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
	mhl047-091	A. BUILDING: _____ B. WING _____	C 06/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HORIZON GROUP HOME, LLC	497 NORTHWOODS DRIVE RAEFORD, NC 28376

(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 A complaint survey was completed on 6/19/18. The complaint was substantiated (Intake #NC138359). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents	V 000	1.Indicate what measures will be put in place to correct the deficient area of practice. a. All staff employed at the Level III group home, including the Qualified Professional, will be re-trained on the Transition & Discharge Criteria and Process Policy (S-3) and the New Horizon Transition and Discharge Planning Form. b. During the training, the trainer will use the incident scenario cited in this deficiency report and provide different approaches that would have been acceptable according to the New Horizon Policy and DMH Rule. c. The trainers will require the trainees to complete the Transition & Discharge Planning Form as it should be completed during a discharge process. Clinical Director will complete all the above-mentioned training. 2.Indicate what measures will be put in place to prevent the problem from occurring again. a. The Clinical Director will immediately be made aware of all incident reports. The Clinical Director will assist the staff in the decision - making process regarding any discharges to ensure the discharge/transition is carried out according to Policy S-3. b. The Clinical Director will review all discharge/transition paperwork, including but not limited to the Discharge/Transition Planning Form and the Discharge Person Centered Plan prior to the last service.	
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations;	V 105		

			3.Indicate who will monitor the situation to ensure it will not occur again. a. Clinical Director will be responsible for monitoring all discharges from the Level III Group Home Residential Service. 4.Indicate how often the monitoring will take place. The monitoring will be ongoing. The monitoring will be ongoing as new consumers enter the service to ensure the treatment plan addresses all the needs reflected in the clinical assessment and any other pertinent documents as well as continued Child & Family Treatment Team paperwork. The Clinical Director will also provide ongoing monitoring of all planned and emergency discharges.	

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V 105	Continued From page 1 (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field; This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to implement their policy for discharge affecting one of one former client (FC	V 105		

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V 105	Continued From page 2 #4). The findings are: Review on 6/15/18 of former client #4 record revealed the following: - Admission date of2/13/18. - Discharge date of4/20/18. - Diagnoses of Oppositional Defiant Disorder and Bipolar Disorder. - No written discharge summary Review on 6/15/18 of the facility's Transition and Discharge Criteria revealed: "Discharge planning begins at the time of admission and continues throughout the relationship with New Horizons, LLC. New Horizons, LLC assist consumers regarding their discharge by: a. Involving the consumer in all aspects of his/her care, including the development and ongoing monitoring of the Person Centered Plan; b. Providing referrals to other communityservices and agencies; and c. Documenting discharge information. The respective county Department of Social Services is notified if the consumer's safety or well being will be endangered in the absence of the services. A written discharge summary, if required, includes at a minimum: a. date of admission; b. the presenting condition; c. description of the person's status and condition at last contact; d. a description of the person's status and condition at last contact; e. the date and reason for discharge f. summary of services provided; g. recommendations for services andsupports; and	V 105		

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V 105	Continued From page 3 h. instructions and referrals provided to the person." Review on 6/15/18 of a Incident Report dated April 20, 2018 written by the Qualified Professional revealed: "On April 20, 2018 around 3:30pm staff received a call from the guidance counselor at [school]that [client #4] attends. Staff (facility staff) was informed that [client #4] was put out of class and when she attempted to talk with [client #4] he was not interested. The counselor was informed that staff would address the incident with [client #4] when he arrived from school. Staff observed when [client #4] stepped from the school bus around 4:30pm that he appeared mad at the world. Upon entering the Group Home [client #4] went to his room, and came back into the sitting area accusing another client of stealing his X-BOX game. Simultaneously, he begin browsing through the other games where he found his games and continued roughly tossing the other games where he found his games and continued roughly tossing the other games, at which point he was approach by staff and asked to stop . [Client #4] did as he was directed to do. But then he went into his room raving and ranting, cursing and threating to kill everybody if he did not get his stuff. Staff and clients were instructed by the Manager not to respond to anything he says, because it was what he wants. [Client #4] came out of his room calling the Manager a b***h and threatening to do to the Manager what he had done to a previous female staff member, which was assault her. [Client #4] stated that the government would be paying the manager a visit. [Client #4] also stated no one better touch him because he knew his rights and he would have whoever touches him arrested, and he would call	V 105		

