


Tammy Statin & Johanna Edwards

Attention: Mrs Johanna Edwards
RN.

North Carolina Department of Health and Human Services
Division of Health Service Regulation
Mental Health Licensure & Certification Section



Johanna Edwards, RN (919) 805-0022
Nurse Consultant

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<http://www.ncdhhs.gov/dhss>



Dee # 2 was cited on Blood Sugar checks, but client wasn't a diabetic And did not require blood sugar checks.

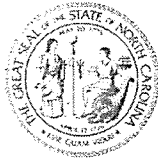
Client was only on MetFormin For weight loss, Due to Obesity. Im sending the information from his doctor as well as the information from Central Regional.

This order wasn't accurate at the FL². Client stated It, then I noticed it over after I read his chart during admission. I noticed it as well That's why we did not take his blood sugar.

FL² has been corrected by physician! Thank you.

Cherry Crisp
336 350-4866

Client was sent back to the physician last week only to confirm again this Client is not a diabetic - And not need to be checking his blood sugar. We did



DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH SERVICE REGULATION

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

MARK PAYNE
DIRECTOR

April 23, 2018

Clara Yancey and Cherry Crisp, Administrators
Dee & G Enrichment #2
PO Box 2073
Burlington, NC 27216

Re: Annual and Follow-Up Survey completed March 21, 2018
Dee & G Enrichment #2, 207 Friendly Road, Burlington, NC 27215
MHL #001-131
E-mail Address: cherrycrisp1968@gmail.com onlyquri02@aol.com

Dear Ms. Crisp and Yancey:

Thank you for the cooperation and courtesy extended during the annual and follow-up survey completed 3/21/18.

As a result of the follow up survey, it was determined that all of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- A Type A1 rule violation is cited for 10A NCAC 27G .5601 Scope, Tag V-289.
- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- The Type A1 violation and all cross referenced citations must be **corrected** within 23 days from the exit date of the survey, which is April 13, 2018. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed Type A1 violation by the 23rd day from the date of the survey may result in the assessment of an administrative penalty of \$500.00 (Five Hundred dollars) against Clara Yancey and Cherry Crisp for each day the deficiency remains out of compliance.

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION
WWW.NCDHHS.GOV
TEL 919-855-3795 • FAX 919-715-8078
LOCATION: 1800 UMSTEAD DRIVE • WILLIAMS BUILDING • RALEIGH, NC 27603
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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-131	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 03/21/2018
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NAME OF PROVIDER OR SUPPLIER DEE & G ENRICHMENT #2	STREET ADDRESS, CITY, STATE, ZIP CODE 207 FRIENDLY ROAD BURLINGTON, NC 27215
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V 000	<p>INITIAL COMMENTS</p> <p>An annual and follow up survey was completed on March 21, 2018. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.</p>	V 000	<p><u>In Order to</u> Correct this deficiency All Staff has a Current CPR & first Aid Training.</p>	3/19/18
V 108	<p>27G .0202 (F-I) Personnel Requirements</p> <p>10A NCAC 27G .0202 PERSONNEL REQUIREMENTS</p> <p>(f) Continuing education shall be documented.</p> <p>(g) Employee training programs shall be provided and, at a minimum, shall consist of the following:</p> <p>(1) general organizational orientation;</p> <p>(2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B;</p> <p>(3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and</p> <p>(4) training in infectious diseases and bloodborne pathogens.</p> <p>(h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction.</p> <p>(i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious</p>	V 108	<p><u>In order to prevent</u> this from reoccurring <u>Dee & G Enrichment's</u> Admin, GP will review files Quarterly in order to Assure that any or All trainings are current And in their files, for The GP and the Administrator will review files and monitor them quarterly So that this oversight will not occur again. Staff has already received the CPR & first Aid training necessary for</p>	

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

Cherry Crisp Administrator

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V 108	Continued From page 1 and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure that A) 1 of 3 direct care staff reviewed (the Program Director/Administrator (PD/A)) had current training in basic First Aid including seizure management, and was currently trained to provide cardiopulmonary resuscitation (CPR) and B) that 3 of 3 direct care staff had training to meet the needs of the clients (PD/A, Staff #1, Staff #2). The findings are: Review on 3/15/18 of Client #1's record revealed the following information; --Admitted to the facility on 1/18/17. -- Age 66 years old. -- Diagnoses include Schizoaffective Disorder, Dementia, Parkinson's - Neuroleptic Induced, Possible Neurocognitive Disorder, Hypothyroidism, Hypertension, GastroEsophageal Reflux Disease, Chronic Obstructive Pulmonary Disease, Incontinence and Status Post Middle Toe Amputation. -- Uses a rolling walker to get himself around. -- Needed dressing changes and treatment on the sight of an amputated toe, and ulcers on his lower leg from 1/24/17 through 11/16/17. Review on 3/16/18 of Client #2's record revealed the following information; -- Admitted to the facility on 1/9/14. -- Age 63 years old. -- Diagnoses include Chronic Schizophrenia, Chronic Personality Disorder, Dementia and	V 108	<i>We will remain compliant All Staff has the necessary trainings required,</i>	<i>3/19/18 Corrected CC</i>

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V 108	<p>Continued From page 2</p> <p>Insomnia.</p> <p>-- An FL-2 dated 11/21/17 indicating the client was "constantly disoriented," and has displayed inappropriate behaviors of wandering and damage to property.</p> <p>-- Has a court appointed Legal Guardian.</p> <p>-- On 3/9/18 was prescribed Aspirin (for prevention of the formation of blood clots in people with coronary artery disease).</p> <p>-- On 3/15/18 was prescribed Plavix (a blood thinner used to prevent stroke, heart attack, and other heart problems).</p> <p>-- On 3/14/18 Client #2 was hospitalized overnight both to have a cardiac catheterization test performed and a stent placed. (A stent is a small device surgically implanted inside a blood vessel that compacts the plaque against the walls of the arteries to create a wider path for blood flow to the lower half of your body. A stent holds tissue in place and keeps it open or relieves blockage.) (Cardiac catheterization is a procedure that uses X-ray imaging to see your heart's blood vessels. The test is generally done to see if there's a restriction in blood flow going to the heart. If necessary, a Physician can open clogged heart arteries (angioplasty) during this procedure.)</p> <p>-- Needed dressing changes and treatment on the sight of lower leg ulcers from 12/6/17 through 3/9/18.</p> <p>1. Review on 3/19/18 of the PD/A's personnel file revealed that the last time she had taken a CPR course had been in September 2015. This certification expired in September 2017, (approximately 6 months ago).</p> <p>Interview on 3/20/18 with the PD/A revealed the following information;</p> <p>-- She confirmed her CPR and First Aid had</p>	V 108	<p>All Employees have thier CPR/First Aid Training. This was corrected on 3/19/18</p> <p>Admin will prevent this problem from occurring by renewing files quarterly. Also the QP will monitor AS well to assure that we remain compliant in this area. CC</p>

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V 108	Continued From page 3 expired. -- She did not realize that it had been out of date for that long. -- It is her responsibility to assure all staff have current training completed. -- She does work alone with the clients. 2. Review on 3/15/18 and 3/19/18 of the personnel files for the PD/A, Staff #1 and Staff #2 revealed no documentation of training on wound management/care or dressing changes. Interview on 3/14/18 with Staff #1 revealed that the facility staff did do some of the dressing changes for both Client #1 and Client #2. Interview on 3/15/18 with the PD/A revealed the following information; -- She confirmed that the facility staff had done some of the dressing changes for both Client #1 and Client #2. -- She confirmed that training in the area of wound care/management and dressing changes had not been conducted for any of the staff. * See Tag V-110, Competency of Paraprofessionals for specific details/examples. This deficiency is cross referenced into: 10A NCAC 27G .5601 Supervised Living - Scope, Tag V-289 for a Type A1 rule violation and must be corrected within 23 days.	V 108	Dee & G Enrichment has corrected this 3/19/18 deficiency. the (1) staff that CPR had expired has received her CPR & first Aid training. In order to prevent this problem from reoccurring. A Checklist has been formatted by the Administrator and on a quarterly basis the staff trainings will be reviewed and they documented to assure that this problem will no occur again. The QP will also monitor Staff Files quarterly in order to prevent this oversight, from reoccurring	
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for	V 110		

But this is not true!
see next page! cc

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V 110	<p>Continued From page 4</p> <p>paraprofessionals.</p> <p>(b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter.</p> <p>(c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served.</p> <p>(d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence.</p> <p>(e) Competence shall be demonstrated by exhibiting core skills including:</p> <ol style="list-style-type: none"> (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. <p>(f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, 1 of 3 Paraprofessionals reviewed failed to demonstrate the knowledge, skills and abilities required by the population served (Program Director/Administrator (PD/A)).</p> <p>Review on 3/19/18 of the PD/A's personnel file revealed the following information;</p>	V 110	<p>2) Dee & G Enrichment's QP has met with the Administrator, AS well as the staff, and (paraprofessionals) that are employed. <u>In order to prevent this deficiency - from reoccurring</u> The QP will train All (PP)'s. And will monitor thier work, documentation, etc <u>In order to prevent another deficiency from reoccurring</u> Again.</p> <p>QP has a training class scheduled for 4/27/18 to assure that All Employees</p>	4/27/18
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are refreshed in Documentat
goals, Any Area that deal
with patients care, etc.

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V 110	<p>Continued From page 5</p> <ul style="list-style-type: none"> -- She is 40 % owner of the facility/business. -- Has been employed with the company working at the group homes since 2007. -- Had training on medication administration by a Registered Nurse (RN) on 12/17/16. <p>Interview on 3/16/18 with the PD/A revealed the following information;</p> <ul style="list-style-type: none"> -- She is responsible for providing oversight in all areas of operations within the group home. -- She is responsible for all the aspects of hiring new staff. -- She is responsible for the oversight of the required training needed by staff. -- She is responsible for the client admission assessments. -- She is responsible for submitting Incident Reports. <p>Interview on 3/16/18 with the PD/A regarding the facility Qualified Professional (QP) revealed the following information;</p> <ul style="list-style-type: none"> -- The QP meets with the staff every two weeks to discuss what is currently occurring at the facility. -- At that time, the QP provides supervision to Paraprofessional staff. -- The QP reviews client records for any issues. -- The QP reviews client records for Physician orders including medications. -- The QP reviews client records looking at progress notes. <p>Interview on 3/22/18 with the QP revealed the following information;</p> <ul style="list-style-type: none"> -- She was responsible only for client treatment plans and providing clinical supervision to the staff. -- She was available to provide other QP services to the facility, but the PD/A or the other Licensee would have to notify her of any requests for 	V 110	<p>ALSO</p> <p>The QP will monitor treatment plans, medication Administration incidents, etc.</p> <p>The Administrator will notify her on a monthly basis so that the QP will be informed of strengths or weaknesses concerning Staff. In order for all Staff to gain the wisdom and knowledge concerning the responsibility of a paraprofessional. The Administrator will suggest that the QP provide any trainings at least twice a month. All paraprofessionals will be supervised by QP, and the trainings etc will be on a log in which all paraprofessionals will sign, this training from the QP.</p>	
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V 110	<p>Continued From page 6</p> <p>additional services.</p> <p>-- She did not review client records for documentation of treatment at the facility or medical treatment.</p> <p>-- The PD/A has not requested additional services for the facility.</p> <p>Interview on 3/16/18 with the PD/A revealed the following information;</p> <p>-- There were two employees who had left their positions with the facility/company within the past several months (December 2017 and January 2018).</p> <p>-- These two employees both quit their jobs, however they did not leave on good terms.</p> <p>-- One of the employees (the first one to leave) was her Sister, and she transported and attended all Physician's appointments for each client, and was responsible for the information from those appointments.</p> <p>-- That employee prior to her departure from the company was not sharing the information about clients from their Physician appointments.</p> <p>-- These employees may have taken some of the missing documentation from client records with them.</p> <p>Review on 3/15/18 of Client #1's record revealed the following information;</p> <p>--Admitted to the facility on 1/18/17.</p> <p>-- Age 66 years old.</p> <p>-- Diagnoses include Schizoaffective Disorder, Dementia, Parkinson's - Neuroleptic Induced, Possible Neurocognitive Disorder, Hypothyroidism, Hypertension, GastroEsophageal Reflux Disease, Chronic Obstructive Pulmonary Disease, Incontinence and Status Post Middle Toe Amputation.</p> <p>-- Uses a rolling walker to get himself around.</p>	V 110	<p>will be A requirement that will be mandatory In order for us/ them to remain an employee</p> <p>All documentation will be reviewed quarterly And placed in a FILE.</p> <p>For Viewing-</p>	
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V 110	<p>Continued From page 7</p> <p>Interview on 3/15/18 with the PD/A regarding Client #1 revealed the following information;</p> <ul style="list-style-type: none"> -- His Parkinson's Disease has gotten much worse than when he arrived at the facility a little over a year ago. -- His hands shake so much that he needs assistance with completing many tasks (buttoning clothing, making his bed, eating, etc.). -- His physical health is declining very rapidly. -- She has been trying to get his Physician "to order him to a higher level of care" so that she could discharge him from the facility. -- She did not understand that if the facility is no longer able to meet the needs of a client, it is her responsibility to identify that fact, and work toward securing a more appropriate placement for the client(s). -- "When he got here we changed dressings on his toe and leg. Then he went to wound care." -- She confirmed that the facility staff had done some of the dressing changes for Client #1. -- She confirmed that training in the area of wound care/management and dressing changes had not been conducted for any of the staff. -- She confirmed that dressing changes and wound treatment need to be done under sterile conditions to prevent infection. -- She thought that Client #1 may have had compression stockings when he first got to the facility. -- She thought that blood pressures and weights had been documented for Client #1, however she could not find this documentation. -- The two staff who left employment with facility/company may have taken this information from Client #1's record. <p>Review on 3/16/18 of Client #2's record revealed the following information;</p> <ul style="list-style-type: none"> -- Admitted to the facility on 1/9/14. 	V 110	<p>PP/ And Admin hadn't received A Formal training from the GP/ Nurse that's employed by Dee 'G' but We had been shown how to Clean the wound and bandage the wound by the nurse. At VA medical Center and as the home health nurse came to our Facility she showed the PP and clients wound was healed and dry. No our Nurse did not train us but some one else did. So In the Future We will monitor daily, report signs of infection to the doctor as we always did. In order to remain compliant. Blood pressures and weights has always</p>	
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PP/ And Admin hadn't received A Formal training from the GP/ Nurse that's employed by Dee 'G' but We had been shown how to Clean the wound and bandage the wound by the nurse. At VA medical Center and as the home health nurse came to our Facility she showed the PP and clients wound was healed and dry. No our Nurse did not train us but some one else did. So In the Future We will monitor daily, report signs of infection to the doctor as we always did. In order to remain compliant. Blood pressures and weights has always

