DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G146	A. BUILDING _____ B. WING _____	04/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXTRA SPECIAL CARE	6214 KILMORY DRIVE FAYETTEVILLE, NC 28304

(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) COMPLETION DATE
E 013	Development of EP Policies and Procedures CFR(s): 483.475(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These	E 013	E 013: CFR(s): 483.475(b) The facility will ensure the policy and procedure will be reviewed and updated annually. Staff will be in-serviced. QIDP and Residential Director will monitor Quarterly and Group Home Manager monitor monthly.	6/1/2018
			E 013: PACE at 460.84(b) The facility will develop and implement Emergency Preparedness Based on Emergency Plan including Risk Assessment and Communication Plan. The Facility will ensure the policies and procedures must address management of medical and nonmedical emergencies, including but not limited to: Fire, equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. Staff will be in-serviced. QIDP and Residential Director monitor Quarterly and Group Home Manager monitor monthly.	6/1/2018
			E 013: ESRD Facilities 494.62(b): The facility will develop and implement Emergency preparedness Policies and procedures, based on the emergency plan; risk assessment; and communication plan. The policies and procedures must be reviewed and updated at least annually. Staff will be in-serviced. QIDP and Residential Director will monitor Quarterly and Group Home Manager will monitor monthly. Training will be ongoing.	6/1/2018

DHSR - Mental Health
APR 18 2018
Lic. & Cert. Section

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

QP | 4/16/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 013	Continued From page 1 emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to develop specific policies and procedures to address emergency preparedness, considering risk assessment. The finding is: During an interview on 4/3/18 with the Division Director and qualified intellectual disabilities professional (QIDP) revealed they did not base their emergency preparedness plan on an actual risk assessment specific to the facility.	E 013		
W 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure client #1 had the right to have access to his personal belongings. This affected 1 of 4 audit clients. The finding is: Client #1's eyeglasses were kept locked. Observations in the home on 4/3/18 at 8:13am revealed client #1's eyeglasses were locked in the medication cabinet inside of a locked office.	W 137	W137: The facility will ensure that Client #1 and all other clients have the right to retain and use appropriate personal possession and clothing. Staff will be in-serviced. This will be monitored by QIDP weekly and Group Home Manager Bi-Weekly.	6/1/2018

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W 137	Continued From page 2 Staff interview on 4/3/18 revealed client #1's eyeglasses are kept in the medication cabinet because he breaks them. Review of client #1's individual program plan (IPP) dated 8/19/17 indicated, "[Client #1] wears corrective lenses. [Client #1] is required to wear his eye glasses. [Client #1] has a history of breaking his eye wear. [Client #1] will wear his eye glasses daily." Additional review of client #1's right's assessment dated 6/26/17 indicated he requires assistance to ensure his rights. During an interview on 4/3/18, the qualified intellectual disabilities professional (QIDP) acknowledged client #1's glasses should not be kept locked.	W 137		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 2 of 4 audit clients (#1, #2) received a continuous active treatment plan consisting of needed interventions and services as identified in the individual program plan (IPP) in the areas of behavior plan	W 249		

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W 249	Continued From page 3 implementation and adaptive equipment use. The findings are: 1. Client #1's Behavior Intervention Plan (BIP) was not implemented as written. During observations in the home and at a local park throughout the survey on 4/2/18, client #1 interacted with the staff assigned as his one-on-one. During several observations, the client periodically hit or lightly tapped the staff on various parts of their body. For example, on 4/2/18 at 4:35pm, the client hit the staff three times on the arm. The staff responded, "You doing a lot of hitting today." On 4/2/18 at 5:25pm, client #1 hit the staff on the buttocks. The staff stated, "I think you just like patting me." Review on 4/3/18 of client #1's BIP dated 11/9/17 revealed an objective to decrease attention seeking behaviors to 10 incidents or fewer per month for 6 consecutive months. Additional review of the plan noted, "Attention Seeking: Defined as playful hitting, tapping/lightly touching or other behavior designed to seek attention, etc....Staff will attempt to ignore this behavior. DO NOT give him any eye contact or talk directly to him. After he stops the inappropriate attention seeking, provide him with attention..." Interview on 4/3/18 with the QIDP confirmed the BIP was current and should be followed as written. 2. Client #2's adaptive helmet was not worn as indicated. During evening observations at the home 4/2/18 at 5:20pm, client #2 was engaged in activities	W 249	W249-1 The Facility will ensure and retrain staff on Client #1 and all other Client's on BIP. Staff will be in-serviced. QIDP will monitor weekly and Group Home Manager bi-weekly.	6/1/2018

