Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-917	A. BUILDING: ______ B. WING ______	R 06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEARNING SERVICES CORPORATION-WILLOW HOU!	570 BUILDING FUTURES CIRCLE RALEIGH, NC 27610

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and follow-up survey was completed 6/28/18. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .2100 Specialized Community Residential Center.	V 000		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders	V 113	DHSR - Mental Health JUL 12 2018 Lic. & Cert. Section	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kate Mikeel — TITLE: Dir of Ops — (X6) DATE: 7/9/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-917	A. BUILDING: ____ B. WING ____	R 06/28/2018

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LEARNING SERVICES CORPORATION-WILLOW HOU!	570 BUILDING FUTURES CIRCLE RALEIGH, NC 27610

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V 113	Continued From page 1 diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record review and interviews, the governing body failed to assure authorization for consent for emergency medical care was maintained in the record for one of three audited clients (#6). The finding are: Review on 6/27/18 and 6/28/18 of client #6's record revealed: - an admission date of 1/3/18 - a Portable Medical Profile and Care Plan dated 6/26/18 with a diagnosis of Traumatic Brain Injury - no evidence of an authorization for consent for emergency medical care During an interview on 6/28/18, the Case Manager reported she was unable to locate the document. The Case Manager reported the document might be part of the purged file in another area.	V 113		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION	V 118		

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	MHL092-917	A. BUILDING: ______ B. WING ______	R 06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEARNING SERVICES CORPORATION-WILLOW HOU!	570 BUILDING FUTURES CIRCLE RALEIGH, NC 27610

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V 118	Continued From page 2 REQUIREMENTS (c) Medication administration: (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. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (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. (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: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (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. This Rule is not met as evidenced by: Based on observation, record review and interview, the governing body failed to assure medications were maintained on site and administered on the written order of a person authorized to prescribe for one of three audited	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-917	A. BUILDING: ______ B. WING ______	R 06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEARNING SERVICES CORPORATION-WILLOW HOU:	**570 BUILDING FUTURES CIRCLE RALEIGH, NC 27610**

(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 118	Continued From page 3 clients (#2). The findings are: Observation on 6/28/18 of client #2's medications revealed Lorazepam 1 mg tablets were not present. Review on 6/28/18 of client #2's record revealed: - an admission date of 1/11/17 - a Portable Medical and Care Profile dated 3/16/18 had diagnoses including Traumatic Brain Injury and Blindness of left eye - a physician's order dated 5/30/18 for Lorazepam 1 mg tablet with instructions to administer 1 tablet every six to eight hours as needed; there was no evidence of a discontinue order until inquired; the order was dated 6/28/18 - April, May and June 2018 medication administration records contained no documentation that reflected the medication had been administered During an interview on 6/28/18, the Program Director reported it had been a long time since client #2 needed the medication due to his ability to cope better with problems.	V 118		

ID PREFIX TAG	Deficiencies	Plan of Correction	Responsible Party	Completion Date
V113	27G.0206 Client Records; Authorization for consent for emergency medical care was not present in the record for client #6.	Compliance-monitoring audits of medical records will be completed quarterly. A medical records review checklist will be utilized to identify any areas of improvement. (Please see attached document)	Program Director, Director of Operations, and assigned clinical team members will complete the quarterly audits. Audits will be submitted to the corporate QA Director and local Director of Operations	First Audit will be completed by July 27th, 2018. Audits will be conducted quarterly thereafter.
V118	27G.0209 Medication Requirements; Failed to assure medications were maintained on site. Client #2 prn medication was not maintained on site. April, May, and June 2018 MAR's contained no documentation that reflected the medication had been administered.	An initial audit of all PRN medication utilization will be completed. Purpose of the prn medication audit will be to ensure medications that are not being given have a discharge order and any medications being given are stocked appropriately. Medication administration records and physician order documents are reviewed monthly by Program Nurse and Nurse Practitioner. During the monthly MAR review process, any prn medications that are not being given, a discharge order will be obtained timely.	Program Nurse, Dian Benge	July 16th, 2018 Ongoing monthly process

LEARNING SERVICES CORPORATION
INFORMED CONSENT AND CONSENT AND AUTHORIZATION FOR PSYCHOLOGICAL SERVICES, MEDICAL AND EMERGENCY CARE AND MEDICATION POLICY

Client Full Name: [redacted]
Date of Admission: [redacted]
Date of Birth: [redacted]
Social Security #: ____
Legal Guardian Full Name: [redacted]
Legal Guardian Phone number: [redacted]