We are also registered nurses ASSISTANTS.

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V 110	<p>Continued From page 9</p> <p>wound care/management and dressing changes had not been conducted for any of the staff.</p> <p>-- She confirmed that dressing changes and wound treatment need to be done under sterile conditions to prevent infection.</p> <p>-- She did not think that Client #2 had any compression stockings.</p> <p>-- He had a history of hoarding small items, mostly rocks, and then putting them down the toilet and flushing the toilet, thus clogging the toilet up.</p> <p>-- Someone has had to come to the facility many times to unclog, or fix the toilet.</p> <p>-- The toilets have had to be replaced before due to the damage caused by Client #2.</p> <p>-- He had done this multiple times both at the facility and at his Psychosocial Rehabilitation program (PSR).</p> <p>-- His PSR had banned him from their program due to these behaviors.</p> <p>-- He now has no activities to occupy his time during the day.</p> <p>-- He does attempt to go out the front door frequently, but has never left the property when he goes outside.</p> <p>-- She agreed that Client #2 was somewhat medically compromised presently due to cardiac stent placement surgery on 3/14/18.</p> <p>-- The staff use "redirection" when Client #2 displays the above behaviors.</p> <p>-- She confirmed that Client #2 probably needed a higher level of care.</p> <p>-- As with Client #1 (above), the PD/A did not recognize that it was her responsibility to identify if the facility could no longer meet client needs, and identify where the clients can be provided a higher level of care.</p> <p>During this survey, the PD/A failed to demonstrate competence in the following areas:</p>	V 110	<p>Dee & G #2 assures that this has been corrected. Client # 2 had compression socks, and he wears them as ordered, during the interview they didn't look like they were covered by his insurance but the Admin purchased them out of her own pocket. I soiled pair was in the laundry, one was on his leg.</p> <p>But! We assure that we (Admin) will inspect client legs daily to assure that he wears them, because he will remove them himself. In order to prevent this deficiency. From reoccurring the Admin & Staff will monitor daily, to ensure that he keeps them on. AS ordered by physician. (But revised)</p>	
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On 4/24/18.

The doctor D/C the Ted Hose stated that they wasn't needed, He had an wound on his leg that's healing wonderful, The TED hose doesn't need to be put on his legs, on top of a wound. (no) Corrected 4/24/18

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NAME OF PROVIDER OR SUPPLIER DEE & G ENRICHMENT #2		STREET ADDRESS, CITY, STATE, ZIP CODE 207 FRIENDLY ROAD BURLINGTON, NC 27215		
(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 110	<p>Continued From page 10</p> <p>-- Assuring an admission assessment was completed including required information to assess if the facility could meet the client's needs. * See Tag V-111, Assessment/Treatment/Habilitation Plans for specific details/examples.</p> <p>-- Assuring client records contained current treatment plans written by the QP. * See Tag V-112, Assessment/Treatment/Habilitation Plans for specific details/examples.</p> <p>-- Assuring Physician ordered therapeutic diets were provided to clients. * See Tag V-115, Client Services for specific details/examples.</p> <p>-- Assuring correct medication administration and documentation. * See Tag V-118, Medication Administration for specific details/examples.</p> <p>-- Assuring an assessment was made of a client's ability to remain safe in the community without supervision. * See Tag V-290, Supervised Living - Staff for specific details/examples.</p> <p>-- Assuring coordination was maintained between herself and other Qualified Professionals responsible for medical and psychiatric services. * See Tag V-291, Supervised Living - Operations for specific details/examples.</p> <p>This deficiency is cross referenced into: 10A NCAC 27G .5601 Supervised Living - Scope, Tag V-289 for a Type A1 rule violation and must be corrected within 23 days.</p>	V 110	<p>(Assessment for Admission) Dee & G Enrichment #2 Assures that a formal Assessment has been implimented, In order to access the client so It will be a tool In which we can decide If the clients needs can be met by our Facility. Our QP has updated all treatment Plans, completed an admission assessments Monitored and renewed the FL's, physician orders, concerning diets etc. The Administrator And the QP have agreed to continue to monitor for compliance quarterly. Admin will be monitoring Clients when they attend any appointments to assure that any changes will be</p>	4/11/18

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V 111	Continued From page 11	V 111		
V 111	<p>27G .0205 (A-B) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to:</p> <ol style="list-style-type: none"> (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. <p>(b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility</p>	V 111	<p><i>renewed and documented, and the MAR will reflect these changes (Assessments has been corrected) Dee & G also has implemented a separate form in which the staff completes on every office visit to assure there is NO LACK of communication that could jeopardize the clients health or well being. This form is in addition to the physician documentation when client attends any appointment. Admin will monitor FL's medications also on a monthly basis. QP will review bi-monthly to prevent this problem from reoccurring.</i></p>	4/3/18

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V 111	<p>Continued From page 12</p> <p>failed to assure that an admission assessment was completed for each client, prior to the delivery of services which included the client's presenting problem, the client's needs and strengths, a pertinent social, family and medical history and evaluations or assessments, such as Psychiatric, substance abuse, medical and vocational, as appropriate to the client's needs affecting 4 of 4 audited clients (#1 #2 #3 #4). The findings are:</p> <p>Review on 3/15/18 of Client #1's record revealed the following information; -- Admitted to the facility on 1/18/17. -- Age 66 years old. -- Diagnoses include Schizoaffective Disorder, Dementia, Parkinson's - Neuroleptic Induced, Possible Neurocognitive Disorder, Hypothyroidism, Hypertension, GastroEsophageal Reflux Disease, Chronic Obstructive Pulmonary Disease, Incontinence and Status Post Middle Toe Amputation. -- Uses a rolling walker to get himself around.</p> <p>Review on 3/16/18 of Client #2's record revealed the following information; -- Admitted to the facility on 1/9/14. -- Age 63 years old. -- Diagnoses include Chronic Schizophrenia, Chronic Personality Disorder, Dementia and Insomnia. -- An FL-2 dated 11/21/17 indicating the client was "constantly disoriented," has displayed inappropriate behaviors of wandering and damage to property. -- Has a court appointed Legal Guardian. -- On 3/14/18 Client #2 was hospitalized overnight both to have a cardiac catheterization performed and a stent placed.</p>	V 111	<p>Each client has had an updated Admission Assessment that includes the Clients diagnosis thier needs, strengths, Family history, medical history. Family history, this also includes any psychiatric Substance Abuse history the client has.</p> <p>We have corrected this deficiency.</p> <p>The GP will renew all admissions ^{to monitor} from now on in order to prevent this problem from reoccurring.</p> <p>The Administrator will renew clients books concern Admissions every other month. to remain in Compliance with</p>

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V 111	<p>Continued From page 13</p> <p>Review on 3/14/18 of Client #3's record revealed the following information;</p> <ul style="list-style-type: none"> -- Admitted to the facility on 10/9/17 following a 1 year and 4 month stay at a state psychiatric hospital. -- Age 28 years old. -- Diagnoses include Schizophrenia, Personality Disorder with Antisocial Features, Cannabis Use Disorder, Obesity, Dyslipidemia and Acne. -- Has a court appointed Legal Guardian. -- The client is a Registered Sex Offender. -- Has a history of committing Arson three times (his Mother's house, his Sister's house and a motel room he was staying in). <p>Review on 3/14/18 of Client #4's record revealed the following information;</p> <ul style="list-style-type: none"> -- Admitted to the facility on 12/29/17. -- Age 26 years old. -- Diagnoses include Chronic Schizoaffective Disorder and Bipolar Disorder. <p>Review on 3/16/18 of the above 4 client records revealed the following;</p> <ul style="list-style-type: none"> -- A form titled "Adult Care Home Personal Care Physician Authorization And Care Plan" which is used by the Adult Care Licensure Section (ACLS) to provide information to the Division of Medical Assistance (DMA) about what level of assistance is required to provide Personal Care Assistance to a client. -- A form titled "Resident Register" written by the ACLS for use in Assisted Living Facilities or Family Care Homes (both of which are licensed by the ACLS) to provide basic information about the assistance the client will need from staff, and the client's preferences. -- Both of the above forms had been completed by the Program Director/Administrator (PD/A) upon the clients admission to the facility, and 	V 111		<p><i>Corrected = 4/3/18</i></p>

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V 111	Continued From page 14 periodically there after. Neither of the above forms address the client's presenting problem, the client's needs and strengths, a pertinent social, family and medical history and evaluations or assessments, such as Psychiatric, substance abuse, medical or vocational, as appropriate to the client's needs. Interview on 3/16/18 with the PD/A revealed the following information; -- She did not realize that the forms she had been using from the ACLS section of the Division of Health Service Regulation did not include all of the required components for a complete assessment to a Mental Health licensed group home. -- She confirmed that the facility management company also owns and operates several Family Care Homes. This deficiency is cross referenced into: 10A NCAC 27G .5601 Supervised Living - Scope, Tag V-289 for a Type A1 rule violation and must be corrected within 23 days.	V 111	ASSESSMENTS ARE CORRECTED Dee & G # 2 ASSURED that the ASSESSMENTS OF clients have been implimented. And they are included in the clients records ASSESSMENTS WILL BE REVIEW & MONITORED BY QP - QUARTERLY, IN ORDER TO PREVENT THIS FROM REOCCURRING AN ASSESSMENT WILL BE PERFORMED AND ACCESSED 30 DAYS.	4/15/18 CC 30 days
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be	V 112	The QP had renew all ASSESSMENTS ARE IS PLEASE WITH THE CORRECTIONS IN order to remain compliant	