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W 249	Continued From page 4 outside with staff. The client was not observed to be wearing a helmet during this time. Staff interview on 4/3/18 revealed client #2 wears a helmet due to seizure activity. Review on 4/3/18 of client #2's IPP dated 3/11/18 revealed client #2 "should wear her helmet when she is outside playing...[Client #2] refuses to wear her helmet and needs additional verbal prompting." Interview on 4/3/18 with the QIDP and medical coordinator confirmed client #2 wears a helmet due to seizures and it should be worn as indicated in her plan. 3. Client #1's adaptive cup was not used as indicated. During 3 of 3 meal time observations in the home on 4/2 - 4/3/18, client #1 was provided two cups with detachable inner concave lids (a sippy cup). At each meal, the lids were removed from the cups and were not utilized when the client drank from the cups. Staff interview on 4/2/18 revealed client #1 does not like they way he "has to suck" on them (the lids) to get a drink. Review on 4/3/18 of client #1's nutritional evaluation dated 2/5/18 revealed, "...use sippy cup..." Interview on 4/3/18 with the QIDP confirmed client #1 should use a sippy cup at meals as indicated.	W 249	W249-2 The Facility will ensure that Client #2 helmet will be worn as indicated on her plan. QIDP will due an addendum to Client #2 IPP as indicated. Staff will be in-serviced. QIDP will monitor weekly and Group Home Manager by weekly. W249-3 The Facility will ensure that any adaptive cup for Client #1 and all other Client's should be used as written by the dietitian. Revision will be made by Dietitian. Staff will be in-serviced. QIDP will monitor weekly and Group Home Manager will monitor bi-weekly.	6/1/2018 6/1/2018

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W 288	Continued From page 5	W 288		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure a technique to address client #1's inappropriate behavior was included in a formal active treatment plan. This affected 1 of 4 audit clients. The finding is: A technique to manage client #1's running behavior was not included in an active treatment plan. During observations in the home throughout the survey on 4/2 - 4/3/18, various staff consistently held client #1 by his hand or wrist while walking with him to/from room to room. The client's movements were frequently directed and restricted by staff while holding onto his hand or wrist. Staff interview on 4/3/18 revealed they do not always hold onto client #1's hand in the home; however, it was likely done "because he runs". Review on 4/3/18 of client #1's Behavior Intervention Plan (BIP) dated 11/9/17 revealed an objective to address "running from staff". The plan noted the client requires one-on-one staff supervision. Additional review of the BIP did not indicate the client required physical restrictions in the home.	W 288	W 288: The facility will ensure and retrain staff on Client #1 and all other Client's BIP. Staff will be in-serviced on client #1 and all other client's about physical restrictions in the home. QIDP will monitor weekly and Group Home Manager will monitor bi-weekly.	6/1/2018

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W 288	Continued From page 6 Interview on 4/3/18 with the QIDP confirmed client #1's movements should not be physically restricted in the home and this technique was not a part of an active treatment plan.	W 288		
W 336	NURSING SERVICES CFR(s): 483.460(c)(3)(iii) Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 4 audit clients (#1, #6) received a review of their health status at least quarterly. The findings are: 1. A quarterly nursing assessment was not completed as indicated for client #1. Review on 4/3/18 of client #1's record revealed he was admitted to the facility on 7/24/17. Additional review of the record indicated a nursing assessment had been completed on 8/5/17. No other assessments could be located. Interview on 4/3/18 with the qualified intellectual disabilities professional (QIDP) revealed the next quarterly nursing assessment would have been due in November 2017. Additional interview confirmed no assessment had been completed.	W 336	W 336-1 The facility will ensure that client #1 and #6 and all other Client's quarterly assessment will be done quarterly. QIDP will monitor monthly.	6/1/2018