1. The resident and/or legal representative certifies that the resident is entering LEARNING SERVICES PROGRAM IN RALEIGH, NORTH CAROLINA (the "Center") on a voluntary basis for the purpose of receiving services for the head injury or other neurological disorder that they have sustained.
2. While in the Program, the resident agrees to participate in the therapeutic activities that will be provided. The resident also agrees to follow the house rules. In addition to the right to receive assessment and support services while in the program, the resident have the rights specified in the "Resident's Bill of Rights"**. Copies have been supplied to the resident and/or the legal representative.
3. The resident and/or legal representative hereby consents to physical contact with Learning Services' staff in the performance of ordinary daily procedures of personal care or in the administration of any treatment prescribed by my physician or the Learning Services' professional treatment staff. Learning Services shall not be liable for any acts or omissions of my physician. The resident and/or legal representative consents to any treatments or services rendered by the Center pursuant to the instructions of my physician.
4. The resident and/or legal representative hereby authorize the Center Including, without limitation, its staff to seek and authorize upon reasonable notice to me, any and all referrals for medical and/or dental assistance, evaluation and treatment as the Center, including its rehabilitation services staff, in its sole discretion, deems necessary or appropriate.
5. The resident and/or legal representative authorizes the Center including, without limitation, its supported living and rehabilitation services staff, to seek and authorize emergency medical assistance and treatment for the resident, including, but not limited to, x-ray examinations, the administration of anesthesia, transfusions, intravenous medications, or drugs, medical or surgical diagnosis or treatment and hospital or dental care, it the Center, including its rehabilitation services staff, determines that an emergency exists which requires such assistance and treatment.
6. The resident and/or legal representative authorizes the Center to provide diagnostic and psychological services determined by the professional psychology staff as necessary or appropriate including, but not limited to, neuropsychological and/or personality assessment, counseling, and behavioral modification treatment programs.
7. If the resident is taking prescribed medication, the resident and/or legal representative agrees to inform the Learning Services' staff of such fact on my admission to the Center and to continue taking it in the prescribed amount. If the resident and/or legal representative wishes to make a change, they will discuss the matter with the prescribing doctor and the Learning Services' staff. The resident and/or legal representative will notify the Learning Services' staff if the amount or kind of medication changes. The resident and/or legal representative understands that the Learning Services' staff members are available to help educate them about medications so that they will be better able to make a responsible decision. The resident will not take any unprescribed medication or share any medications with anyone at any time.

8. The resident and/or legal representative hereby acknowledges that the Learning Services assumes no responsibility for residents engaging in voluntary sexual contact with others while residing at Learning Services with or without the Learning Services' knowledge. The resident and/or legal representative hereby acknowledges that such sexual contact may result in venereal or other sexually transmitted diseases and/or pregnancy. In consideration of admission to Learning Services, the resident and/or legal guardian hereby agrees to hold Learning Services, its employees and agents, harmless from any and all consequences or expenses of such sexual contact, including but not limited to medically curable, incurable, or possible fatal venereal or other sexually transmitted diseases, sterility, pregnancy, abortion, complication of pregnancy, or birth of a child.

[redacted]	6-28-18
Resident	Date
[redacted]	6-28-18
Legal representative	Date
[signature]	6/28/18
Learning Services representative	Date

LEARNING SERVICES CORPORATION
MEDICAL RECORDS REVIEW CHECKLIST

COMMITTEE MEMBER NAME: ______________________________________

SIGNATURE____________________________________DATE____________

CLIENT'S NAME: ____

DATE OF ADMISSION:____

Service Line (check one): ______Active Rehabilitation______SLP______Day Treatment

1. Is a current (less than one year old) Per Diem Work Sheet included in the file?

   ______Yes _______No

2. Are the medical records controlled from a central location?

   _______Yes _______No

3. Are the records systematically organized in a three-ring binder?

   _______Yes _______No

4. Is the medical record organized according to the table of contents and all contents are present and up to date

   _______Yes _______No

5. Are the medical records protected in a locked environment and safe from permanent loss??

   _______Yes _______No

6. Have the records been "thinned" to contain the designated items needed and evidence that the overflow has been "dead filed" properly.

   _______Yes _______No

7. Is there a completed alignment of expectations form for the client that is less than one year old?

   _______Yes _______No

8. Does this record accurately reflect discharge and follow-up record keeping practices listed below? (for records of discharged clients only)

a. Discharge report and/or summary

_______Yes _______No _______Not Applicable

b. Follow-up report

_______Yes _______No _______Not Applicable

c. Written discharge recommendations provided

_______Yes _______No _______Not Applicable

9. Does the record contain:

a. Referrals for, and reports of services obtained through other agencies?