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V 105	Continued From page 4 CPS again. [Client #4] had also stated that someone was coming to shoot the house up, not him but somebody. [Client #4] saw that no one was responding to his ranting and raving and returned to his room. [Client #4] emerged from his room seconds later and ran out the back door. Staff met him at the front and stated to the manager "b***h I will kill you if touch me". The manager did not respond and call into the police. Less than an hour later [client #4] was returned to the group home. He tried to get the police officer to believe that he was threatened by the manager and had been bullied by the clients in the group home. [client #4] also stated the manager needed to be arrested and the boys needed to be removed from the group home. The police officer determined that [client #4] was not in any danger from anyone at the group home. When the officer did not find him believable [client #4] went to his room and returned carrying a book and walked out of the front door approximately 5 minutes after the Officer left. Staff pursued him he returned at went to the backyard of the group home and entered a wooded area. Staff called the local police again. The same officer and two others came out and combed the wooded area and could not find him and placed an alert in there system. Because [client #4]had refused to take his medication and was pretending to take his medication when it was administered, his threats to do harm, challenging staff authority, disruption in the group home, and his lack of safety and/or concern for himself, [facility] made the decision to IVC him followed by discharging him. [client #4] was given a second chance in the group home after he had caused a disruption at a prior time telling school officials that he being abused by one of the staff that led to a CPS coming out to the group home and what CPS discovered is that he was not the victim nor was	V 105		

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V 105	Continued From page 5 he abused. [client #4] has been in the system long enough to know what to say. He hates authority and he's vindictive when he cannot have his way, and when he can't get his way. DSS in [county] took him back into their custody on this date 4/21/18 after [client #4] called [local police department] from the local Walmart around 12:00pm on this day to be picked up. [Local Police Department] transported [client #4] to [hospital]." Interview on 6/15/18 the QP (Qualified Professional) stated: -"we discharged [client #4] immediately when the Sheriff Department transported him to the hospital for an evaluation." - She acknowleged the facility participated in treatment team meetings, however; they where unable to provide written documentation to support their discharge policy. Interview on 6/19/18 the licensee stated: - She confirmed they did not follow the facility's discharge policy.			
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 achieved by provision of the service and a	V 112		

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V 112	Continued From page 6 projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (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. This Rule is not met as evidenced by: Based on record review and interview the facility failed to implement strategies developed to address client #4's elopement. The findings are: Review on 6/15/18 of former client #4 record revealed the following: - Admission date of2/13/18. - Discharge date of4/20/18. - Diagnoses of Oppositional Defiant Disorder and Bipolar Disorder. Further review revealed a PCP (Personal Centered Plan) dated 4/21/18 with no written strategies addressing client #4's elopement. Further review revealed a plan update meeting ocurring April 12, 2018. Review on 6/15/18 of a Incident Report dated April 20, 2018 written by the Qualified Professional revealed:	V 112	1.Indicate what measures will be put in place to correct the deficient area of practice. a. All group home staff, including the Qualified Professional, will be trained on New Horizon Person Centered Plan Policy (S-4) emphasizing strongly the sections regarding the goals and interventions/strategies that are contained in the PCP along with the parameters that mandate the revision of the plan, including the changing needs of the consumer. b. The Clinical Director will be notified of all aspects of any changes noted with consumers and assist with advising to ensure the consumer's PCP is revised to reflect the additional need(s). 2.Indicate what measures will be put in place to prevent the problem from occurring again. a. The closer involvement of the Clinical Director in all aspects of the consumer's needs and continued monitoring of the PCP goals/interventions to ensure all needs are addressed and that any newly presented needs are reflected in a revised PCP. 3.Indicate who will monitor the situation to ensure it will not occur again. a. The Clinical Director will provide	