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W 336	Continued From page 7 2. Client #6's record did not reveal nursing quarterlies as indicated. Record review on 4/3/18 of client #6's chart did not reveal nursing quarterlies for the period of 4/2017 to 4/2018. Further review revealed an annual nursing assessment for 5/30/17, but, no quarterly nursing assessments could be located. Interview on 4/3/18 with the qualified intellectual disabilities professional (QIDP) confirmed there were no quarterly nursing assessments after talking with the facility nurse via telephone on 4/3/18. Interview on 4/3/18 with the qualified intellectual disabilities professional (QIDP) revealed the next quarterly nursing assessment would have been due in November 2017. Additional interview confirmed no assessment had been completed.	W 336	W 336-2 The facility will ensure that Client #1, Client #6 and all other Client's quarterly assessment will be done Quarterly. QIDP and Nurse will monitor monthly.	6/1/2018
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to assure all medications were administered without error for 1 of 3 clients (#4) for whom medications were observed being administered. The findings are: Client #4 did not receive levocarnitine as prescribed by the physician.	W 369	W 369 The facility will ensure that all medication are administered without error on Client #4 and all other Client's. The facility will ensure that Client #4 medication will be administered as prescribed by physician. Staff will be trained on administering medication appropriately and the correct conversion of dosage from 1tsp to ml. Staff will be in-serviced. QIDP will monitor weekly, Medical Support Bi-Weekly, and Nurse Monthly.	6/1/2018

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W 369	Continued From page 8 During morning medication administration on 4/3/18 @ 6:41 am client #4 was administered phenobarbital 32.4 mg, 1 tablet, vitamin D3 1000 iu, 1 tablet, clonidine 0.1 mg, 1 tablet, Depakote sprinkles 125 mg capsule, 4 capsules, Flonase 2 sprays per each nostril and levocarnitine susp 1 gm/10 ml,10 ml. Review on 4/3/18 of the medication labels on the containers of the medications administered revealed "levocarnitine susp 1 gm/10 ml give 1 teaspoonful". The label did not specify the ml equivalent of 1 teaspoonful which converts to 5 ml. Review on 4/3/18 of the physician orders revealed "levocarnitine 1 gm/10ml 1 teaspoonful". Interview on 4/3/18 with direct care that administered medications to client #4 revealed she could not explain the correct conversion of the dosage from one teaspoonful to milliliters. Staff was not aware she had given 10 ml of levocarnitine. Interview on 4/3/18 with management revealed the medication should have been administered per the physician orders.	W 369		
W 418	CLIENT BEDROOMS CFR(s): 483.470(b)(4)(ii) The facility must provide each client with a clean, comfortable mattress. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure client #3 had a comfortable	W 418	W 418 The facility will ensure Client #3 and all other Clients have appropriate and comfortable mattress. Staff will be in-service. QIPD will monitor monthly and Group Home manager weekly.	6/1/2018

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W 418	Continued From page 9 mattress. This affected 1 of 4 audit clients. The finding is: Client #3 was in need of a new mattress. During observations in the group home on 4/2/18, client #3's mattress was noted to have a large indentation or dip in the middle of it and was slanted to one side. The head and foot of the mattress were noticeably higher than the middle of the mattress. During an interview on 4/2/18, staff acknowledged the mattress had a noticeably large dip or sink in the middle. Additional interview indicated the dip in his mattress was likely because client #3 likes to jump on it. Interview on 4/3/18 with the qualified intellectual disabilities professional (QIDP) and medical coordinator confirmed the mattress had a large dip in the middle and was also slanted to one side. Additional interview revealed they are aware that client #3 likes to jump on his mattress and his current one needs to be replaced.	W 418		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by:	W 436		

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W 436	Continued From page 10 Based on observations, record review and interviews, the facility failed to ensure 2 of 4 audit clients (#1, #6) were taught to use their necessary adaptive equipment and to make informed choices about their use. The findings are: 1. Client #1 was not taught to wear and use his eye glasses appropriately. During observations in the home throughout the survey on 4/2/18, client #1 did not wear eyeglasses. The client was not prompted or encouraged to wear eyeglasses. Staff interview on 4/3/18 revealed client #1 does have eyeglasses which he wears on 2nd shift for about an hour. Additional interview indicated the client will break his glasses. Review on 4/3/18 of client #1's individual program plan (IPP) dated 8/19/17 revealed, "[Client #1] wears corrective lenses. [Client #1] is required to wear his eye glasses. [Client #1] has a history of breaking his eye wear. [Client #1] will wear his eye glasses daily." Additional review of client #1's vision examination dated 9/29/17 indicated, "...still (left) eye turns in with glasses but much improved. Suspect some vision weakness (amblyopia) (left) eye...Continue to wear glasses full time ..." Further review of an vision examination dated 12/1/17 noted, "...Continue glasses wear full time." Review of the client's IPP did not include training to teach client #1 to wear his eye glasses appropriately. Interview on 4/3/18 with the qualified intellectual disabilities professional (QIDP) and medical coordinator confirmed client #1 will break his	W 436	W 436-1 The facility will ensure that Client #1 and all other client as needed when trained to war his/her eye glasses. QIPD will put program in place to assist with wearing eye glasses appropriately. Staff will be in-serviced. QIPD will monitor monthly. Group Home Manager will monitor Bi-Weekly and Medical Support will monitor weekly.	6/1/2018

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W 436	Continued From page 11 eyeglasses; however, no training has been implemented to teach him to use his eyeglasses appropriately. 2. Client #6 was not taught to use and care for his eyeglasses. During observations on 4/2/18 and 4/3/18 and 1/23/18, throughout the survey client #2 wore no eyeglasses. During record review on 4/3/2018 a vision evaluation dated 9/19/18 revealed client #6 had a diagnosis of "astigmatism bilaterally" and on this visit he was prescribed eyeglasses for the first time. The physician's recommendation revealed "eyeglasses fulltime and a minimum at school for reading". There was no objective in client #6's individual program plan (IPP) dated 6/22/17 to address the care and wear of his eyeglasses. Review on 4/3/18 of client #6's individual education plan (IEP) dated 3/27/18 did not reveal he uses eyeglasses. Interview on 4/3/18 with staff revealed client #6 has 2 pairs of eyeglasses, "..one pair at school and a pair for wearing at home", saying "he should be wearing the eyeglasses all of the time and will not wear them". Client #6's eyeglasses were in a case in his book bag as the clients were getting ready to leave the home for an outing. Further interview with staff revealed she did not know if client #6 was wearing his eyeglasses at school. Interview on 4/3/18 with the with the QIDP revealed client #6 should be wearing his	W 436	W 436-2 The facility will ensure that client #6 and all other client's as needed is trained to wear his/her eye glasses. QIPD will put program in placed to assist with wearing eye glasses appropriately. The facility will ensure that Client #6 and all other clients school addresses the care and wear of his/her eye glasses in IEP. Staff will be in-serviced. QIPD will monitor monthly. Group Home Manager and Medical Support bi-weekly.	6/1/2018

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G146	A. BUILDING _____ B. WING _____	04/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXTRA SPECIAL CARE	6214 KILMORY DRIVE FAYETTEVILLE, NC 28304

(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) COMPLETION DATE
W 436	Continued From page 12 eyeglasses at all times and did not have an objective to wear and care for his eyeglasses.	W 436		

THE CARTERCLINIC
CONTINUING A LEGACY OF EXCELLENCE IN BEHAVIORAL HEALTH

Dear Wilma Worsley-Diggs,

Here is the plan of correction for Extra Special Care. If you have any questions, please feel free to call Asia Parker, Qualified Professional at office number (910) 491-2352 or mobile number (910) 978-3675.

Sincerely,

Asia Parker, QP