502 ~~305~~ East Broad Avenue
Rockingham, North Carolina 28379
(910)-417-4950 Phone
(910)-417-4953 Fax
divinekoncepts@etiw.net

June 20, 2018

To Whom It May Concern:

Please find enclosed, the Plan of Correction for the deficiencies found during the Annual Survey at the Steele Group Home on June 4, 2018.

Should you need additional information, or further assistance, please do not hesitate to contact me at the above address or phone number.

Sincerely,

Brenda T. Capel
CEO/President
Divine Koncepts, Inc.

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

June 13, 2018

Brenda Capel, President/CEO
Divine Concepts, Inc.
315-A South Long Drive
Rockingham, NC 28379

Re: Annual Survey completed June 4, 2018
Steele Street House, 418 Steele Street, Rockingham NC, 28379
MHL # 077-044
E-mail Address: divineKoncepts@etiw.net

Dear Ms. Capel:

Thank you for the cooperation and courtesy extended during the annual survey completed.6/4/18.

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

- All tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is 8/4/18.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records.
Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.

June 13, 2018
Ms. Capel
Divine Koncepts, Inc.

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please contact the South Piedmont Team Leader, Mr. Bryson Brown at (919) 855-3822.

Sincerely,

Johanna Edwards RN
Nurse Consultant
Mental Health Licensure & Certification Section

Cc: Victoria Whitt, Director, Sandhills Center LME/MCO
Mary Kidd, Quality Management Director, Sandhills Center LME/MCO
File

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	MHL077-044		06/04/2018

NAME OF PROVIDER OR SUPPLIER: STEELE STREET HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE: 418 STEELE STREET, ROCKINGHAM, NC 28379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual survey was completed on June 4, 2018. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600C Supervised Living for Adults with Developmental Disabilities.	V 000	DHSR-Mental Health JUN 2 6 2018 Lic. & Cert. Section	
V 116	27G .0209 (A) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (a) Medication dispensing: (1) Medications shall be dispensed only on the written order of a physician or other practitioner licensed to prescribe. (2) Dispensing shall be restricted to registered pharmacists, physicians, or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy. If a permit to operate a pharmacy is Not required, a nurse or other designated person may assist a physician or other health care practitioner with dispensing so long as the final label, Container, and its contents are physically checked and approved by the authorized person prior to dispensing. (3) Methadone For take-home purposes may be supplied to a client of a methadone treatment service in a properly labeled container by a registered nurse employed by the service, pursuant to the requirements of 10 NCAC 45G .0306 SUPPLYING OF METHADONE IN TREATMENT PROGRAMS BY RN. Supplying of methadone is not considered dispensing. (4) Other than for emergency use, facilities shall not possess a stock of prescription legend drugs for the purpose of dispensing without hiring a pharmacist and obtaining a permit from the NC	V 116	Arrangements were made with local pharmacy on 6/19/18 to deliver bubble pks and supply at least three pill separately for consumers to utilize during homevisits. Should consumer need more than three of each med, the bubble packs will be taken back to the pharmacy for dispensing. The new pharmacy will initiate this procedure with the current meds since the current pharmacy	08/01/18

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Brenda Kapel 06/20/2018

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	MHL077-044		06/04/2018

NAME OF PROVIDER OR SUPPLIER: STEELE STREET HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE: 418 STEELE STREET, ROCKINGHAM, NC 28379

(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 116	Continued From page 1 Board of Pharmacy. Physicians may keep a small locked supply of prescription drug samples. Samples shall be dispensed, packaged, and labeled in accordance with state law and this Rule. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure that dispensing of medications was restricted to persons authorized by law to do so affecting 1 of 3 audited clients (#1). The findings are: Review on 6/1/18 of Client #1's record revealed the following information; -- Admitted to the facility on 3/7/06. -- 67 years old. -- Diagnoses include Severe Intellectual Developmental Disability, Intermittent Explosive Disorder, Type A Psychosis, Obsessive Compulsive Disorder, Hypertension, Hyperlipidemia and Seasonal Allergies. Review on 6/4/18 of the facilities Level I Incident Reports notebook revealed documentation that on 11/6/17 Client #1 was given Amlodipine that was prescribed for another client. This report indicated "wrong meds (medications) was pulled." (Amlodipine is used to treat high blood pressure) Interview on 6/4/18 with the Group Home Manager regarding the above medication error revealed the following information; -- Client #1 was on a home visit when he received the Amlodipine. -- When the clients go on overnight home visits their medications are punched out from the	V 116	Has already delivered the July meds to the facility. The new procedure will eliminate this error from occuring in the future. Home Mgr. will inspect all meds upon delivery and report any/all discrepancies to the Op. Supervisors Completed to inform Employees of correct procedures to follow.	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	MHL077-044		06/04/2018

NAME OF PROVIDER OR SUPPLIER: STEELE STREET HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE: 418 STEELE STREET ROCKINGHAM, NC 28379

(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 116	Continued From page 2 bubble-pack the pharmacy sends them in and put into a weekly plastic medication holder. -- The staff filling this medication holder punched the Amlodipine from another client's bubble-pack. -- She was not aware that preparing any more than one dose of any medication was by definition dispensing medication, and the facility therefore could not punch several days of medication out of client's bubble-packages and send them with the client for administration while away from the facility. During interview on 6/4/18 the Qualified Professional nor the Licensee CEO were aware of this dispensing definition either.	V 116		
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	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	MHL077-044		06/04/2018

NAME OF PROVIDER OR SUPPLIER: STEELE STREET HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE: 418 STEELE STREET, ROCKINGHAM, NC 28379