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V 112	Continued From page 6 projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (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. This Rule is not met as evidenced by: Based on record review and interview the facility failed to implement strategies developed to address client #4's elopement. The findings are: Review on 6/15/18 of former client #4 record revealed the following: - Admission date of 2/13/18. - Discharge date of 4/20/18. - Diagnoses of Oppositional Defiant Disorder and Bipolar Disorder. Further review revealed a PCP (Personal Centered Plan) dated 4/21/18 with no written strategies addressing client #4's elopement. Further review revealed a plan update meeting ocurring April 12, 2018. Review on 6/15/18 of a Incident Report dated April 20, 2018 written by the Qualified Professional revealed:	V 112	1.Indicate what measures will be put in place to correct the deficient area of practice. a. All group home staff, including the Qualified Professional, will be trained on New Horizon Person Centered Plan Policy (S-4) emphasizing strongly the sections regarding the goals and interventions/strategies that are contained in the PCP along with the parameters that mandate the revision of the plan, including the changing needs of the consumer. b. The Clinical Director will be notified of all aspects of any changes noted with consumers and assist with advising to ensure the consumer's PCP is revised to reflect the additional need(s). 2.Indicate what measures will be put in place to prevent the problem from occurring again. a. The closer involvement of the Clinical Director in all aspects of the consumer's needs and continued monitoring of the PCP goals/interventions to ensure all needs are addressed and that any newly presented needs are reflected in a revised PCP. 3.Indicate who will monitor the situation to ensure it will not occur again. a. The Clinical Director will provide	

			ongoing monitoring of clinical assessments, PCPs, and any additional relevant paperwork to ensure all needs of the consumers are addressed appropriately. 4.Indicate how often the monitoring will take place. a. The monitoring will be ongoing.	

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V 112	Continued From page 7 "On April 20, 2018 around 3:30pm staff received a call from the guidance counselor at [school]that [client #4] attends. Staff (facility staff) was informed that [client #4] was put out of class and when she attempted to talk with [client #4] he was not interested. The counselor was informed that staff would address the incident with [client #4] when he arrived from school. Staff observed when [client #4] stepped from the school bus around 4:30pm that he appeared mad at the world. Upon entering the Group Home [client #4] went to his room, and came back into the sitting area accusing another client of stealing his X-BOX game. Simultaneously, he begin browsing through the other games where he found his games and continued roughly tossing the other games where he found his games and continued roughly tossing the other games, at which point he was approach by staff and asked to stop . [Client #4] did as he was directed to do. But then he went into his room raving and ranting, cursing and threating to kill everybody if he did not get his stuff. Staff and clients were instructed by the Manager not to respond to anything he says, because it was what he wants. [Client #4] came out of his room calling the Manager a b***h and threatening to do to the Manager what he had done to a previous female staff member, which was assault her. [Client #4] stated that the government would be paying the manager a visit. [Client #4] also stated no one better touch him because he knew his rights and he would have whoever touches him arrested, and he would call CPS again. [Client #4] had also stated that someone was coming to shoot the house up, not him but somebody. [Client #4] saw that no one was responding to his ranting and raving and returned to his room. [Client #4] emerged from his room seconds later and ran out the back door.	V 112		

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V 112	Continued From page 8 Staff met him at the front and stated to the manager "b***h I will kill you if touch me". The manager did not respond and call into the police. Less than an hour later [client #4] was returned to the group home. He tried to get the police officer to believe that he was threatened by the manager and had been bullied by the clients in the group home. [client #4] also stated the manager needed to be arrested and the boys needed to be removed from the group home. The police officer determined that [client #4] was not in any danger from anyone at the group home. When the officer did not find him believable [client #4] went to his room and returned carrying a book and walked out of the front door approximately 5 minutes after the Officer left. Staff pursued him he returned at went to the backyard of the group home and entered a wooded area. Staff called the local police again. The same officer and two others came out and combed the wooded area and could not find him and placed an alert in there system. Because [client #4]had refused to take his medication and was pretending to take his medication when it was administered, his threats to do harm, challenging staff authority, disruption in the group home, and his lack of safety and/or concern for himself, [facility] made the decision to IVC him followed by discharging him. [client #4] was given a second chance in the group home after he had caused a disruption at a prior time telling school officials that he being abused by one of the staff that led to a CPS coming out to the group home and what CPS discovered is that he was not the victim nor was he abused. [client #4] has been in the system long enough to know what to say. He hates authority and he's vindictive when he cannot have his way, and when he can't get his way. DSS in [county] took him back into their custody on this date 4/21/18 after [client #4] called [local police	V 112		

