hand", when

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he attempted to go outside. Then contradicted himself and stated, "the day before (9/12/24), I punched a door at the day program;"
-No additional information was provided about his hand.

Interview on 11/26/24 with staff #1 revealed:
-He denied smashing client #1's hand in the door and client #1 was not restrained;
-Emergency Medical Services came and checked out client #1's hand;
-The day before (9/12/24), client #1 punched a door at the day program.

Interview on 11/26/24 with the Legal Guardian of client #1 revealed:
-"I absolutely have no concerns about the licensee. [Client #1] always makes allegations (false allegations) against staff to leave the facility;"
-On 9/12/24, he received a call from client #1's day program about him, "going off" (having a behavior). "[Client #1] damaged a door and his hand;"
-"[Client #1] blamed [staff#1] for hurting his hand."

Interview on 11/26/24 and 12/4/24 with the Qualified Professional revealed:
-No risk cause analysis was completed of the incident on 9/13/24;
-"They (licensee) have not had a formal meeting with [client #1's] team" to discuss the incident that occurred on 9/13/24;
-She received a telephone call from staff #1 during the incident. She overheard client #1 calling staff #1 derogatory names "porch monkey;"
-The reason client #1 became upset was unknown. Client #1 also "bucked up" to staff #1 (like he wanted to fight him);

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V 366	Continued From page 5 -Staff #1 contacted law enforcement and client #1 asked to be transported to the hospital; -The next day (9/14/24) she received a message from the hospital that client #1 was ready for discharge. She contacted staff #1 and notified him to pick up client #1 from the behavioral health hospital; -"I thought that some of client #1's behaviors were mimicking or feeding off of his roommate's behavior."	V 366		
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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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 7 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 ensure a Level III incident report was submitted to the Local Management Entity (LME)/Managed Care Organization (MCO) within 72 hours as required. The findings are: Review on 11/26/24 of client #1's record revealed: -Date of Admission: 3/20/24; -Diagnoses: Schizophrenia Disorder; other Psychotic Disorders, Atopic Dermatitis, and Gastroesophageal Reflux Disease (GERD); -Hospitalization dated 9/13/24 for aggressive behavior. Review on 11/26/24 of the facility's internal incident report dated 9/13/24 revealed: -Client #1 came into the livingroom and was	V 367		

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cursing/yelling. Client #1 called staff #1 several racial slurs;
-Client #1 contacted law enforcement from his cellphone and alleged that staff #1 "smashed his hand" in the door. Client #1 was taken to the behavioral health hospital;
-Law enforcement and a social worker arrived at the facility and spoke with client #1;
-Law enforcement contacted client #1's guardian to confirm client #1's injury occurred at the day program.

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Interview on 11/26/24 with client #1 revealed:
-He and staff #1, "got into it" (argument) because all he had to eat was fish sticks;
-On 9/13/24, "I called the police on myself and I told law enforcement that I needed to go to the hospital;"
-"[Staff #1] slammed the door on my hand", when he attempted to go outside. Then contradicted himself and stated, 'the day before (9/12/24), I punched a door at the day program;'
-No additional information was provided.

Interview on 11/26/24 with staff #1 revealed:
-He denied smashing client #1's hand in the door and client #1 was not restrained;
-Emergency Medical Services came and checked out client #1's hand;
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Interview on 11/26/24 and 12/4/24 with the

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V 367	Continued From page 9 Qualified Professional revealed: -"I probably did not complete an IRIS report because, I'm the world's worst at completing those;" -"I could not find an IRIS report and to be honest, I'm really bad about completing IRIS reports;" -She received a telephone call from staff #1 during the incident. She overheard client #1 calling staff #1 derogatory names (porch monkey).	V 367		