STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	220376	A. BUILDING: _____ B. WING _____	R 08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUARRY PARK HOME	1701 BUTLER STREET WINSTON SALEM, NC 27107

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V 000	INITIAL COMMENTS An annual and follow up survey was completed on August 1, 2025. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 5600F Supervised Living for Alternative Family Living. 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 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 (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in	V 366		

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V 366	Continued From page 1 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 LME in whose catchment area the provider is located and to the LME where the client resides, if different; and	V 366		

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V 366	Continued From page 2 (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 review and interviews, the facility failed to implement policies governing their response to level II incidents. The findings are:	V 366		

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Review on 7/31/25 of client #1's record revealed:
-Date of Admission: 12/12/24;
-Diagnoses: Mild, Intellectual Developmental Disability, Major Depressive Disorder with psychotic features; Impulse Control Disorder NOS; Nicotine Related Disorder NOS; Attention-Deficit Hyperactivity Disorder, combine type; Obsessive-Compulsive and related disorder due to another medical condition;
-An internal incident report dated 6/24/25, reflected client #1 caused an injury to his neck and caused a small amount of bleeding. Law enforcement, emergency medical services (EMS), and the fire department responded to the home;
-Progress note dated 7/1/25, reflected client #1 was hospitalized for suicidal ideations and attempted to cut himself on the arm/neck. Client #1 was taken to the hospital for evaluation and observation;
-Progress note dated 7/8/25, reflected client #1 was back and forth in the hospital for suicidal ideations. The hospital kept client #1 for observation because he reopened his wounds.

Interview on 8/1/25 with client #1 revealed:
-He was unsure if he had attended any meetings with his clinical team to discuss his hospitalizations.

Interview on 8/1/25 with the AFL Provider revealed:
-She requested a meeting with the LME/MCO, but had not received a return call;
-She was unaware of the date she called the LME/MCO;
-She spoke with the Licensee about client #1's behavior, but his clinical team had not meet.

Interview on 7/31/25 and 8/1/25 with the Program

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V 366	Continued From page 4 Manager revealed: -"That I am aware of there had been no emergency team meeting called to discuss the recent behaviors."	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 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:	V 367		

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(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 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;

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V 367	Continued From page 6 (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 Level II incident reports were submitted to the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours of becoming aware of incident. The findings are: Review on 7/31/25 of client #1's record revealed: -Date of Admission: 12/12/24; -Diagnoses: Mild, Intellectual Developmental Disability, Major Depressive Disorder with psychotic features; Impulse Control Disorder NOS; Nicotine Related Disorder NOS; Attention-Deficit Hyperactivity Disorder, combine type; Obsessive-Compulsive and related disorder due to another medical condition; -An internal incident report dated 6/24/25, reflected client #1 caused an injury to his neck and caused a small amount of bleeding. Law enforcement, emergency medical services (EMS), and the fire department responded to the home; -Progress note dated 7/1/25, reflected client #1	V 367		

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was hospitalized for suicidal ideations and attempted to cut himself on the arm/neck. Client #1 was taken to the hospital for evaluation and observation;
-Progress note dated 7/8/25, reflected client #1 was back and forth in the hospital for suicidal ideations. The hospital kept client #1 for observation because he reopened his wounds.

Review on 8/1/24 of the Incident Response Improvement System (IRIS) from May 31, 2025, to July 31, 2025, revealed:
-No level II incident reports were submitted for 6/24/25, 7/1/25 or 7/8/25.

Interview on 8/1/25 with client #1 revealed:
-On 6/24/25, "I was hearing voices and seeing things. My medication was not really helping me, but his medicine is right now;"
-"I called EMS and told them (operator) that I was hearing voices (his father was telling him to kill himself) and seeing things (being molested by his father) and I could not take it anymore. I wanted to kill myself;"
-He was hospitalized at a local hospital on 7/1/25 and 7/8/25;
-He could not remember specific details of what occurred on 7/1/25 and 7/8/25.

Interview on 8/1/25 with the AFL Provider revealed:
-She completed an incident report for the last incident. She was unsure of the date of that incident report;
-On 7/1/25 and 7/8/25 client #1 called 911, the ambulance responded, and took client #1 to the hospital;
-Client #1's guardian was notified, and kept up to date;
-Client #1 previously called a crisis number. He

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V 367	Continued From page 8 was picked up and transported to a local crisis center to be evaluated. She was unsure of the date. Interview on 7/31/25 and 8/1/25 with the Program Manager revealed: -She was not notified of the incidents that occurred on 6/24/25, 7/1/25, and 7/8/25. That she recalled; -"I have not heard back from the [LME/MCO] about if the incident reports were completed;" -"The QP's usually notified her by text, calls, and sent her a copy of the incident report completed by the AFL;" -Incident reports were discussed during monthly supervision meetings; -She is the Program Manager for the licensee; -Her duties were to supervise the QP's and AFL providers; -The protocol for serious incidents was, "the AFL was to complete an incident report. Contact the QP, and the QP should complete the IRIS report. The QP notifies the Program Manager who completes the critical incident report an internal form;" -The previous QP resigned on 7/24/25. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 367		