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V 112	Continued From page 9 department] from the local Walmart around 12:00pm on this day to be picked up. [Local Police Department] transported [client #4] to [hospital]." Interview on 6/15/18 the QP (Qualified Professional) stated: -"we discharged [client #4] immediately when the Sheriff Department transported him to the hospital for an evaluation." - she acknowleged the facility participated in treatment team meetings, however; they where unable to provide written documentation to support how they were addressing his elopement behaviors. - no treatment goals have been developed to address client #4's elopement behaviors. - she acknowleged client #4 demonstrated walking out of the classroom at school and at the facility several times prior to the incident occurring April, 20 2018. Interview on 6/19/18 the licensee stated: - She confirmed the facility should have developed goals to address client #4's elopement behaviors.	V 112		

New Horizons, LLC	Policy No.: S-3 Page 1 of 3
Subject: Transition & Discharge Criteria & Process	Effective Date: 01/01/09
	Revised Date: 1-23-13; 4/21/2015

Policy

New Horizons, LLC ensures that consumers are knowledgeable concerning transition and the criteria that could result in discharge from services and the processes to follow for discharge. Discharge and referrals, to assist consumers to move from one level of care to another within the organization, and to obtain services, is shared with consumers at the time of intake and is reviewed with them at each subsequent consumer treatment team meeting.

Procedures

1. Transition and Discharge Planning Form is completed at the initial Child and Family Treatment Team meeting. At the same time, a discussion regarding goals and interventions/activities to meet the consumer's needs are documented in the Person Center Plan. Continuing Care criteria are included in the Program Descriptions for each service and discussed at staffing for individuals. Utilization of services and authorization reviews are conducted per service definition requirements, and within the authorized time period, but no later than quarterly. The person served is involved in all reviews and signs the PCP indicating involvement.

2. The written transition plan is developed when a person is transferring to another level of care or prepares for a planned discharge but is reviewed with the consumer at least quarterly. The Plan is developed with input from the person served, employees, and team members. It identifies the person's current progress in recovery or move toward well being; identifies the gains achieved in the program; identifies the needs for supports or other services; includes information of medication, when applicable; includes referral resource information and includes communication of information on options available if symptoms recur or services are needed. Persons served are provided a copy of the transition plan. The transition/discharge activities and documentation are facilitated by the clinical staff assigned to the consumer, e.g. Clinician/Qualified Professional. Recommendations made by consumers, caregivers and staff are agreed upon by all parties. (see procedure for transition and follow up attached) (see planning form attached)

3. The Qualified Professional (QP) shares with consumers and/or guardians at the time of admission the circumstances that might result in a consumer being discharged from services. The criteria includes:
   a. The consumer no longer needs services (goals are complete);

b. The consumer no longer desires to receive services from New Horizons, LLC;
c. The consumer becomes ineligible for the services in accordance with guidelines, regulations or criteria;
d. New Horizons, LLC cannot meet the consumer's needs;
e. New Horizons, LLC discontinues the service;
f. The consumer becomes a danger to self or others;
g. The consumer repeatedly does not follow policies or procedures;
h. The consumer refuses services over a prolonged period of time; or
i. Payment for the treatment or services is unavailable.

4. Discharge planning begins at the time of admission and continues throughout the relationship with New Horizons, LLC. New Horizons, LLC assist consumers regarding their discharge by:
   a. Involving the consumer in all aspects of his/her care, including the development and ongoing monitoring of the Person Centered Plan;
   b. Providing referrals to other community services and agencies; and
   c. Documenting discharge information.

5. If an consumer becomes ineligible for services, New Horizons, LLC:
   a. discusses the reason for ineligibility with the consumer and/or guardian;
   b. provides appropriate referrals and recommendations;
   c. coordinates with the consumer and guardian, if applicable, the date for final service;
   d. notifies referring agency, if appropriate;
   e. completes discharge information in the consumer record; and
   f. provides copies of the discharge information and/or summary to the referring agency, as appropriate, and others as indicated by the consumer's consent for release of information.