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V 112	<p>Continued From page 15</p> <p>achieved by provision of the service and a projected date of achievement;</p> <p>(2) strategies;</p> <p>(3) staff responsible;</p> <p>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;</p> <p>(5) basis for evaluation or assessment of outcome achievement; and</p> <p>(6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to have documentation of a current treatment plan affecting 4 of 4 audited clients (#1 #2 #3 #4), and also failed to follow diet and weight management orders for 2 of 4 audited clients (#1 #3). The findings are:</p> <p>A. Review on 3/15/18 of Client #1's record revealed the following information; --Admitted to the facility on 1/18/17. -- Age 66 years old. -- Diagnoses include Schizoaffective Disorder, Dementia, Parkinson's - Neuroleptic Induced, Possible Neurocognitive Disorder, Hypothyroidism, Hypertension, GastroEsophageal Reflux Disease, Chronic Obstructive Pulmonary Disease, Incontinence and Status Post Middle Toe Amputation. -- Uses a rolling walker to get himself around.</p>	V 112	<p>The QP has developed Treatment Plans for all 5 of our clients, This deficiency has been corrected. 4/10/18</p> <p>The QP will monitor quarterly to assure that any goals that has been met, or any new goals will be implemented in thier treatment plans including unsupervised time. In order to prevent this from reoccurring the Admin will have more than one copy of the clients treatment plans, In case of loss, or damaged etc.</p> <p>The Administrator will monitor as needed In order to remain compliant. (every other month) but more</p>

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V 112	<p>Continued From page 16</p> <p>-- No documentation of a treatment plan.</p> <p>Review on 3/16/18 of Client #2's record revealed the following information;</p> <p>-- Admitted to the facility on 1/9/14.</p> <p>-- Age 63 years old.</p> <p>-- Diagnoses include Chronic Schizophrenia, Chronic Personality Disorder, Dementia and Insomnia.</p> <p>-- An FL-2 dated 11/21/17 indicating the client was "constantly disoriented," and displayed inappropriate behaviors of wandering and damage to property.</p> <p>-- On 3/14/18 Client #2 was hospitalized overnight both to have a cardiac catheterization performed and a stent placed.</p> <p>-- No documentation of a treatment plan.</p> <p>Review on 3/14/18 of Client #3's record revealed the following information;</p> <p>-- Admitted to the facility on 10/9/17 following a 1 year and 4 month stay at a state psychiatric hospital.</p> <p>-- Age 28 years old.</p> <p>-- Diagnoses include Schizophrenia, Personality Disorder with Antisocial Features, Cannabis Use Disorder, Obesity, Dyslipidemia and Acne.</p> <p>-- The client is a Registered Sex Offender.</p> <p>-- Has a history of committing Arson three times (his Mother's house, his Sister's house and a motel room he was staying in).</p> <p>-- No documentation of a treatment plan.</p> <p>Review on 3/14/18 of Client #4's record revealed the following information;</p> <p>-- Admitted to the facility on 12/29/17.</p> <p>-- Age 26 years old.</p> <p>-- Diagnoses include Chronic Schizoaffective Disorder and Bipolar Disorder.</p> <p>-- No documentation of a treatment plan.</p>	V 112	<p>Frequent if needed.</p> <p>Dee & G Enrichment #2 assure that this citation will not occur again.</p> <p>Treatment Plans ARE IN THE FACILITY they have been copied And placed in Folder. To assure that this will never happens again The QP will develop, AND Train PP to document goals AS well as monitor for any changes quarterly.</p> <p>This deficiency has been corrected.</p>	<p>4/3/18 CC</p>

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V 112	<p>Continued From page 17</p> <p>Interview on 3/16/18 with the Program Director/Administrator (PD/A) revealed the following information;</p> <ul style="list-style-type: none"> -- There were no current treatment plans in the facility for any of the 6 current clients. -- The facility Qualified Professional (QP) is responsible for the client's treatment plans. -- She confirmed that they had all been updated by the QP as the facility was expecting their annual survey to occur sometime in December 2017. -- There were two employees who had left their positions with the facility within the past several months (December 2017 and January 2018). -- These two employees both quit their jobs, however they did not leave on good terms. -- These employees may have taken some of the missing documentation from client records with them. <p>Interview on 3/22/18 with the QP revealed the following information;</p> <ul style="list-style-type: none"> -- She was responsible for client treatment plans. -- An employee left her position at the facility at the end of 2017. -- She had to replicate or reproduce the missing pieces of client records during November 2017 to be ready for the upcoming annual survey that she thought would occur in December 2017. -- Another employee left her position at the facility in January 2018. -- She was unaware that client documentation was again missing from the facility, and that the above employee must have taken the missing documentation. -- The PD/A had not had alerted her that client documentation was missing again. <p>B. 1. Review on 3/15/18 of Client #1's record</p>	V 112		<p><i>Corrected</i> <i>(cc)</i></p>

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V 112	<p>Continued From page 18</p> <p>revealed the following information; --Admitted to the facility on 1/18/17. -- Age 66 years old. -- Diagnoses include Schizoaffective Disorder, Dementia, Parkinson's - Neuroleptic Induced, Possible Neurocognitive Disorder, Hypothyroidism, Hypertension, GastroEsophageal Reflux Disease, Chronic Obstructive Pulmonary Disease, Incontinence and Status Post Middle Toe Amputation. -- Uses a rolling walker to get himself around.</p> <p>Review on 3/16/18 of Client #1's record revealed the following documentation from his Physician's regarding both his diet and his weight loss; -- 5/22/17 - Seen at the Veterans Administration (VA) Hospital: Has lost 13 pounds, 191.4 pounds today. Client was last seen by this Physician on 3/7/17 (approximately 10 weeks prior). Instructions: Needs more protein in diet. -- 9/5/17 - Seen at the VA: Weight loss of 10 pounds since May (5/22/17, last weight was 191.4 pounds, so weight at this appointment should be 181.4). Instructions: 3000 calorie diet. Nutritional consult. -- 11/8/17 - Seen at the VA: Weight loss of 4 pounds (9/5/17, last weight was 181.4 pounds, so weight at this appointment should be 177.4). Instructions: Increase food calorie to 3000 calories a day. Refer to Nutrition placed. Please check weight (does not indicate how often) and "call if < 5 (greater than 5) pound weight loss." -- 11/17/17 - 11/21/17 - The client was hospitalized due to "weight loss and low blood pressure." Discharge note "Your main problem treated during this hospital stay (discharge diagnosis) was: Low blood pressure. You have lost a significant amount of weight..." Current weight is 171.5 pounds. Following this hospitalization the Physician discontinued 4</p>	V 112	<p>Dee & G #2 assures that client #1 has been transferred to a higher level of care. we also didn't know This deficiency ^{3/20/18} has been corrected. CC All Clients are on a N.S.S. A regular diet etc per their individual FL2, weights And vitals are checked Bi-weekly and documentat is inside a book, that remain in the facility. Admin will monitor weekly in order to prevent this problem from reoccurring. Admin will review carefully the weights concerning 5 lbs over or under. And if so then the physician will be contacted directly. AS before.</p>	
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V 112	<p>Continued From page 19</p> <p>medications he had been taking for his blood pressure/heart (Lasix, Carvediolol, Lisinopril, and Potassium).</p> <p>-- 11/29/17 - Seen at the VA: Weight gain of 8 pounds (gained 8 pounds in 8 days following the discontinuation of Lasix 9 days prior).</p> <p>Additional review on 3/16/18 of Client #1's record revealed documentation that the client was weighed 3 times while in the facility as follows:</p> <p>-- 2/10/18 - 180 pounds. -- 2/24/18 - 180 pounds. -- 3/7/18 - 180 pounds.</p> <p>Interview on 3/14/18 with Staff #1 revealed none of the clients in the facility were on a therapeutic diet.</p> <p>Interview on 3/16/18 with the PD/A revealed her not to be aware of any clients in the facility being on a Physician's ordered therapeutic diet.</p> <p>Interview on 3/16/18 with the PD/A revealed the following information:</p> <p>-- She was sure that vital signs and weights had been checked for Client #1 more than 3 times. -- She remembers seeing them in a notebook, and thought that staff checked them several times a week. -- She was unable to produce documentation of any other vital signs including weights for Client #1 other than the above ones. -- She had not, nor the other staff working with Client #1 alerted any Physician to his weight loss. -- She was not aware of the Physician's order of 11/17/17 to notify this Physician if the client had lost more than 5 pounds. -- There were 2 employees who had left their positions with the facility within the past several months (December 2017 and January 2018).</p>	V 112	<p><i>Duplicate page</i></p>	
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V 112	<p>Continued From page 20</p> <p>-- These 2 employees they both quit their jobs, however they did not leave on good terms. -- These employees may have taken some of the missing documentation with them.</p> <p>2. Review on 3/14/18 of Client #3's record revealed the following information; -- Admitted to the facility on 10/9/17 following a 1 year and 4 month stay at a state psychiatric hospital. -- Age 28 years old. -- Diagnoses include Schizophrenia, Personality Disorder with Antisocial Features, Cannabis Use Disorder, Obesity, Dyslipidemia and Acne. -- A discharge summary from the hospitalization dated 2/15/18 had a Physician's order for a "Low Sodium Heart Healthy" diet. -- Documentation that on 10/17/17 while at a Physician's visit his weight was 226 pounds. -- On 2/20/18 during an appointment with his Psychiatrist following his recent hospitalization, his weight was 247 pounds. -- The above documentation represents a 21 pound weight gain in a period of 4 months.</p> <p>Interview on 3/16/18 with the PD/A revealed the following information; -- She was not aware of Client #3's Physician ordered therapeutic diet.</p> <p>This deficiency is cross referenced into: 10A NCAC 27G .5601 Supervised Living - Scope, Tag V-289 for a Type A1 rule violation and must be corrected within 23 days.</p>	V 112	<p><i>Duplicate page</i></p>	
V 118	<p>27G .0209 (C) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p>	V 118		

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NAME OF PROVIDER OR SUPPLIER DEE & G ENRICHMENT #2	STREET ADDRESS, CITY, STATE, ZIP CODE 207 FRIENDLY ROAD BURLINGTON, NC 27215
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(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
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V 118	<p>Continued From page 21</p> <p>(c) Medication administration:</p> <p>(1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.</p> <p>(4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p> <p>(D) date and time the drug is administered; and</p> <p>(E) name or initials of person administering the drug.</p> <p>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to assure prescription medications were administered to clients as written by a Physician and assure that MARs were kept current affecting 1 of 4 audited clients (#2). The findings are:</p>	V 118	<p>In order to correct this deficiency, we've updated the MARs, And medications are being given as ordered. All orders are current and have been reviewed by PP/b Admin.</p> <p>In order to prevent this from reoccurring we've implemented a new form that staff must complete that states any medication changes etc. The medications will be monitored weekly. to assure All MARs & medications are current and All medications are given as prescribed. Also A new GP has been</p>	4/1/18
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NAME OF PROVIDER OR SUPPLIER DEE & G ENRICHMENT #2		STREET ADDRESS, CITY, STATE, ZIP CODE 207 FRIENDLY ROAD BURLINGTON, NC 27215		
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V 118	<p>Continued From page 22</p> <p>Review on 3/16/18 of Client #2's record revealed the following information;</p> <ul style="list-style-type: none"> -- Admitted to the facility on 1/9/14. -- Age 63 years old. -- Diagnoses include Chronic Schizophrenia, Chronic Personality Disorder, Dementia and Insomnia. -- An FL-2 dated 11/21/17 indicating the client was "constantly disoriented," and has displayed inappropriate behaviors of wandering and damage to property. -- On 3/14/18 Client #2 was hospitalized overnight both to have a cardiac catheterization test performed and a stent placed. (A stent is a small device surgically implanted inside a blood vessel that compacts the plaque against the walls of the arteries to create a wider path for blood flow to the lower half of your body. A stent holds tissue in place and keeps it open or relieves blockage.) (Cardiac catheterization is a procedure that uses X-ray imaging to see your heart's blood vessels. The test is generally done to see if there's a restriction in blood flow going to the heart. If necessary, a Physician can open clogged heart arteries (angioplasty) during this procedure.) -- An order from Client #2's Psychiatrist dated 1/26/18 changing his scheduled dose of Cogentin 2 mg. every night to "PRN (as needed) every night ONLY for muscle tremor." <p>Review on 3/16/18 of Client #2's January, February and March 2018 MARs revealed the following information;</p> <ul style="list-style-type: none"> -- The Physician's order of 1/26/18 changing a scheduled dose of Cogentin to be administered only if needed had not been transcribed on any of these 3 MARs. -- Documentation on all 3 of the above MARs 	V 118	<p>hired who has already began to renew needs, goals, weights, vitals, Appointments, as well as consult with Admin About clients Assessments. And treatment goals. and well as PCP.</p> <p>IN order for this deficiency to never reoccur.</p> <p>(This has been corrected.)</p>	<p>CR</p>

