STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL034-156	A. BUILDING: _____ B. WING _____	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HINKLE HOUSE AT BETHABARA	2030 CLYDE HAYES DRIVE WINSTON SALEM, NC 27106

(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 follow up survey was completed on June 10, 2025. 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 4. 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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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 II incident reports to the Local Management Entity (LME) within 72 hours of becoming aware of the incident. The findings are: Review on 6/10/25 of the Incident Response Improvement System (IRIS) revealed: -No level II incident report Review of the facility ' s internal incident report dated 4/15/25 revealed: -Staff #1 let client #4 know she always checked the bathrooms when coming on shift. -While checking the bathroom staff #1 noticed client #4 had not flushed the "commode." -Client #4 responded she did flush and wanted to	V 367		

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know why staff #1 did not believe her.
- Client #4 kept taking about the situation and refused redirection to talk about something else.
-The Program Director was called as client #4 refused to take her seat on the van.
-Client #4 made statements she was going to call the police and "let them know I am going to put my hands on you when we get back to the house."
-"When staff was entering the house and turned the corner, [client #4] had a pair of scissors."
-Client #4 pointed the scissors at staff #1 ' s stomach and then her face.
-Client #4 refused to put the scissors down
-The Qualified Professional was called and client #4 agree to go to her room.
-While going to her room, client #4 stabbed the wall.
-The police arrived at the facility due to client #4 calling them.
-Client #4 ' s brother arrived also, asked client #4 for the scissors and packed her items to take her home for several days
-Client #4 saw a counselor and now has coping skills
-All sharp objects are out of reach and locked in the staff ' s office.

Review on 6/10/25 of client #4 ' s record revealed:
-An admission date of 6/1/21
-Diagnoses of Autism Spectrum Disorder and Attention Deficit Hyperactivity Disorder.

Interview on 6/10/25 with client #4 revealed:
-Did not want to discuss the incident.

Interview on 6/10/25 with staff #1 revealed:
-An incident occurred on 4/15/25 with client #4.
-"[Client #4] was upset because I told her she did

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V 367	Continued From page 4 not flush the commode. She pulled scissors on me and pointed to my stomach and my face." -There were no injuries -The Qualified Professional (QP) was made aware of the incident. -All sharps are now locked up Interview on 6/10/25 with the QP revealed: -Was not aware a level II incident report needed to be submitted into IRIS "since there were no injuries." -Was aware client #4 had called the police to the facility on 4/15/25. -"I believe [client #4] called the police because she was afraid she would put her hands on somebody." -Would ensure incidents were submitted into IRIS in the future -All sharps were locked up and client #4 used safety scissors for her arts and crafts.	V 367		