6. If a consumer repeatedly does not follow policies and procedures, New Horizons, LLC:
   a. meets/ discusses with consumer's team to determine if the consumer should exit services;
   b. reviews policies and procedures with the consumer and family and/or guardian; and
   c. notifies them in writing that continued violations will result in discharge.

7. Termination or denial of services from New Horizons, LLC cannot be appealed. New Horizons, LLC may refuse to provide services to any consumer. New Horizons, LLC notifies the consumer and/or guardian in writing of any decision to terminate a service and provides the consumer two

weeks notice from the date or receipt of the letter before the effective date of termination unless a health or safety issue is the reason for the termination.

8. When a person is discharged for aggressive behavior an incident report is completed, and LME and others are notified, as appropriate. The QP follows up with the LME within 72 hours to ensure the linkage to care is provided.

9. The respective county Department of Social Services is notified if the consumer's safety or well being will be endangered in the absence of the services.

10. A written discharge summary, if required, includes, at a minimum:
    a. date of admission;
    b. the presenting condition;
    c. description of the extent to which goals and objectives were achieved;
    d. a description of the person's status and condition at last contact;
    e. the date and reason for discharge;
    f. summary of services provided;
    g. recommendations for services and supports;
    h. instructions and list of referrals provided to the person; and
    i. includes information on medication(s) prescribed or administered, when applicable.

11. Except as provided in G.S 90-21.4, discharge of a minor includes notice to and consultation with the legally responsible person and in no event is a minor discharged from treatment upon the minor's request alone.

NEW HORIZON, LLC
CHILD and FAMILY TREATMENT TEAM MEETING
TRANSITION/DISCHARGE PLANNING FORM

Consumer Name:_____ MR#:_____ Medicaid #: _____

Please check as appropriate:
□ Child and Family Team Meeting □ Transition/Discharge Planning

Facilitator_____

Date of Meeting_____ Next Meeting_____

Current Level of Care/Services Received _____

Consumer's View of Program effectiveness and interventions. How do you feel your treatment program is progressing?

_____

Significant events/information that occurred or became available since last meeting:

_____

_____

_____

Referral/Intervention Suggestions:

Referral/Interventions	**Check if needed**	**Date Completed**	**Notes**
Physical Examination/Health Services			
Psychological Testing			
Revision of Service Plan			
Consultation			
Juvenile Justice			
Social Services			
Other			

NEW HORIZON, LLC
CHILD and FAMILY TREATMENT TEAM MEETING
TRANSITION/DISCHARGE PLANNING FORM

Consumer Name:_____ MR#:_____ Medicaid #: _____

Natural Supports in Place: (family, religious supports, neighbors, friends, etc.)

_____

_____

Progress/Lack of Progress since last meeting:

(Check which block applies)

GOALS	*REGRESS	MAINTAINED	PROGRESS	ACHIEVED

***If regression, what treatment changes have been made to treatment plan?**

_____

_____

_____

CALOCUS @ CHART OPENING	
CALOCUS @ LAST REVIEW DATE	
CALOCUS @ CURRENT (assess at time of meeting)	

Current psychotropic meds? □ Yes □ No **If yes, please complete below:**

Current Psychotropic Medications:

Meds:	Dose:	Freq.	Usually Adherent?
			□ Yes □ No
			□ Yes □ No
			□ Yes □ No

<u>Comprehensive Clinical Assessments</u>: Does clinical review (physician's notes, psychological, new information, etc.) require the client's diagnosis be updated at this time? ____no ____yes If yes, complete assessment revision on ITR.

<u>Service Planning:</u> Are revisions to the client's service plan indicated at this time? ____no ____yes If yes, please complete all relevant areas in service plan, to include any new goals/interventions and time frames.