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V 118	<p>Continued From page 23</p> <p>indicated the client was administered a scheduled dose of Cogentin every night from the date of the order (1/26/18) through last night (3/15/18).</p> <p>Interview on 3/1/18 with the Program Director/Administrator revealed the following information;</p> <ul style="list-style-type: none"> -- She was unaware of the above Physician's order. -- She confirmed that Client #2 had not been administered his Cogentin as his Physician ordered during the above time period. <p>Observation on 3/16/18 at 11:30 am of Client #2's medications on hand revealed the scheduled dose of Cogentin to be in the client's bubble pack of medications along with written instructions to take the Cogentin every night.</p> <p>This deficiency is cross referenced into: 10A NCAC 27G .5601 Supervised Living - Scope, Tag V-289 for a Type A1 rule violation and must be corrected within 23 days.</p>	V 118		
V 289	<p>27G .5601 Supervised Living - Scope</p> <p>10A NCAC 27G .5601 SCOPE</p> <p>(a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence.</p> <p>(b) A supervised living facility shall be licensed if the facility serves either:</p> <ul style="list-style-type: none"> (1) one or more minor clients; or (2) two or more adult clients. 	V 289		

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V 291	<p>Continued From page 36</p> <p>inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure coordination was maintained between the facility operator and the Qualified Professionals (QPs) responsible for treatment/habilitation or case management affecting 4 of 4 audited clients (#1 #2 #3 #4). The findings are:</p> <ol style="list-style-type: none"> 1. Review on 3/15/18 of Client #1's record revealed the following information; <ul style="list-style-type: none"> --Admitted to the facility on 1/18/17. -- Age 66 years old. -- Diagnoses include Schizoaffective Disorder, Dementia, Parkinson's - Neuroleptic Induced, Possible Neurocognitive Disorder, Hypothyroidism, Hypertension, GastroEsophageal Reflux Disease, Chronic Obstructive Pulmonary Disease, Incontinence and Status Post Middle Toe Amputation. -- Uses a rolling walker to get himself around. <p>Interview on 3/15/18 with the Program Director/Administrator (PD/A) revealed the following information regarding Client #1;</p> <ul style="list-style-type: none"> -- Prior to being admitted to the facility (on 1/18/17), Client #1 had been the subject of a Silver Alert (on 10/26/16). -- He had been at a hospital, and told them he was going to leave. -- He walked off from the hospital to go to his Sister's house. -- There was snow on the ground at this time. -- While attempting to get to his Sister's, he 	V 291	<p><i>* Duplicate page</i></p>	
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V 291	<p>Continued From page 37</p> <p>walked for an unknown amount of time, and also fell in the snow. -- This exposure to the elements resulted in one of his toes having to be amputated.</p> <p>Interview on 3/16/18 with the PD/A revealed the following information regarding Client #1; -- His Parkinson's Disease has gotten much worse than it was when he arrived at the facility a little over a year ago. -- His hands shake so much that he needs assistance with completing many tasks (buttoning clothing, making his bed, eating, etc.). -- His physical health is declining very rapidly. -- She has been trying to get his Physician "to order him to a higher level of care." -- She did not understand that if the facility is no longer able to meet the needs of a client, it is her responsibility to identify that fact, and work toward securing a more appropriate placement for the client(s).</p> <p>Review on 3/15/18 and 3/16/18 of Client #1's record revealed he was experiencing multiple medical and psychiatric issues since his arrival at the facility on 1/18/17 regarding his circulation, blood pressure changes, weight loss and wound care. The following are Physician's orders, and examples of the facilities failure to coordinate medical services for Client #1:</p> <p>a. Client #1's mental health; Review on 3/15/18 of Client #1's record revealed the following information; -- Documentation from a Physician at a Veterans Administration (VA) Hospital dated 12/27/17 as follows: "Please increase Zyprexa to 12.5 mg. at night (Antipsychotic Medication). Please record Patient's complaints about voices daily and chart..."</p>	V 291		

FAX: 336-524-0256

FACILITY: Dee's Enrichment #2

RETURN FAX #: 336 2228338

Facility telephone #: 336 2270824

PHYSICIAN INFORMATION REQUEST FAX

INSTRUCTIONS: Nursing staff will write out recommendation regarding specific resident.

Nurse will fax request to MD for response.

MD will agree or disagree with recommendation and note any comments.

MD will sign & fax form back to facility.

Nurse will process form as a telephone order.

Physician: Amed isys

Date: _____

We need the following information/orders/comments/recommendations

from you on the following resident.

RESIDENT: Sammy Burton

Rm #: _____

Floor: _____

Diagnoses: _____

Request: Your agency provided wound care for me of my clients and you discharged him on 11/29/17.

Do you feel in your opinions that he was healing like he should, or that the staff here didnt provide the care for his leg at the best of thier ability. Many times staff would water the nurse as she cleaned and wrapped it!

Nurse Signature: _____

Physician's Response: _____

Agree

Disagree

Comments: _____

MD SIGNATURE: _____

DATE: _____

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336 210-4414

FACILITY: Dee's G Enrichment #2

RETURN FAX #: 336 222-9338

Facility telephone #: 336 227 0524

PHYSICIAN INFORMATION REQUEST FAX

INSTRUCTIONS: Nursing staff will write out recommendation regarding specific resident.

Nurse will fax request to MD for response.

MD will agree or disagree with recommendation and note any comments.

MD will sign & fax form back to facility.

Nurse will process form as a telephone order.

Physician: Cheryl Lindley

Date: 4/30/18

We need the following information/orders/comments/recommendations

from you on the following resident.

RESIDENT: Michael hunter

Rm #: _____ Floor: _____

Diagnoses: _____

Miss (Leg)

Request: Lindley Could the infection that Michael hunter has or had, been caused by the SIC that assist with cleaning and bandaging It on a daily basic. Its healed, looking great

Nurse Signature: now but the E-Coli that he had how can we be the blame for this occurring.

Physician's Response: _____ Agree

_____ Disagree

Comments: _____

MD SIGNATURE: _____ DATE: _____

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FACILITY: Dee & G Enrichment #2

RETURN FAX #: 336 222-8338

Facility telephone #: 336 2270824

PHYSICIAN INFORMATION REQUEST FAX (1-980-225-0102)

INSTRUCTIONS: Nursing staff will write out recommendation regarding specific resident.

Nurse will fax request to MD for response.

MD will agree or disagree with recommendation and note any comments.

MD will sign & fax form back to facility.

Nurse will process form as a telephone order.

Physician: Guardian

Date: 4/30/18

We need the following information/orders/comments/recommendations

from you on the following resident.

RESIDENT: Michael hunter. Rm #: _____ Floor: _____

Diagnoses: _____

Request: Can you please write me to explain the care that Michael has received since he has been in my Facility. Do you feel like he has been neglected in any way.

Nurse Signature: _____

Physician's Response: _____ Agree _____ Disagree

Comments: _____

MD SIGNATURE: _____ DATE: _____

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V 110	<p>Continued From page 8</p> <p>-- Age 63 years old. -- Diagnoses include Chronic Schizophrenia, Chronic Personality Disorder, Dementia and Insomnia. -- An FL-2 dated 11/21/17 indicating the client was "constantly disoriented," and had displayed inappropriate behaviors of wandering and damage to property. -- No documentation of any strategies/interventions to address Client #2's mental health needs including wandering, hoarding and property destruction.</p> <p>Interview on 3/15/18 with Staff #1 revealed the following information regarding Client #2: -- Client #2 had gone into his room during the early afternoon after lunch and had removed all of his clothing from his dresser and closet strewing the items throughout his room. -- This behavior occurred fairly often. -- Staff redirected the client during these times.</p> <p>Observation on 3/15/18 of Client #2 throughout the day (from approximately 11:00 am, when he arrived back at the facility following a one day hospitalization, until approximately 4:25 pm) revealed him to mostly be sitting in the living room in his chair, however multiple times (approximately 4 to 5 times), he would get up and walk to the front door in an effort to get outside. During these times either the PD/A or Staff #1 would redirect him to come back away from the door and to sit back down. He complied with their requests.</p> <p>Interview on 3/16/18 with the PD/A regarding Client #2 revealed the following information; -- She confirmed that the facility staff had done some of the dressing changes for Client #2. -- She confirmed that training in the area of</p>	V 110	<p>Been taken on Wednesday And documented in the book, faxed to doctors so they are aware of any weight loss or gain. We assisted client #1 daily on his diet, It wasn't on his FL2 but we worked diligently by purchasing Ensure that he drank at every meal, protein bars that we purchased to assist him in weight gain. Even though he attended a workshop daily we sent him xtra protein to add to what they served at the program he attended. I understood the importance of client #1 health concern. But because the book could not be located then we have</p>	3/19/18 com
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Since documented all weights and vitals & they are in a book in the staff room. For viewing. In order to prevent this loss of informati I have camera's installed at this location so even when I'm not at the location I can see when

everything is at all times.

I love my clients and I will do my very best to care for them as I always have done.

The QP will review all documentations weights, vitals, and orders monthly to assure that we remain compliant.

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V 290	Continued From page 33	V 290		
V 290	<p>27G .5602 Supervised Living - Staff</p> <p>10A NCAC 27G .5602 STAFF</p> <p>(a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs.</p> <p>(b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time.</p> <p>(c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present:</p> <p>(1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or</p> <p>(2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body.</p> <p>(d) In facilities which serve clients whose primary diagnosis is substance abuse dependency:</p> <p>(1) at least one staff member who is on</p>	V 290	<p>Client #4 attends the together house daily or psychotherapeutic services. A Mental health Serv</p> <p>We have had training on alcohol, substance abuse, etc. (past)</p> <p>Client #4 has not had any problems with drugs or alcohol since he's been in my facility.</p> <p>Client #4 upon admission was asked if he needs to attend meetings etc. Client declined, but if ever the need I will assure I will transport them to meetings, bring in substance abuse counsilar's etc.</p> <p>We have meetings at several churches that offer substance abuse meetings. Also ^{some of} my client</p>	

occasionally attend A substance Abuse/ alcohol meeting here called Men of Steal. on Monday night when they agree to go, It will be offered more in order to correct this deficiency, The Admin will

Back.

monitor weekly and allow them to sign in whether they want to attend or not. We will implement more substance abuse meetings in order for us to remain compliant.

Also John Teer from Cardinal Innovations has had several meetings on Substance Abuse / Alcohol with me and my staff.

You never asked me for this? Where is this rule, per state we gave all of our files to the state

For approval, how can I be written up for something that I wasn't informed per policy, procedure, and rules.

But I agree to attend substance abuse trainings as well as staff in continue education

I will monitor to assure that this deficiency never occurs.

Training in Files

CC
4/30/18.