(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 291	Continued From page 3 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 inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain coordination between the facility and the Qualified Professionals responsible for health care affecting 1 of 3 audited clients (#2). The findings are: Review on 5/31/18 of Client #2's record revealed the following information; -- Admitted to the facility on 12/9/16. -- Diagnoses include Moderate Intellectual Developmental Disability, and Schizoaffective Disorder-Undifferentiated Type. -- A Physician's order dated 4/20/18 for Pataday eye drops, 1 drop in each eye every morning. Interview on 5/1/18 with the Group Home Manager revealed the following information; -- The pharmacy told her that they did not receive a copy of the above prescription. -- Without a paper prescription or an Emailed prescription from the Physician's office they would not be able to dispense this medication to the facility for administration to the client. -- The pharmacy told her that they would attempt to contact the Physician for the order. -- She has not heard anything since from either	V 291	Home Mgr. did make serveral attempts to obtain prescription but did not have documentation of phone calls to pharmacy or doctor's office. Supervisor completed with home manager which included each contact to physician and/or pharmacy in reference to meds must be documented and filed in each consumer's chart. All difficulties with prescriptions must be reported to DP and/or CED. This is effective immediately.	6/20/18

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	MHL077-044		06/04/2018

NAME OF PROVIDER OR SUPPLIER: STEELE STREET HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE: 418 STEELE STREET, ROCKINGHAM, NC 28379

(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 291	Continued From page 4 the pharmacy or the Physician's office. – She did not follow-up trying to obtain this medication, or get clarification about the medication with the pharmacy or the Physician's office. During interview on 6/4/18 with the Licensee revealed she was not aware this medication had not been obtained/administered to Client #2 for over 5 weeks. She stated she would look at the current process for obtaining medications, and address it with staff.	V 291		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the	V 367	All staff and sp to receive updated Addendum Incident Report Training by CEO. This training to be documented and placed in Employees personnel file. All Employees will adhere to Incident Reporting policies as outlined in policy from State as well as LME. All training to be completed by 6/30/18	6/30/18

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	MHL077-044		06/04/2018

NAME OF PROVIDER OR SUPPLIER: STEELE STREET HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE: 418 STEELE STREET, ROCKINGHAM, NC 28379

(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 367	Continued From page 5 cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall	V 367	DP and CEO will monitor monthly reporting to make sure incident Reports are Completed in timely manner as well as proper procedures followed, and reported to LME. Please note that restrictive interventions used in facility are a part of each consumer's service plan	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	MHL077-044		06/04/2018

NAME OF PROVIDER OR SUPPLIER: STEELE STREET HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE: 418 STEELE STREET, ROCKINGHAM, NC 28379

(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 367	Continued From page 6 include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure that all Level II incidents were reported to the LME (Local Management Entity) within 72 hours of becoming aware of the incident. Review on 6/1/18 of Client #1's record revealed the following information; -- Admitted to the facility on 3/7/06. -- 67 years old. -- Diagnoses include Severe Intellectual Developmental Disability, Intermittent Explosive Disorder, Type A Psychosis, Obsessive Compulsive Disorder, Hypertension, Hyperlipidemia and Seasonal Allergies. Review on 5/31/18 of Client #2's record revealed the following information; -- Admitted to the facility on 12/9/16.	V 367	See page 5+6	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	MHL077-044		06/04/2018

NAME OF PROVIDER OR SUPPLIER: STEELE STREET HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE: 418 STEELE STREET, ROCKINGHAM, NC 28379

(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 367	Continued From page 7 -- Diagnoses include Moderate Intellectual Developmental Disability, and Schizoaffective Disorder-Undifferentiated Type. Review on 5/31/18 of Client #3's record revealed the following information; -- Admitted to the facility on 7/6/06. -- Diagnoses include Moderate Intellectual Developmental Disability, Schizophrenia-Paranoid Type, Intermittent Explosive Disorder and Hearing Loss. Review on 5/31/18 of the North Carolina IRIS (Incident Response Improvement System) program revealed that no level I or level II reports had been submitted since 2015. Review on 6/4/18 of the facilities Level I Incident Reports notebook revealed documentation of the following events; -- Client aggressive/destructive behavior and/or threats of harm to others (without police involvement): Client #2 - four times (8/12/17, 1/17/18, 3/15/18 and 5/14/18). Client #3 - two times (8/1/17 and 8/3/17). -- Client destructive behavior (with Police involvement): Client #2 - once (11/3/17). -- Clients requiring physical restraint (therapeutic holds): Client #2 - twice (3/21/17 and 11/3/17). Client #3 - once (8/1/17). -- Client physical aggression toward staff: Client #3 - once (7/12/17, punched a staff member in the mouth). -- Client injury requiring medical treatment: Client #1 - once (6/9/17, fell during the night and sustained multiple skin tears/cuts).	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	MHL077-044		06/04/2018

NAME OF PROVIDER OR SUPPLIER: STEELE STREET HOUSE

STREET ADDRESS, CITY, STATE, ZIP CODE: 418 STEELE STREET, ROCKINGHAM, NC 28379

(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 367	Continued From page 8 Interview on 6/3/18 with the Licensee revealed that the facility's Qualified Professional (QP) is responsible for submitting incident reports to the LME through the IRIS system. Interview on 6/4/18 with the QP revealed she was unaware that events requiring police, medical treatment or physical restraint are classified as level II incidents, and should be entered into IRIS.	V 367	QP and staff to be retrained as stated on pages 5 & 6 in reference to incident reporting. All staff to be retrained and completed by 6/30/18. CEO will be responsible for training and evidence of training to be placed in each Employee's personnel file. Incident Report Book to be viewed by QP and QA/QI for errors and inappropriate documentation.	