NEW HORIZON, LLC
CHILD and FAMILY TREATMENT TEAM MEETING
TRANSITION/DISCHARGE PLANNING FORM

Consumer Name:_____ MR#:_____ Medicaid #: _____

Current Level(s) of Benefits:
Requires updating ____ no ____ yes If yes, expected completion date: _____

Do the PCP goals need to be revised?_____

Team Feedback/Recommendations/Referral/Resource Information:

Discharge/Transition Plan: (where, when, level of care ie . TCM, OPT, IIH):
Step Up: _____

Step Down:_____

Child & Family Team Members in Attendance

Printed Name	Signature	agree	disagree	Comments

Facilitator Signature **Date**

Client/Parent/Guardian Signature **Date**

Rev 8-08-14

New Horizon, LLC	Policy No.: S-4 Page 1 of 5
Subject: Person Centered Plan	Effective Date: 01/01/09
	Revised Date: 1-05-11 7-29-14; 5-19-15

Policy

New Horizon, LLC involves consumers in the planning, implementation, monitoring, revision, and evaluation of services provided. The Person Centered Plan (PCP) reflects the documentation of these steps.

All requirements set forth in the DMH Records and Management and Documentation Manual, PCP Manual and DMA Clinical Coverage Policy 8A and 8C will be adhered by New Horizon.

The PCP is the umbrella under which all planning for treatment, services and supports occurs. Person-centered planning begins with the identification of the reason the individual/family is requesting assistance.

Procedures

1. The PCP is the foundation upon which all planning for treatment, services, and support is built. The PCP development begins at the time the consumer is admitted for services and is updated and revised to reflect changes in the consumer's condition and additional needs. The PCP is developed based on the consumer's assessment, in partnership with the consumer, guardian, and appropriate natural supports. For children and adolescents, the Child and Family Team develop the PCP. A one-page Profile Page relevant to the consumer gathering information from natural supports and other persons that are involved with assisting in meeting the needs of the consumer.

2. For persons with MH or SA issues, the PCP is a standardized template/form developed by a Qualified Professional (QP) or a licensed professional from the clinical home of an individual.

3. The PCP recognizes the consumer's and his/her family's capabilities, interests, preferences, aspirations, and treatment and personal support needs. The PCP includes:
    a. consumer's outcomes (goals) that are anticipated to be achieved;
    b. specific strategies, service modalities/interventions with frequency and duration;
    c. responsibilities of each member of the team;
    d. a schedule (target date) for review of the PCP, to include goals, modalities/interventions and frequency/duration and responsibilities in consultation with the consumer and the legally responsible person or both. A target date does not exceed 12 months;

e. basis for evaluation or assessment or outcome achievement;
f. information necessary to carry out a crisis intervention;
g. written consent or agreement by the consumer and/or guardian and date signed, or a written statement by staff stating why such consent could not be obtained. Ongoing efforts are made and documented to obtain written consent; and
h. signature of staff and date signed.

4. At a minimum, the PCP is re-written annually based on the date the PCP was valid for billing. (A PCP is valid for billing when the last of the three required signatures is in place: dated signature of the person ordering the services; dated signature of the person to whom the PCP belongs; and dated signature of the QP or licensed professional who is responsible for the PCP and authorization for the service has been obtained from the appropriate authorizing vendor.)

5. The PCP must be reviewed and revised whenever the following situations occur:
   a. The target date assigned to each goal is due to expire and is in need of review;
   b. The individual's needs change and a new service is being requested;
   c. The individual's needs change and an existing service is being reduced or terminated;
   d. The individual's needs change and goals needs to be revised, added, or terminated;
   e. The designated service provider changes; or
   f. It is time for the annual rewrite of the PCP, based on the date the PCP was valid for billing.

6. A licensed professional - a licensed physician [MD or DO], licensed psychologist, licensed physician assistant, or a licensed family nurse practitioner must sign and date the review and revision of the PCP whenever the following occur:
   a. A new service is requested; or
   b. It is time for the annual review to re-establish medical necessity for the services identified on the PCP and execute a new service order.

7. If a minor is receiving mental health services as allowed in G.S. 90-21.5, the minor's signature on the PCP is sufficient. If the legally responsible person becomes involved, the legally responsible person also signs the PCP. (A minor can give effective consent to a physician licensed to practice medicine in N.C. for medical health services for the prevention, diagnosis and treatment

of ...iii) abuse of controlled substances or alcohol, and (iv) emotional disturbance.)

8. When services are provided prior to the development and implementation of the PCP, strategies to address the consumer's presenting problem are documented.

9. The official request for services outlined in the PCP, when signed and dated on the PCP signature page by the appropriate professional becomes the service order. All MH/DD/SA services reimbursed by Medicaid must be ordered prior to, or on the date of the service and re-ordered, at a minimum, on an annual basis. Anytime the PCP is revised to request a new service, there must be a signature constituting the service order to establish medical necessity for that service. (Shown on the revision/update page.) PCPs for individuals who are not eligible for Medicaid must also have a signature to reflect the service order by at least the QP who facilitates the development of the PCP; but it is advised to have the professional who would sign if it were Medicaid. If a verbal service is necessary in order to expedite services in an emergency situation when the individual's need has been identified, the verbal order is documented in the consumer's record on the date of the verbal order that specifies who gave the order, who received the order, each distinct service ordered and why a verbal order was obtained in lieu of a written order. The appropriate professional countersigns the order with a dated signature within 72 hours of the verbal order date.

10. The PCP is sent to the MCO for administrative review and authorization as well as administrative purposes which include, but are not limited to:

    a. Care coordination;
    b. Quality management;
    c. Review of a sample of PCPs for consumers in the MCO's catchment area who receive Medicaid-funded services; and
    d. Monitoring the effectiveness of the PCPs.

11. The Crisis Plan is a required component of all PCPs. A PCP is not considered complete without a Crisis Plan. . At a minimum, the Crisis Plan addresses the following when the PCP has been competed:
    a. Supports/interventions aimed at preventing a crisis [proactive];
    b. Supports/interventions to employ if there is a crisis [reactive];
    c. Symptoms or behaviors that may trigger the onset of a crisis;
    d. Crisis prevention and early intervention strategies;
    e. Strategies for crisis response and stabilization;

f. Specific recommendations if person arrives at the Crisis and Assessment Service;
g. All current medications;
h. Strategies for determining, after the crisis, what worked and what did not, and for making changes in the plan;
i. Contact list, including First Responder information;
j. Advance directives, if required for the service;
k. Emergency contacts and natural supports;
l. Crisis Plan distribution list.

12. The Person-Centered Plan Instructions specify who should sign the PCP. Guidance regarding signature requirements on the PCP is as follows:
    a. All signatures must contain the appropriate credentials/degree/licensure or title when signatures are entered on the signature pages of the PCP. Dated signatures are also required for most signatories of the PCP. The signature is authenticated when the person responsible for the plan [QP], the individual and/or legally responsible person, and the licensed professional [constituting the service order], each enter the date next to their signature. In addition, it is recommended that all signatures are legible and contain at least the first and last name of the person signing.
    b. For medical necessity of Medicaid-covered non-CAP-MR/DD services and State Funded services, a licensed physician [MD or DO], licensed psychologist, licensed physician assistant, or a licensed family nurse practitioner must sign and date the PCP, indicating that the requested services are medically necessary and constituting the service order. Sometimes a verbal order may be utilized to allow a service to be initiated.
    c. The Licensed Professional/Qualified Professional who is responsible for the individual's clinical home and responsible for developing the PCP must sign the PCP.
    d. The person receiving the services is required to sign and date the PCP, indicating confirmation and agreement with the services/supports outlined in the PCP, as well as confirming choice of service providers if the person is his/her own legally responsible party.
    e. The legally responsible person, if not the person receiving the services, signs and dates the PCP confirming involvement and agreement. If the provider who developed the PCP is unable to obtain the signature of the legally responsible person, there shall be documentation on the signature page or in a service note, reflecting due diligence in the efforts to obtain the signature and documentation stating why the signature could not be obtained. When this occurs, there shall be ongoing attempts to obtain the signature as soon as possible.
    f. When the CEO of an MCO or the director of a local department of social services is the legal representative/legally responsible person for an

individual, and the director delegates authority to another staff person to act on his behalf in participating in PCP and other planning meetings, that staff person may sign the PCP, subsequent revisions, and/or other such documents as the legally responsible person. Such delegation must be in writing [delegation letter] and signed by the agency director. A copy of this letter should be presented at the meeting and then filed in the service record. The designee would sign the PCP, stating that he/she is signing for the actual guardian, i.e., Suzie Smith [agency director] by John S. Doe [designated person].

g. Other team members involved in the development of the PCP may also sign the PCP to confirm participation and agreement with the services/supports listed, but these signatures are not required.