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V 291	<p>Continued From page 38</p> <p>-- No documentation regarding any voices in this record.</p> <p>-- No documentation of any strategies/interventions to address Client #1's mental health needs including auditory hallucinations.</p> <p>Interview on 3/20/18 with the PD/A revealed she was unaware of the Physician's order to document Client #1's 'voices.'</p> <p>b. Treatment of Client #1's toe amputation site and leg wounds;</p> <p>-- 1/24/17 - Physician's order: Clean right toe amputation site well, wash with soap and water, pat it dry and apply dressing over it and tape it daily. Monitor for signs and symptoms of infection and treat/contact appropriately for evaluation and treatment.</p> <p>-- 2/21/17 - Physician's order: "Rehab Center (the group home staff) to continue daily dressing changes.. Monitor site for infection.."</p> <p>-- 4/4/17 - Physician's order: Right third toe amputation site healed. Patient discharged from Vascular Clinic.</p> <p>-- 6/6/17 - Primary Care Physician's (PCP's) order: "Patient to go directly to Emergency Department for infection in left leg. Prescribed Ativan as needed for anxiety."</p> <p>-- 6/6/17 - Emergency Room Physician's order: Use Neosporin Ointment twice per day to left lower leg.</p> <p>-- 6/21/17 - PCP's order: Start Keflex (an antibiotic medication). Home Health RN for wound consult and care.</p> <p>-- 7/6/17 - Physician's order: Start Augmentin and Doxycycline (two antibiotic medications). Dermatology outpatient consult placed.</p> <p>-- 7/7/17 - Wound Care Clinic (WCC): Start Santyl to wound, prescription given.</p>	V 291	<p>Dee & G Enrichment #2 provided the best care for Client #1 After his Toe was amputated It was our duty to Follow the nurses orders, cleaning the area daily keeping it dry, and dressing it! And his toe healed fast and Client #1 was released from the home health nurse on 11/29/17 with no swelling, NO draining, leg was dry, And It was with our care following the nurses care that this occurred,</p> <p>I will Add the Fact that If any time we saw signs or IF Client #1 Complained of it hurting, we always transported client to the physician we are not or have been negligent in Any way.</p>	
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V 291	<p>Continued From page 39</p> <p>-- 7/10/17 - Physician's order: Follow up with Dermatology as needed.</p> <p>-- 7/12/17 - Performed Arterial Doppler and Duplex. (These are tests that measure the amount of blood flow in the body, and produce internal images of areas of the body).</p> <p>-- 7/13/17 - WCC: Blood Pressure 82/45 pulse 71. Notify [name of Physician] of blood pressure. Orders have been changed from Santyl to Prisma AG dressing. Orders will be sent to Home Health.</p> <p>-- 7/13/17 - Cardiology/Vascular evaluation of left leg ulcer: Follow up as needed.</p> <p>-- 7/13/17 - Skilled Nursing: Visit made to provide wound care. Assessment within normal limits with exception of wound of left lower leg.</p> <p>-- 7/19/17 - WCC: We are applying Prisma AG to wound every other day.</p> <p>-- 7/26/17 - Skilled Nursing: Visit made to provide wound care.</p> <p>-- 7/28/17 - Skilled Nursing: Visit made to provide wound care.</p> <p>-- 8/3/17 - WCC: Seen for follow up on ulcers on his left lower leg. Eschar covered. Wound debrided. (Eschar is a scab or dry crust that results from trauma, such as burns, infection or an excoriating skin disease.) (Debridement is the medical removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue).</p> <p>-- 8/17/17 - WCC: Continue application of Prisma AG to wound bed.</p> <p>-- 8/24/17 - WCC: Will continue to apply Prisma AG on wound bed.</p> <p>-- 8/26/17 - Skilled Nursing: Visit for recertification for wound care as ordered. No signs of infection noted.</p> <p>-- 8/31/17 - WCC: Seen for wound check. Noted</p>	V 291	<p>Client was transported to the VA for all of his medical needs and they would sometimes drag thier leg in getting what client #1 needed, but we never sat down on our responsibility. I even got him another physician in Alamance Co to take care of client #1 needs when VA didnt.</p> <p>We assure you that all doctors appots, medicine changes, will be followed as prescribed.</p> <p>We will continue to monitor and provide the best service no matter the circumstance.</p> <p>We have A New Q P who will be more obserrant and have the time to focus on Dee & G clients and employees.</p>

This
has been corrected
Client has been
discharged to be closer
to his hometown.

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V 291	<p>Continued From page 40</p> <p>bigger in size. Will continue Prisma AG application to wound bed, covered with telfa island (a type of wound dressing).</p> <p>-- 9/7/17 - WCC: Seen for wound check. Doing better. Continue to apply Prisma AG and cover with telfa island.</p> <p>-- 9/14/17 - WCC: Seen for wound check. Will ask Home Health to order compression stockings. Continue to use Prisma AG.</p> <p>-- 9/28/17 - WCC: Seen for wound check. Looks good and stable. "Please, patient needs compression stockings."</p> <p>-- 10/5/17 - WCC: Seen for wound check.</p> <p>-- 10/19/17 - WCC: Seen for wound check. Improvement noted to wound. Will continue applying Prisma AG to wound bed.</p> <p>-- 11/2/17 - WCC: Seen for wound check. Progressing well. Continue to apply Prisma AG to wound.</p> <p>-- 11/9/17 - WCC: Continue Prisma AG to left lower leg wound. Wrap with gauze and Kerlix. DO NOT use adhesive due to tape burn.</p> <p>-- 11/16/17 - WCC: Patient's wound is healed. Continue covering with a foam bandage and change every 3 to 4 days for the next two weeks. May change bandage if needed more often if soiled.</p> <p>-- 1/11/18 - PCP's order: Venous Doppler of left lower leg performed today. Start Xarelto 15 mg. twice a day for 21 days, then 20 mg. daily (Xarelto is a medication that thins the blood). Return to clinic in 6 weeks for evaluation of DVT. (Deep Vein Thrombosis occurs when a blood clot (thrombus) forms in one or more of the deep veins in your body, usually in your legs. DVT can be very serious because blood clots in your veins can break loose, travel through your bloodstream and lodge in your lungs, blocking blood flow (pulmonary embolism). If you develop signs or symptoms of a pulmonary embolism - a</p>	V 291		
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V 291	<p>Continued From page 41</p> <p>life-threatening complication of deep vein thrombosis - seek immediate medical attention.) -- 2/19/18 - PCP's order: Patient following up on left lower leg DVT. Firm area still noted on left lower leg. Continue elevating leg. Start Keflex (an antibiotic medication). -- 2/12/18 - Seen at the VA: Restart Carvediolol 3.25 mg twice a day (a medication for control of high blood pressure). Please call office and let us know if he is on Xarelto. He has had chronic left lower leg edema (swelling) due to an old injury. He is high risk for falls. "Check blood pressure daily and call if over 150/85."</p> <p>Interview on 3/15/18 with the PD/A revealed the following information: -- She confirmed that the facility staff had done some of the dressing changes for Client #1. -- She confirmed that dressing changes and wound treatment need to be done under sterile conditions to prevent infection. -- She confirmed that training in the area of wound care/management and dressing changes had not been conducted for any of the staff. -- She was unaware if anyone had requested the above training from Client #1's Physician's office. -- She was not sure if Client #1 knew to elevate his legs to reduce the swelling in them.</p> <p>c. Client #1's diet and weight loss: -- 5/22/17 - Seen at the VA Hospital: Has lost 13 pounds, 191.4 pounds today. Client was last seen by this Physician on 3/7/17 (approximately 10 weeks prior). Instructions: Needs more protein in diet. -- 9/5/17 - Seen at the VA: Weight loss of 10 pounds since May (5/22/17, last weight was 191.4 pounds, so weight at this appointment should be 181.4). Instructions: 3000 calorie diet. Nutritional consult.</p>	V 291	<p>Dee & G Enrichment Administrator purchases protein bars, and ensure to assist with clients weight loss. Client #1 would did eat at every meal, but when he'd go to his workshop he would refuse to eat, because he did not like sandwiches so I decided to send extra drinks & protein & anything that he wanted to encourage weight gain. We constantly took him to the doctors office and they were searching in every area, but it was not due to our negligent I apologize, but I cannot agree. We will continue to monitor daily and before, we will continue consult @ doctors etc to assure that we remain compliant in this area but clients has been discharged. 4/5/18</p>

before, we will continue consult @ doctors etc to assure that we remain compliant in this area but clients has been discharged. 4/5/18

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V 291	<p>Continued From page 42</p> <p>-- 11/8/17 - Seen at the VA: Weight loss of 4 pounds (9/5/17, last weight was 181.4 pounds, so weight at this appointment should be 177.4). Instructions: Increase food calorie to 3000 calories a day. Refer to Nutrition placed. Please check weight (does not indicate how often) and "call if < 5 (greater than 5) pound weight loss."</p> <p>-- 11/17/17 - 11/21/17 Client was hospitalized due to "weight loss and low blood pressure." Discharge note "Your main problem treated during this hospital stay (discharge diagnosis) was: Low blood pressure. You have lost a significant amount of weight..." Current weight is 171.5 pounds. Following this hospitalization the Physician discontinued 4 medications he had been taking for his blood pressure/heart (Lasix, Carvediolol, Lisinopril, and Potassium).</p> <p>-- 11/29/17 Seen at the VA: Weight gain of 8 pounds (gained 8 pounds in 8 days following the discontinuation of Lasix 9 days prior).</p> <p>Additional review on 3/16/18 of Client #1's record revealed documentation that the client was weighed 3 times while in the facility as follows: -- 2/10/18 - 180 pounds. -- 2/24/18 - 180 pounds. -- 3/7/18 - 180 pounds.</p> <p>Interview on 3/15/18 with the PD/A revealed the following information; -- She was certain that Client #1's weight had been checked more than 3 times while he was at the facility. -- She remembers them being recorded in a notebook. -- She was unable to locate the notebook. -- She was unaware of the Physician's order for the facility to notify him of a weight loss of greater than 5 pounds. -- No one at the facility had notified Client #1's</p>	V 291	<p>We at the Facility will assure that we check all blood pressure and weights as before. I have a duplicate copy as well as a camera installed in order for this to never occur again. In the future we the QP will renew all weights & vitals weekly And fax to their physician. This deficiency has been corrected.</p>	4/1/18 cc

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V 291	<p>Continued From page 43</p> <p>Physician as ordered of weight loss of greater than 5 pounds. * See Tag V-115, Client Services for specific details/examples of Client #1's therapeutic diet.</p> <p>d. Client #1's blood pressures; -- 7/13/17 - Seen at Wound Care Clinic: "Blood Pressure 82/45 pulse 71. Notify [name of Physician] of blood pressure." -- 11/17/17 - 11/21/17 Client was hospitalized due to "weight loss and low blood pressure." Discharge note "Your main problem treated during this hospital stay (discharge diagnosis) was: Low blood pressure. You have lost a significant amount of weight..." "Other instructions: You have been given a blood pressure cuff. Please take your blood pressure twice a week and bring the readings with you to your appointments." Your blood pressure is now under control, likely due to your weight loss so discontinue taking Carvediolol, Lisinopril, Lasix and Potassium (all medications prescribed to treat blood pressure/heart conditions). -- 2/12/18 - Seen at the VA: Restart Carvediolol 3.25 mg twice a day. Please call office and let us know if he is on Xarelto. He has had chronic left lower leg edema (swelling) due to an old injury. He is high risk for falls. "Check blood pressure daily and call if over 150/85."</p> <p>Additional review on 3/16/18 of Client #1's record revealed documentation that his blood pressure was checked 3 times while in the facility as follows: -- 2/10/18 - 148 (or 198)/114. -- 2/24/18 - 165/89. -- 3/7/18 - 157/86.</p> <p>Interview on 3/15/18 with the PD/A revealed the</p>	V 291		

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V 291	<p>Continued From page 44</p> <p>following information;</p> <ul style="list-style-type: none"> -- She was certain that Client #1's blood pressure had been checked more than 3 times while he was at the facility. -- She remembers them being recorded in a notebook. -- She was unable to locate the notebook. -- She was unaware of the Physician's order for the facility to notify him of blood pressures within certain parameters. -- No one at the facility had notified Client #1's Physician as ordered of the high blood pressure readings above. <p>e. Client #1's compression stockings;</p> <ul style="list-style-type: none"> -- 3/7/17 - Physician's order: "Compression stockings for edema (swelling) of LE (lower extremity)." -- 9/14/17 - Seen at Wound Care Clinic for a wound check: "Will ask home health to order compression stockings." -- 9/28/17 - Seen at Wound Care Clinic for a wound check: "Please, Patient needs compression stockings." <p>(Compression stockings improve blood flow. They can lessen pain and swelling in your legs. They can also lower your chances of getting a deep vein thrombosis (DVT), a kind of blood clot, and other circulation problems.)</p> <p>Interview on 3/20/18 with the PD/A revealed the following information;</p> <ul style="list-style-type: none"> -- She was not sure if Client #1 had compression stockings, and she was unaware of the above multiple Physician's orders to obtain them for Client #1 to wear to assist with leg swelling and to aid his circulation. <p>Surveyor attempted to interview Client #1 at the Durham VA on 3/16/18 and was not successful.</p>	V 291		
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V 291	Continued From page 45 As of date of survey exit (3/21/18), Client #1 remained hospitalized. 2. Review on 3/16/18 of Client #2's record revealed the following information; -- Admitted to the facility on 1/9/14. -- Age 63 years old. -- Diagnoses include Chronic Schizophrenia, Chronic Personality Disorder, Dementia and Insomnia. -- An FL-2 dated 11/21/17 indicating the client was "constantly disoriented," and has displayed inappropriate behaviors of wandering and damage to property. -- On 3/9/18 was prescribed Aspirin (for prevention of the formation of blood clots in people with coronary artery disease). -- On 3/15/18 was prescribed Plavix (a blood thinner used to prevent stroke, heart attack, and other heart problems). -- On 3/14/18 Client #2 was hospitalized overnight both to have a cardiac catheterization test performed and a stent placed. (A stent is a small device surgically implanted inside a blood vessel that compacts the plaque against the walls of the arteries to create a wider path for blood flow to the lower half of your body. A stent holds tissue in place and keeps it open or relieves blockage.) (Cardiac catheterization is a procedure that uses X-ray imaging to see your heart's blood vessels. The test is generally done to see if there's a restriction in blood flow going to the heart. If necessary, a Physician can open clogged heart arteries (angioplasty) during this procedure.) Review on 3/15/18 and 3/16/18 of Client #2's record revealed he was experiencing multiple medical issues from 12/6/17 through the present time related to his circulation and wound care.	V 291		