_______Yes _______No

b. Referrals for, and reports of, services obtained from outside consultant

_______Yes _______No

10. Does this record contain the following HIPAA consent forms?

a. Acknowledgement of Receipt:
_______Psychological Services
_______Rehabilitation Services

b. _______Consent for Psychological Services

c. _______HIPAA Consent

d. _______Disclosure Tracking (found in the LSCares System)

11. Does this medical record contain the following legal forms:

a. Correspondence related to this Clients record
_______Yes _______No

b. Name, address, etc. of the Client's guardian, conservator, representative payee, or personal representative
_______Yes _______No

c. Court ordered documentation proving guardianship, conservator or any legal documentation for a representative and <u>are current</u>? of the Client
_______Yes _______No ______Not Applicable

d. Physicians notes, Nursing notes, case management notes current through previous
month
_______Yes _______No

g. Does the record contain evidence of Client and/or family Conferences (every month for active rehab client; every 12 months for supported living clients)

_________Client/family/sponsor input reflected in staff conference minutes
_________Review of targeted goals
_________Client preferences

12. Does this medical record reflect the following

___________Reports of staff conferences

___________Client Inventory (Updated within at least one year)

___________Portable Health Care Profile (updated within one year)

___________Family Education (may be found in case management notes)

13. Does the record contain fully completed consent for release of information documentation using the most current version (dated 11/2016)?

Is a fully completed release in place for the sponsor/payer?

______Yes ______No _______NA

Is a fully completed release(s) in place for the spouse or other family members?

______Yes ______No _______NA

Are releases in place for external physicians and other providers seen by the client?

______Yes ______No _______NA

14. Does adequate supporting documentation exist in the record to support that all services specified in the care plan and on the Per Diem Work Sheet are being provided at the appropriate frequency? If no, please specify:

___

___

___

___

15. Status Reports/Care Plans are current and up to date? (No more than 3 months old for supported living and 4 weeks for active rehabilitation including day treatment)

____

____

____

____

____

16. (California Only) Does the record contain the following forms that have been updated for the last year:

A Identification and Emergency Information (LIC601) admission and as changes occur

B: Consent for Emergency Medical Treatment (LIC 627C) admission and if guardian changes

C: Centrally Stored meds (LIC622) monthly or as changes occur

D: Personal Property and Valuables (LIC621) ongoing but at least annually

E: Personal Rights (LIC613) admission and annual

F: Safeguarded Cash Resources (LIC405) monthly sent to Janet and Guardians

G: Functional Capacity Assessment (LIC9172) admission and annually

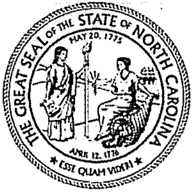
H: Needs and Service Plan (LIC625) admission and annually

I: Physicians Statement (LIC602) admission and annually

16. Problems encountered and/or corrective action needed.

____

____



NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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

DHSR - Mental Health

JUL 12 2018

Lic. & Cert. Section

July 6, 2018

Kate MeKeel; Director of Operations
Learning Services Corporation
5301 Robbins Drive
Raleigh, NC 27610

Re: Annual and Follow-up Survey completed June 28, 2018
Learning Services Corporation-Willow House, 570 Building Futures Circle, Raleigh, NC 27610
MHL # 092-917
E-mail Address: kmekeel@learningservices.com

Dear Ms. MeKeel:

Thank you for the cooperation and courtesy extended during the annual and follow-up survey completed June 28, 2018.

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

- All other 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 August 27, 2018.

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.

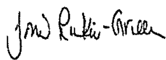
Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

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 call Renee Kowalski-Ames at (919) 552-6847.

Sincerely,



Toni Rankin-Green
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: Rob Robinson, Director, Alliance Behavioral Health LME/MCO
Wes Knepper, Quality Management Director, Alliance Behavioral Health LME/MCO
File

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
MHL092-917 (Y1)	(Y2)	6/28/2018 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LEARNING SERVICES CORPORATION-WILLOW HOUSE	570 BUILDING FUTURES CIRCLE RALEIGH, NC 27610

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0105 Reg. # 27G .0201 (A) (1-7) LSC	Correction Completed 06/28/2018	ID Prefix V0114 Reg. # 27G .0207 LSC	Correction Completed 06/28/2018	ID Prefix V0133 Reg. # G.S. 122C-80 LSC	Correction Completed 06/28/2018
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 6/27/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO