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
	mhl095-044	A. BUILDING: _____ B. WING _____	06/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDSAY HOME	394 CAMP JOY ROAD ZIONVILLE, NC 28698

(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 on June 12, 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	Responsible Individuals: Pamela Edwards, QP Peggy Pennington, Director Guardian for resident has signed appropriate PCP/Goals.	07/11/18
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 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.	V 112	DHSR - Mental Health AUG 06 2018 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Pam Edwards — TITLE: QP — (X6) DATE: 8/2/18

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure a client's service plan was reviewed annually and in consultation with the client or legally responsible person affecting 1 of 3 clients (Client #2). The findings are: Review on 6/11/18 of Client #2's record revealed: Admission date: 9/27/10 Diagnoses: Generalized Anxiety Disorder, Asthma, Hypertension, Dysthymia, Gastroesophageal Reflux Disease, Mild Mental Retardation History: Explosive behaviors that include yelling, cursing, bullying others, major mood swings, extreme jealousy issues with peers and disruptive in relationships with others. -Client #2's individualized service plan was dated 6/1/17 with the guardian's signature on 3/8/17; -There was no annual review of Client #2's service plan. Interview on 6/11/18 with Client #2 revealed: -Her service goals were to stay calm, tell time on a clock, read and write, not disclose personal information to strangers, and prepare side meal dishes; -She had a one-on-one person who helped her with her goals; -She, her guardian and the Qualified Professional went over her goals at times to see how she was doing; -She could not recall when the last time a meeting was held to review her goals; -Her guardian signed all her paperwork that included her goals. Interview on 6/12/18 with the Administrative Assistant revealed:	V 112	Client #2 has a signed service plan.	7/11/18

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V 112	Continued From page 2 -She worked with Client #2 Monday through Friday on Client #2's goals; -She did not know if the Qualified Professional had held a review of Client #2's service plan this year; -She was responsible for maintaining client records; -She was unable to find an updated annual service plan for Client #2. Interview on 6/12/18 with the Director of Developmental Disability Ministry for the facility revealed: -She provided supervision to the Qualified Professional (QP); -The updated the client service plans were completed annually by the QP with the client or client's guardian; -She was not certain if the QP had conducted the annual review on Client #2's service plan; -The QP was on vacation.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use.	V 114		

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V 114	Continued From page 3 This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure fire drills were held at least quarterly and repeated for each shift. The findings are: Review on 6/11/18 of the fire and disaster drill log revealed: -No morning or daytime fire drills were conducted in the fourth quarter, 2017 (October-December) -A policy statement that fire drills were to be conducted twice quarterly, 1 daytime and 1 nighttime. Interview on 6/11/18 with Client #1 revealed: -She had just moved into the facility last week and had not participated in fire drills yet. Interview on 6/11/18 with Client # 2 revealed: -Fire and disaster drills were done at the facility in the morning and at night; -Staff and residents went to the group home next door as their meeting place during fire drills; -She could not recall the last fire drill that occurred. Interview on 6/12/18 with Client #3 revealed: -Fire and disaster drills took place once a month at the facility; -Fire and disaster drills occurred in the morning and at night; -She and her peers met over at the boys' group home when they did fire drills. Interview on 6/11/18 and 6/12/18 with Staff #1 revealed: -Her position was Direct Support Professional;	V 114	There are scheduled morning and night time drills for each shift, per calendar quarter.	7/11/18

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V 114	Continued From page 4 -She had worked at the facility almost 4 years; -Her work schedule was 7 days on and 7 days off; -Fire and Disaster drills were conducted at different times each month; -She conducted many of the fire drills. Interview on 6/11/18 with Staff #2 revealed: -Her position was Direct Support Professional; -She had worked at the facility about 2 years; -Her work schedule was 7 days on and 7 days off; -Fire and Disaster drills were conducted at different times each month; -She had conducted fire drills at the facility. Interview on 6/12/18 with the Director of Developmental Disability Ministry for the facility revealed: -The facility had 1 shift of 7 days; -She was aware of the monthly fire and disaster schedule posted at the facility; -She had surveyor to read the statement that fire drills were to be conducted twice quarterly, 1 daytime and 1 nighttime; -She would have to look further into this issue.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION 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	V 118		

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V 118	Continued From page 5 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 record review and interview, the facility failed to ensure a medication self-administered by a client was on written authorization by the client's physician affecting 1 of 3 clients (Client #3). The findings are: Review on 6/12/18 of Client #3's record revealed: Admission date: 12/4/12 Diagnoses: Downs Syndrome, Mental Retardation, Allergic Rhinitis, Mitral Valve Prolapse, Chronic Conjunctivitis, Scoliosis and Psoriasis -Physician's order dated 11/28/17 for Gold Bond Powder, apply 1-2 times daily. Review on 6/11/18 of Client #3's April-June 2018	V 118	Client #3 was discharged from facility on July 9.	7/11/18

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V 118	Continued From page 6 MARs revealed: -Documentation of Gold Bond Powder, apply to affected area (anal cleft 1 to 2 times daily); -Staff initialed Gold Bond Powder administered to Client #3 twice daily (8:00 am and 8:00 pm) from 4/1/18-4/30/18, 5/1/18-5/31/18, and 6/1/18 to 6/11/18 at the 8:00 am dosage time. Interview on 6/12/18 with Client #3 revealed: -She had powder she put on her bottom every day to keep dry; -She kept the powder in her bedroom to use in the morning and before bedtime. Interview on 6/11/18 with Staff #1 revealed: -Her position was Direct Support Professional; -Her job duties included medication administration; -Client #3 applied the Gold Bond Powder to herself; -Staff did not apply the powder to Client #3; -"We tell her to put it on"; -There was no physician order for Client #3 to self-administer the prescribed powder; -She would contact Client #3's physician to get a self-administration order for the powder.	V 118		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal	V 119		

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V 119	Continued From page 7 shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge. This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to dispose of a prescription medication in a manner that guards against diversion or accidental ingestion. The findings are: Review on 6/12/18 of Client #2's record revealed: Admission date: 9/27/10 Diagnoses: Generalized Anxiety Disorder, Asthma, Hypertension, Dysthymia, Gastroesophageal Reflux Disease, Mild Mental Retardation -Physician's order dated 6/8/18 for Advair Diskus, 250-50, inhale 1 puff twice daily (rinse mouth after use-discard 30 days after opening). Review on 6/11/18 of Client #2's April-June 2018	V 119		

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V 119	Continued From page 8 MARs revealed: -Client #2 was administered the Advair Diskus, 250-50 twice daily (8:00 am and 8:00 pm) from 4/1/18-4/30/18, 5/1/18-5/31/18, and 6/1/18 to 6/11/18 at the 8:00 am dosage time. Observation on 6/11/18 at approximately 12:00 pm of the label on Client #2's Advair Diskus, 250-50 revealed: -Administration direction was to inhale 1 puff twice daily; -Quantity of 60 puffs; -Pharmacy dispense date of 3/4/18; -Disposal instruction to discard 30 days after opening. Interview on 6/11/18 with Client #2 revealed: -She took medications in the mornings and evening hours; -She used an inhaler for asthma. Interview on 6/11/18 with Staff #1 revealed: -Her position was Direct Support Professional; -Her job duties included medication administration, ensuring client medications were current and preparing expired medications for disposal; -Client #2 took the Advair Diskus for her asthma; -The Advair Diskus, 250-50 had 5 puffs remaining; -She did not know if Client #2's Advair Diskus had expired or not because of the manufacturer expiration date of 3/2019; -"With inhalers and eye drops that don't come in every month, we don't generally check the dates"; -She would prepare disposal of the Advair Diskus, 250-50 with dispense date of 3/4/18; -Client had a current Advair Diskus, 250-50 sealed in a foil package.	V 119	Date stickers were obtained from pharmacy to be placed on medications that expire within 30 days, and date of removal from foil pack is written on the label.	7/11/18

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V 119	Continued From page 9 Interview on 6/11/18 with the certified pharmacy technician revealed: -The Advair Diskus, 250-50 came sealed in a foil package before use; -The diskus was only effective for 30 days after removed from the foil pack.	V 119		

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

June 22, 2018

Peggy Pennington, Director DD Ministry
Baptist Children's Home of NC, Inc.
1425 Old 60
Wilkesboro, NC 28697

Re: Annual Survey completed June 12, 2018
Lindsay Home, 394 Camp Joy Road, Zionville, NC 28698
MHL # 095-044
E-mail Address: ppenington@bchfamily.org

Dear Ms. Pennington:

Thank you for the cooperation and courtesy extended during the annual survey completed June 12, 2018.

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

The following standard level deficiencies cited were:

- 10A NCAC 27G .0205 (c-d) Assessment and Treatment/Habilitation or Service Plan
- 10A NCAC 27G .0207 Emergency Plans and Supplies
- 10A NCAC 27G .0209 (c) Medication Administration
- 10A NCAC 27G .02.09 (d) Medication Disposal

Time Frames for Compliance

Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is August 11, 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 Lisa Niemas-Holmes at (828) 686-0750.

Sincerely,

Rebecca Hensley

Rebecca Hensley
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: Brian Ingraham, Director, Vaya Health LME/MCO
Patty Wilson, Quality Management Director, Vaya Health LME/MCO
File