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V 291	<p>Continued From page 46</p> <p>The following are Physician's orders, and examples of the facilities failure to coordinate medical services for Client #2:</p> <p>-- 9/17/17 - Primary Care Physician's (PCP's) order: Dehydrated, increase fluids, compression stockings for bilateral leg edema, encourage to elevate legs above heart level. (Compression stockings improve blood flow. They can lessen pain and swelling in your legs. They can also lower your chances of getting a deep vein thrombosis (DVT), a kind of blood clot, and other circulation problems.)</p> <p>-- 12/6/17 - PCP's order: Swab sent for wound culture. Start Bactroban and Keflex (two antibiotic medications). Dry dressing to wound.</p> <p>-- 12/12/17 - PCP's order: Continue dressing changes. Start Levaquin (an antibiotic medication).</p> <p>-- 1/8/18 - PCP's order: Echocardiogram normal. Start Cipro (an antibiotic medication). Bactroban for wound care (an antibiotic cream). Dressing changes. Wound is positive for E. Coli. (E. Coli is a bacterial infection and these bacteria produce toxins that have a wide range of effects. Symptoms caused by some E. Coli infections range from mild to severe.)</p> <p>-- 1/23/18 - Physician's order: Start Augmentin (an antibiotic medication). Refer to Wound Care Clinic (WCC).</p> <p>-- 2/7/18 - PCP's order: Continue wound care.</p> <p>-- 2/12/18 - WCC Physician's order: Client would not allow Physician to debride. Applied a Medihoney gel (a wound care dressing) and cover with self adherent dressing. Change daily.</p> <p>-- 2/22/18 - WCC Physician's order: Wound debrided, continue Medihoney, will schedule for arterial study.</p> <p>(Debridement is the medical removal of dead, damaged, or infected tissue to improve the</p>	V 291		

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V 291	<p>Continued From page 47</p> <p>healing potential of the remaining healthy tissue.)</p> <p>-- 2/28/18 - WCC Physician's order: Start Levaquin (an antibiotic medication).</p> <p>-- 3/1/18 - WCC Physician's order: Not much improvement. Tolerated debridement partially. Will use Santyl for wound care.</p> <p>-- 3/8/18 - WCC Physician's order: Wound Debrided. Continue Santyl.</p> <p>-- 3/9/18 - Physician's order: Non-healing wounds on right lower leg. ABI was <0.4 with severe Iliac Disease and occluded SFA. Recommend Abdominal Angiogram. Start Aspirin 81 mg. every day.</p> <p>(ABI is an Ankle-Brachial Index, which is a test used to gauge circulation (blood flow) and measure blood pressure in the arteries. ABI results of 0 to 0.40 indicate severe arterial disease.)</p> <p>(Iliac artery occlusive disease occurs when the arteries in your abdomen become narrowed with plaque and cannot bring enough blood to organs and muscles in your legs.)</p> <p>(SFA is a superficial femoral artery.)</p> <p>(Occlusion is the blockage or closing of a blood vessel.)</p> <p>-- 3/14/18 - Abdominal Angiogram performed with placement of a stent.</p> <p>(An Angiogram is an imaging test that uses X-rays to look at your blood vessels.)</p> <p>-- 3/13/18 - Physician's order: Elevated PSA, refer to Urology.</p> <p>(PSA is a Prostate-specific antigen, and the blood level of PSA is often elevated in men with prostate cancer.)</p> <p>Interview on 3/16/18 with the PD/A revealed the following information;</p> <p>-- She confirmed that the facility staff had done some of the dressing changes for Client #2.</p> <p>-- She confirmed that dressing changes and</p>	V 291		

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V 291	<p>Continued From page 48</p> <p>wound treatment need to be done under sterile conditions to prevent infection.</p> <ul style="list-style-type: none"> -- She confirmed that training in the area of wound care/management and dressing changes had not been conducted for any of the staff. -- She was unaware if anyone had requested the above training from Client #2's Physician's office. -- She was not sure if Client #2 knew to elevate his legs to reduce the swelling in them. -- She was not sure if Client #2 had compression stockings, and she was unaware of the above Physician's orders to obtain them for Client #2 to wear to assist with leg swelling and to aid his circulation. -- She was unaware of the Physician's order for a referral to a Urologist, and was unable to confirm that an appointment had been scheduled for this. <p>Several attempts were made to interview Client #2 on 3/15/18 which were unsuccessful due to his cognitive ability.</p> <p>3. Review on 3/14/18 of Client #3's record revealed the following information;</p> <ul style="list-style-type: none"> -- Admitted to the facility on 10/9/17 following a 1 year and 4 month stay at a state psychiatric hospital. -- Age 28 years old. -- Diagnoses include Schizophrenia, Personality Disorder with Antisocial Features, Cannabis Use Disorder, Obesity, Dyslipidemia and Acne. -- An FL-2 dated 10/29/17 with a Physician's order to check the client's blood sugar level twice a day. -- No documentation that any blood sugar levels were checked. -- No documentation of any substance abuse treatment. <p>Interview on 3/14/18 with Staff #1 revealed they</p>	V 291	<p>Dee & G Enrichment Centers PP's was shown by the home health nurse and by the wound care center how to clean the wound, apply cream, etc and wrap. NO WE DID NOT HAVE A RN COME INTO THE FACILITY AND HAVE A DRESSING CLASS BUT THE PP'S AS WELL AS MYSELF HAVE WATCHED THE NURSE/WOUND CARE CENTER EVERY TIME THEY CAME TO DRESS HIS WOUND, WHETHER IT WAS CLIENT #1 OR CLIENT #2.</p> <p>WE ASSURE THAT THIS DEFICIENCY HAS BEEN CORRECTED IT WILL BE A DAILY MONITOR TO ASSURE THAT IT CONTINUES TO HEAL ANY THERES NO DRAINING AT ALL ON CLIENT #2.</p>	4/10/18
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Client #2 had compression hoses but physician stated he doesn't need to wear them any longer, she prescribed them due to his leg swelled last year but because he'd remove them, it wasn't needed (continua

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V 291	<p>Continued From page 49</p> <p>had never checked Client #3's blood sugar levels, and that she was unaware this Physician's order was in his record.</p> <p>Interview on 3/15/18 with the PD/A revealed the following information;</p> <ul style="list-style-type: none"> -- She confirmed that Client #3 had never had any blood sugar levels checked while he has been at the facility. -- She also stated that she had not tried to get in touch with the psychiatric hospital that discharged him to the facility for clarification of this order. -- She was unaware that a substance abuse diagnoses should be discussed with the client's Physician so that proper referral and treatment is obtained. -- She confirmed that he had not been refereed for any substance abuse assessment and/or treatment. <p>4. Review on 3/14/18 of Client #4's record revealed the following information;</p> <ul style="list-style-type: none"> -- Admitted to the facility on 12/29/17. -- Age 26 years old. -- Diagnoses include Chronic Schizoaffective Disorder and Bipolar Disorder. -- A Physicians order dated 12/28/17 as follows: "Schedule Vascular test. May need Sleep Study." <p>Interview on 3/15/18 with the PD/A revealed she was unaware of the above Physician's order and unsure if vascular testing had been scheduled.</p> <p>Interview on 3/15/18 with Client #4 revealed he had no issues with the facility or the facility staff.</p> <p>This deficiency is cross referenced into: 10A NCAC 27G .5601 Supervised Living - Scope, Tag V-289 for a Type A1 rule violation and must be corrected within 23 days.</p>	V 291	<p>Client # 3 does not have diabetes, he did not have an order to check his Blood sugar from the psychiatric hospital prior to him being Admitted. (Admin did consult)</p> <p>Client was only on metformin has a form of weight management.</p> <p>He did not have diabetes (did not require blood sugar checks) The Admin has contacted his doctor a D/C order has been sent to correct this oversight.</p> <p>The GP will renew FLZ'S, MAR'S ACCESSMENTS</p>	4/15/18
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to assure this oversight will not occur again. Dee & G #2 assure that we do exactly what the clients Physician suggest. In order to remain compliant and successful

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-131	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/21/2018
NAME OF PROVIDER OR SUPPLIER DEE & G ENRICHMENT #2		STREET ADDRESS, CITY, STATE, ZIP CODE 207 FRIENDLY ROAD BURLINGTON, NC 27215		
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V 367	<p>27G .0604 Incident Reporting Requirements</p> <p>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(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:</p> <p>(1) reporting provider contact and identification information;</p> <p>(2) client identification information;</p> <p>(3) type of incident;</p> <p>(4) description of incident;</p> <p>(5) status of the effort to determine the cause of the incident; and</p> <p>(6) other individuals or authorities notified or responding.</p> <p>(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:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p>	V 367		

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V 367	<p>Continued From page 51</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <ol style="list-style-type: none"> (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. <p>(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).</p> <p>(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:</p> <ol style="list-style-type: none"> (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; (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 	V 367		
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V 367	<p>Continued From page 52</p> <p>(a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure Level II incidents were reported to the Local Management Entity (LME) within 72 hours of becoming aware of the incident. The findings are:</p> <ol style="list-style-type: none"> Review on 3/15/18 of Client #1's record revealed the following information; <ul style="list-style-type: none"> --Admitted to the facility on 1/18/17. -- Age 66 years old. -- Diagnoses include Schizoaffective Disorder, Dementia, Parkinson's - Neuroleptic Induced, Possible Neurocognitive Disorder, Hypothyroidism, Hypertension, GastroEsophageal Reflux Disease, Chronic Obstructive Pulmonary Disease, Incontinence and Status Post Middle Toe Amputation. -- Uses a rolling walker to get himself around. <p>Interview on 3/15/18 with the Program Director/Administrator (PD/A) revealed the following information;</p> <ul style="list-style-type: none"> -- Client #1's sister came to the facility on 3/11/18 and picked him up for a day visit. -- Today (3/15/18) is the first time since the client left that she has heard from his sister to let the facility know where he is. -- She had not called the Police to report him missing, request assistance locating him or to issue a Silver Alert. <p>* See Tag V-289. Supervised Living - Scope for additional details.</p>	V 367	<p>Client #1 is safe and discharged</p> <p>Dee & G ASSURES That all incidents will be documented and will be filed online (IRIS) If there is a level I, II, or three, death, missing etc.</p> <p>Dee & G Did Not File AN incident Report because Client #1's Sister signed him out, she did not specify how long she'd keep him, but I knew Client #1 was safe. He has a large family w/ love and support. (MR) Client #1 had not wandered or lost. He was with his sister. We assure this client is now closer to family, which had spike with Administrator about.</p>	4/1/18
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Admin knew his sister was signing him out picking him up. He was happy to be with his family - (Client was not missing) But in the future, I will consult with GP concerning incidents, file them on IRIS, etc. Document

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V 367	<p>Continued From page 53</p> <p>2. Review on 3/14/18 of Client #3's record revealed the following information; -- Admitted to the facility on 10/9/17 following a 1 year and 4 month stay at a state psychiatric hospital. -- Age 28 years old. -- Diagnoses include Schizophrenia, Personality Disorder with Antisocial Features, Cannabis Use Disorder, Obesity, Dyslipidemia and Acne. -- Documentation that the client had had an emergency hospitalization from 2/2/18 through 2/15/18 due to "increased hallucinations and self harm."</p> <p>Interview on 3/14/18 with Staff #1 revealed the following information; -- The client was hitting himself causing him to be bleeding a lot. -- She called the PD/A, who arrived before emergency personnel, and she transported him to the hospital for treatment.</p> <p>Review on 3/14/18 of the IRIS (Incident Response Improvement System) website revealed no report submitted for the above event.</p> <p>Interview on 3/20/18 with the PD/A revealed her to confirm that neither of the above incidents was entered into the NC IRIS website.</p>	V 367	<p>Dee & G #2 Assure that PP will be trained and reminded that the Admin, Guardian, casemanager are to be contacted before 911.</p> <p>Admin was in the area when PP called about client hearing voices, stating the voices punched him in the nose. This was not a need for 911, PP overreacted but 911 was recalled to tell them we didnt need them after all.</p> <p>Client has recieved a medication changed since then, he is doing better since then guardian and I have been working with Client #3 in order for him to have the help he needs,</p>	4/16/18 CC
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We will document any incidents that we have in our Facility And the DP will go on IRIS to report ANY incidents.
Incident Reports will be renewed quarterly unless there arises a new incident. But DP will monitor all incidents to order to be...

fax # 336 222 - 8388

PREFERRED PRIMARY CARE, PLLC
CHERYL EINDLEY, F.N.P.
DEA # ML 3057882 LIC. # 6008289 NPI # 3616508123
KIMBERLY R. SHELLON, M.D.
DEA # BS 4648860 LIC. # 9501417 NPI # 1648270884
3128 COMMERCE PLACE
BURLINGTON, NC 27215
(336) 270-4884

NAME Samuel Woods DATE 4/12/2018
ADDRESS _____

TAMPER-RESISTANT SECURITY FEATURES LISTED ON BACK OF SCRIPT

R

*Die Blood
Sugar Checks*

- 1-24
 - 25-49
 - 50-74
 - 75-100
 - 101-150
 - 151 and over
- Units

Refill NR 1 2 3 4 5 *5*

PRODUCT SELECTION PERMITTED DISPENSE AS WRITTEN
001508 8B23IM0132850

5/16/17: EKG - sinus rhythm, normal EKG; 89 bpm, QTc 381 ms
 ANC 3.2
 Myocarditis panel normal except high sens CRP 3.9 (H)

5/10/17: EKG - sinus rhythm, normal EKG; 76 bpm, QTc 402 ms

5/09/17: ANC 2.3
 Myocarditis panel normal
 Clozapine 249 (on 100 mg qhs)

5/02/17: ANC 2.6, EOS 0.6 (H)
 Myocarditis panel normal
 EKG - sinus rhythm, normal EKG; 91 bpm, QTc 381 ms

4/26/17: ANC 2.2
 Myocarditis panel normal

4/12/17: CBC normal except for EOS-MD 6.0% (H); ANC noted to be 3.1
 CMP normal except for anion gap 4.5 (L), AST 11 (L)
 CK 348 (H)
 EKG - sinus rhythm with sinus arrhythmia; 62 BPM, QTc 376 ms

4/04/17: CBC normal except for EOS-MD 12.0% (H), EO# 0.6 (H)
 CMP normal except for chloride 108 (H), anion gap 6.3 (L), AST 8 (L)
 Hgb Alc 5.6%
 Lipids normal except for HDL 33 (L)

2/09/17: CMP unremarkable
 CBC unremarkable

2/08/17: EKG - sinus rhythm, 67 BPM, QTc 399 ms

12/13/16: CBC unremarkable
 CMP unremarkable
 Lipids normal except for HDL 35 (L)
 TSH normal

10/13/16: CBC normal except for MPV 7.3 (L), NE-Man Diff 28.0 (L), LY-Man Diff 62.0 (H)
 CMP normal
 Vitamin D normal at 35.4

6/04/16: CBC normal except for RBC 5.92 (H), Hgb 18.1 (H), Hct 55.8 (H)
 CMP normal except phos 5.0 (H)
 Vitamin D 21.0 (L)
 Lipids normal except HDL 24 (L)
 Hgb Alc normal at 5.6%
 TSH normal
 Vitamin B12 normal
 Folate normal
 RPR NR

=====PROGRESS TOWARD TREATMENT PLAN GOALS=====

Problem 1: Command AH and cannabis use leading to dangerous behavior (fire setting/breaking things) prior to admission.

LTG: Mr. Weaks will demonstrate improved insight into his previous dangerous behaviors, substance use, and legal issues so that he can return to a safe, supervised living situation in the community.

STG 1.1: Mr. Weaks will be able to earn STAR level 2 and maintain it over the next 60 days, AEB STAR book documentation. ATTAINED
 7/25/17.

STG 1.2: Mr. Weaks will recognize 1 symptom and 1 benefit of continuing treatment in meetings with treatment team members 1x/week over the next 60 days, AEB Vista documentation.

- Progress: Good. He is able to recognize now that "hearing voices" is a symptom that he has experienced, and understands it is part of his illness. He says 1 benefit of continuing treatment is to control his symptoms. He also says that another benefit is "being able to stay out of the hospital".

treatment, improvement on clozapine, insight has improved in recent months

=====MEDICATION MANAGEMENT=====
=====CURRENT MEDICATIONS=====

Active Inpatient Medications [including Supplies]:

Table with 2 columns: Active Inpatient Medications and Status. Lists 11 medications including Acetaminophen, Benzotropine, Cholecalciferol, Clozapine, Folic Acid, Glycopyrrolate, Ipratropium, Magnesium Hydroxide, Omega-3 Fatty Acids, Fluphenazine, and Metformin.

=====SIDE EFFECTS=====

Metabolic syndrome - on metformin
TD - improved following course of pyridoxine and current clozapine treatment
Sialorrhea - improved with ipratropium and glycopyrrolate but still an issue

=====RISK/BENEFIT=====

There have been no changes in risk/benefit analysis of current medications for this patient. Education of risks/benefits, etc., has been provided to patient/guardian.

=====MULTIPLE ANTIPSYCHOTICS=====

Patient does take two or more antipsychotics. He did not respond to numerous trials of monotherapy (not clozapine) in the past. There was a trial of ECT which was helpful, but patient refused after 10 treatments were completed. Pt has improved significantly since clozapine was added to medication regimen...

=====PRN PSYCHOTROPICS=====

Psychotropic PRN/STAT medications uses (describe circumstances, appropriateness, and efficacy of use in interval since last note):
None.

=====MENTAL STATUS EXAM=====

General appearance, psychomotor activity, behavior and attitude: Pt was very cooperative with interview and was calm and pleasant. He was wearing sweats, and had good eye contact. No abnormal movements noted. Some mild drooling evident, which he wiped away with a washcloth. Speech: Fluent. Slow rate with normal tone and volume. Mood and Affect: Good; affect constricted but more reactive than prior to clozapine.

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V 289	<p>Continued From page 31</p> <p>name and phone number]"</p> <p>The Program Director/Administrator did not recognize and understand the facility was unable to continue to meet the needs of Client #1 and Client #2, as it was her responsibility to assess the client's ability to be in the facility. She also did not work towards securing an appropriate placement that can provide a higher level of care required for both Client #1 and Client #2.</p> <p>Client #1 required dressing changes and treatment on the site of an amputated toe, and to ulcers on his lower leg from 1/24/17 through 11/16/17. During this period, he required specialized treatment and services provided by a Wound Care Clinic, a Vascular Clinic and in-home services by Home Health Skilled Nursing staff to provide treatment for and assessment of his multiple wounds. During this time he underwent painful debridement of these wounds to remove dead and infected tissue. Client #1 developed multiple infections at his wound sites requiring 5 courses of antibiotic treatment (both oral and topical) within a period of 8 months. Because staff were not trained in wound care, dressing changes and the sterile process/procedures required in providing these treatments, it may have contributed to client #1's risk for, and the manifestation of multiple infections to his wound sites requiring antibiotic therapy. The Program Director/Administrator did not obtain compression stockings, although ordered multiple times to assist client #1's circulation and reduce swelling. Because there was no coordination with other health care providers, Client #1 exhibited unexplained weight loss and uncontrolled blood pressures. This resulted in a hospitalization from 11/17/17 through 11/21/17.</p>	V 289	<p>meet every wednesday afternoon with the GP. She monitors weekly To remain compliant In every Area. In order for us to continue to provide the best care physically mentally & emotionally. (New GP hired) But we will continue to receive Trainings from the GP in the past as well.</p> <p>4/25/18 CG</p> <p>ALL ASSESSMENTS HAS BEEN UPDATED AND REVIEWED AS REQUIRED. ALSO STAFF WERE SHOWN HOW TO DRESS Client #1 & #2</p>	
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513P11 If continuation sheet 32 of 54

(To continue)

IF For Any reason there arises a situation where a client has walked away from the Facility, harmed himself, or has a need to move to a higher level of care, I will call 911 to report the incident, or IRIS also. I will reported before, I have had the

IRIS training in Alamance Co.


I agree and will follow the rules and regulations of the policy and procedures set forth by the State of NC.

I will continue to monitor, and document with the Assistance of the New & P that's hired, she will be more available on a daily basis.

In order to prevent this deficiency from reoccurring.

4/30/18.

Thank You.

Cherry 

13. The resident/family/responsible party is required to cooperate with staff and the Alamance Fire Department with required number of fire drills mandated by state regulations.
14. The resident/family/responsible party is responsible for private sitters if necessary or desired, but facility reserves the right to approve anyone selected.
15. The resident/family/responsible party is responsible for payment of all keys after the first key to lockable space areas.
16. The resident/family/responsible party is responsible for any damages to facility or furnishings other than everyday wear while residing in facility.
17. The resident/family/responsible party is responsible for payment of all toll and long-distance calls made by the resident.

18. (Mr. Burton.)

Dee + G Enrichment Center will not tolerate, you walking or leaving the Facility at any time without being accompanied by SIC or Administrator or Family. You have the right to if for any reason move from this Facility, we ask that you give a 14d notice but for any reason you dont wish to remain here we ask that you speak to Mrs Insp or Staff, let us contact your Sister (Anassa) to allow us (staff) and you + family a chance to find the appropriate placement for you. If you leave the Facility without permission one time, you will not be allowed to return! And you will be immediately discharged. We do not tolerate wandering, or leaving the Facility not accompanied by Staff or your Family members! Cherry Crisp Admin
 X [Signature] [Signature] 1/19/17

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V 289	Continued From page 24 Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC	V 289		

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NUMBER OF DEFICIENCIES NUMBER OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-131	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/21/2018
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W & G ENRICHMENT #2

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BURLINGTON, NC 27215**

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V 289	<p>Continued From page 25</p> <p>27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL).</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide care, habilitation or rehabilitation and supervision within the scope of residential services to individuals affecting 4 of 6 current audited clients (#1 #2 #3 #4). The findings are:</p> <p>Cross Reference: 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS, Tag V-108. Based on interview and record review, the facility failed to assure that A) 1 of 3 direct care staff reviewed (the Program Director/Administrator (PD/A)) had current training in basic First Aid including seizure management, and was currently trained to provide cardiopulmonary resuscitation (CPR) and B) that 3 of 3 direct care staff had training to meet the needs of the clients (PD/A, Staff #1, Staff #2).</p> <p>Cross Reference: 10A NCAC 27G .0204 - COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS, Tag V-110. Based on observation, interview and record review, 1 of 3 Paraprofessionals reviewed failed to demonstrate the knowledge, skills and abilities required by the population served (Program Director/Administrator (PD/A)).</p> <p>Cross Reference: 10A NCAC 27G .0205 -</p>	V 289	<p><i>duplicate page</i></p> <p><i>* SEE CPR / First Aid Correction has been Corrected, and documentation was made on page 1 of 54. ADMINISTRATOR AND ALL STAFF have a current CPR / First Aid, seizure management etc. In order to prevent this oversight from occurring The Admin will review all Employee files every other month.</i></p>	

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V 289	<p>Continued From page 26</p> <p>ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN, Tag V-111. Based on interview and record review, the facility failed to assure that an admission assessment was completed for each client, prior to the delivery of services which included the client's presenting problem, the client's needs and strengths, a pertinent social, family and medical history and evaluations or assessments, such as Psychiatric, substance abuse, medical and vocational, as appropriate to the client's needs affecting 4 of 4 audited clients (#1 #2 #3 #4).</p> <p>Cross Reference: 10A NCAC 27G .0205 - ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN, Tag V-112. Based on interview and record review, the facility failed to have documentation of a current treatment plan affecting 4 of 4 audited clients (#1 #2 #3 #4), and also failed to follow diet and weight management orders for 2 of 4 audited clients (#1 #3).</p> <p>Cross Reference: 10A NCAC 27G .0209 MEDICATION REQUIREMENTS, Tag V-118. Based on observation, interview and record review, the facility staff failed to A) assure prescription medications were administered to clients as written by a Physician and assure that MARs were kept current affecting 1 of 4 audited clients (#2).</p> <p>Cross Reference: 10A NCAC 27G .5602 SUPERVISED LIVING - STAFF, Tag V-290. Based on interview and record review, the facility failed to assure an assessment was completed of clients' capability of remaining in the community without staff supervision affecting 1 of 1 audited</p>	V 289	<p>ASSESSMENTS FOR ADMISSIONS, corrected. Documented on the prior pages.</p> <p>Treatment Plans have been updated and written by the GP. Admin will renew quarterly In order to prevent any reoccurrence of this deficiency.</p> <p>All medications from Any physician orders are on the MAR, All medications have been given as ordered. This problem has been corrected and the Admin will renew weekly All MARs, and medications to assure that all orders are followed</p>	

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V 289	Continued From page 27 client utilizing unsupervised time in the community (#4). Cross Reference: 10A NCAC 27G .5603 SUPERVISED LIVING - OPERATIONS, Tag V-291. Based on interview and record review, the facility failed to assure coordination was maintained between the facility operator and the Qualified Professionals responsible for treatment/habilitation or case management affecting 4 of 4 audited clients (#1 #2 #3 #4). Review on 3/15/18 of Client #1's record revealed the following information; --Admitted to the facility on 1/18/17. -- Age 66 years old. -- Diagnoses include Schizoaffective Disorder, Dementia, Parkinson's - Neuroleptic Induced, Possible Neurocognitive Disorder, Hypothyroidism, Hypertension, GastroEsophageal Reflux Disease, Chronic Obstructive Pulmonary Disease, Incontinence and Status Post Middle Toe Amputation. -- Uses a rolling walker to get himself around. Interview on 3/15/18 with the Program Director/Administrator (PD/A) revealed the following information regarding Client #1; -- Prior to being admitted to the facility (on 1/18/17), Client #1 had been the subject of a Silver Alert (on 10/26/16). -- He had been at a hospital, and told them he was going to leave. -- He walked off from the hospital to go to his Sister's house. -- There was snow on the ground at this time. -- While attempting to get to his Sister's, he walked for an unknown amount of time, and also fell in the snow.	V 289	In order to monitor ^{weekly} monthly and remain compliant An admin assistant has been hired to assist in anyway possible. So this area will remain in compliance	4/3/18 te (cc)

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V 289	<p>Continued From page 28</p> <p>-- This exposure to the elements resulted in one of his toes having to be amputated. -- When Client #1 first arrived at the facility he "tried to leave a few times."</p> <p>Review on 3/15/18 of the web site for the North Carolina Silver Alert system revealed the following information; -- During the above Silver Alert, Client #1 left the hospital wearing only a shirt, jeans and tennis shoes.</p> <p>Continued interview on 3/15/18 with the PD/A revealed the following information; -- Client #1's sister came to the facility on 3/11/18 and picked him up for a day visit. -- Today (3/15/18) is the first time since the client left that she has heard from his sister to let the facility know where he is. -- Client #1 is currently admitted to the Veteran's Administration (VA) Hospital. -- She has been trying to call Client #1's sister, but her cell phone had been disconnected. -- She has Client #1's sister's home address in Durham in the client record, but had not gone to her house in an attempt to find the client. -- She has Client #1's son's phone number in the client record, but had not tried to call him in an attempt to find the client. -- She had not called the Police to report him missing, request assistance locating him or to issue a Silver Alert.</p> <p>On 3/15/18, the PD/A stated that Client #1's sister called her today (for the first time since she took him from the facility on 3/11/18) and reported to her the following information; -- When she picked Client #1 up on 3/11/18 from the facility for a visit, he complained to her that he had fallen recently at his Psychosocial</p>	V 289	<p>Dee & G Enrichment #2 has never had a problem with Me(S) Client #1 walking away from the facility. Prior to him being admitted, I met with him & his social worker. Typed up a letter explaining the importance. It is to communicate with me. Client #1 has never walked away from our facility. Also we have Alarms on our doors just in case he tried but he never did! Also Client #1's sister signed him out of the facility and that's his right. She hadn't communicated daily about how long she would keep him but he was safe and never lost.</p>	
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That's why I never contacted 911 or issued a Silver alert, He was never missing. Client #1 has a long family they are always active and concerned about his care.

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V 289	<p>Continued From page 29</p> <p>Rehabilitation (PSR) program, and his knee was hurting from this fall.</p> <ul style="list-style-type: none"> -- He requested, and she took him to the VA Hospital to have his knee evaluated. -- When he got to the VA Hospital he was evaluated, and Physician(s) saw that his knee was swollen, so they admitted him. -- He had a hard knot in his leg, and the Physician(s) thought it was a blood clot. -- The Physician(s) cut this area open and drained it. -- The VA Hospital told her today that Client #1 is ready for discharge. <p>Interview on 3/16/18 with the PD/A revealed the following information regarding Client #1:</p> <ul style="list-style-type: none"> -- His Parkinson's Disease has gotten much worse than it was when he arrived at the facility a little over a year ago. -- His hands shake so much that he needs assistance with completing many tasks (buttoning clothing, making his bed, eating, etc.). -- His physical health is declining very rapidly. -- She has been trying to get his Physician "to order him to a higher level of care." -- She did not understand that if the facility is no longer able to meet the needs of a client, it is her responsibility to identify that fact, and work toward securing a more appropriate placement for the client(s). <p>Review on 3/22/18 of the Plan Of Protection dated 3/20/18 written by the PD/A revealed the following information;</p> <p>"What immediate action will the facility take to ensure the safety of the consumers in your care? In order to ensure the safety of all of our consumers in our care, Dee & G Enrichment #2 assures that any client that needs a higher level of care will be discharged to a suitable facility.</p>	V 289	<p>A silver alert was <u>NEVER</u> Needed.</p> <p>This client was never unsafe. My facility take pride in the care of our clients and this violation I do not agree with but just realize I will remain and continue to monitor daily the health and wellbeing of our clients.</p> <p>The QP (New) will access clients care, clients health, etc to assure all clients are healthy and mentally as well as physically.</p> <p>In order to remain compliant, Client #1 has been discharge to a facility closer to home.</p>

this wasnt any information that we didnt expect, because I his family and client #1 were already in conversation concerning client #1's health, his parkinsons as well as him moving closer to home, prior to him being signed out by his sister Clarissa.

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V 289	<p>Continued From page 30</p> <p>[Client #1's initials] will not be readmitted, [Client #2's initials] has a 30 day notice of discharge. Also the QP will preform accurate assessments on consumers to assure that they are suitable for our facility as well as update Treatment Plans annually, which will include Supervised or Unsupervised time away from the facility. All appointments will be attended as well as all orders will be followed as ordered by Physician. Incompetent staff will be discharged due to poor job performance. QP will have a more broader job performance also.</p> <p>Describe your plans to make sure the above happens:</p> <p>Dee & G #2 plans are to assure that these corrections are made by monitoring monthly, Appointments, Treatment Plans will be reviewed Quarterly. QP will be in the facility monitoring medication compliance, orders, patient care, Treatment Plans, etc, as well as training the PP (Para Professionals) on documenting progress notes weekly. I assume responsibility to have a Form developed where all appointments are documented of any changes, labs, orders Another Form that have the QP to sign in when she checks meds, treatment plans, orders, etc, on a monthly basis. If for any reason the QP cannot Forfill her job performance She will be terminated and another QP will be hired in order to provide the best services for our consumers. Dee & G #2 will also copy every important paper in order to have a duplicate in case of loss. All Blood pressures, progress notes will be renewed yearly to assure [unable to read this word]. In order to provide the best care and service that we can. We take pride in our work, our care and compassion will continue to strive to be the best ever. Any corrections that need to be made we will assure that they will be corrected, in the appropriate time allowed. Thank you [PD/A's</p>	V 289	<p>After consulting with Clients #2 We thought he would need a higher level of care, And we were considering a discharge but we along with his doctor feel he doesnt need a higher level of care. Client #2 has a mental illness, thats why he is here. His strit that was placed in his leg is doing well, client #2 has been assessed by QP Also, she agrees with Physician.</p> <p>This deficiency has been corrected.</p> <p>In order For this violation not reoccur, the Admin and QP will consult weekly,</p>	

with each other concerning residents care, employees trainings, medications (ETC) The QP now has a more broader job requirement that will assure this problem will not reoccur. Again! Also PP's

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V 289	Continued From page 32 Client #2 required dressing changes and treatment on the site of lower leg ulcers from 12/6/17 through 3/9/18, and surgical placement of a stent on 3/14/18 to assist with the circulation of blood throughout his body. During this period, he required specialized treatment and services provided by a Wound Care Clinic and a Vascular Clinic. During this time he underwent painful debridement of these wounds to remove dead and infected tissue. Client #2 developed multiple infections at his wound sites including E Coli requiring 7 courses of antibiotic treatment (both oral and topical) within a period of 2 1/2 months. Because staff were not trained in wound care, dressing changes and the sterile process/procedures required in providing these treatments, it may have contributed to Client #2's risk for, and the manifestation of multiple infections to his wound sites requiring antibiotic therapy. The Program Director/Administrator did not obtain compression stockings ordered to assist Client #2 with circulation and to reduce leg swelling. Client #2 also displayed disruptive behaviors related to his Dementia and memory loss that could potentially have the effect of him placing himself in a position unsupervised by staff where he may be harmed or exploited. These failures resulted in serious neglect and constitute a Type A1 rule violation and must be corrected within 23 days. An administrative penalty in the amount of \$2,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of \$500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 289	PROCESS, AND EVEN THOUGH CLIENT HAS SOME DEMENTIA CLIENTS HIGH FUNCTIONING AND IS A PLEASURE TO HAVE, HE'S NOT VIOLENT, HE DOESN'T WANDER, I SPOKE TO HIS GUARDIAN AND HIS PHYSICIAN CONCERNING HIS PLACEMENT. WE BOTH AGREE THAT IT WILL NOT BE MENTALLY HEALTHY TO CHANGE IF I SEE THAT HE BECOMES TOO MUCH FOR THE SERVICE WE PROVIDE I ASSURE YOU I WILL DISCHARGE I'VE SPOKE TO HIS GUARDIAN ALSO. OP WILL BE MONITORING ALL ACCESSMENTS AND ALL PATIENT CARE. IN ORDER TO PREVENT THIS VIOLATION FROM REOCCURRING	

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V 290	<p>Continued From page 34</p> <p>duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and</p> <p>(2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure an assessment was completed of clients' capability of remaining in the community without staff supervision affecting 1 of 1 audited client utilizing unsupervised time in the community (#4). The findings are:</p> <p>Review on 3/14/18 of Client #4's record revealed the following information; -- Admitted to the facility on 12/29/17. -- Age 26 years old. -- Diagnoses include Chronic Schizoaffective Disorder and Bipolar Disorder. -- No documentation that an assessment had been completed to ensure the client could remain safe in the community without the supervision of staff.</p> <p>Interview on 3/14/18 with Staff #1 revealed that Client #4 is employed at two different restaurants working a few hours a day, several days a week.</p> <p>Interview on 3/16/18 with the Program Director/Administrator revealed the following information; -- She was not aware that there was no assessment in Client #4's record indicating he could safely remain in the community at his</p>	V 290	<p>This defenacy has been corrected and now</p> <p>The GP has written a unsupervised Assessment for Client #1.</p> <p>when client is on his part time Job in the community without Staffs supervision We assure that Any or all unsupervised time will be agreed upon and signed by the GP, Admin, and the client. Its also included in his treatment plan</p> <p>The GP will monitor quarterly in order to remain compliant.</p> <p>In order to prevent this from reoccurring the Admin will review quartely to assure that this doesn't</p>	<p>4/5/18</p> <p>reoccur again</p>
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V 290	Continued From page 35 places of employment without staff supervision. -- She indicated that doing this assessment was the responsibility of the facility Qualified Professional. This deficiency is cross referenced into: 10A NCAC 27G .5601 Supervised Living - Scope, Tag V-289 for a Type A1 rule violation and must be corrected within 23 days.	V 290		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community	V 291		