

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL001-245	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/02/2018
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

B AND R PROVIDERS

**2445 ROGERS COURT
GRAHAM, NC 27253**

(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 August 2, 2018. Deficiencies were cited. The facility is licensed for the following service category: 10A NCAC 27 G .5600F Supervised Living for Individuals of all Disability Groups in a Private Residence.	V 000		
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; (7) quality assurance and quality improvement	V 105	DHSR - Mental Health AUG 13 2018 Lic. & Cert. Section	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Brenda W. Reese (Licensee) 08/11/2018

STATE FORM

6899

Q6U311

If continuation sheet 1 of 3

Division of Health Service Regulation

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V 105	<p>Continued From page 1</p> <p>activities, including:</p> <p>(A) composition and activities of a quality assurance and quality improvement committee;</p> <p>(B) written quality assurance and quality improvement plan;</p> <p>(C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services;</p> <p>(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;</p> <p>(E) strategies for improving client care;</p> <p>(F) review of staff qualifications and a determination made to grant treatment/habilitation privileges;</p> <p>(G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death;</p> <p>(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;</p> <p> </p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement adoption of standards that ensured operational and programmatic performance meeting applicable</p>	V 105		

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER B AND R PROVIDERS			STREET ADDRESS, CITY, STATE, ZIP CODE 2445 ROGERS COURT GRAHAM, NC 27253		
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V 105	<p>Continued From page 2</p> <p>standards of practice for the use of a Glucometer instrument including the CLIA (Clinical Laboratory Improvement Amendments) waiver. The findings are:</p> <p>Review on 8/2/18 of client #1's record revealed:</p> <ul style="list-style-type: none"> -Admission date of 4/11/14. -Diagnoses of Autism, Moderate Intellectual Disability and Type II Diabetes. -Physician's order dated 1/24/17 for blood sugar to be checked once a week. -Client #1's August 2018 MAR had a blood sugar check done on 8/1. -Client #1's July 2018 MAR had the following blood sugar checks: 7/4, 7/11, 7/18 and 7/25. -Client #1's June 2018 MAR had the following blood sugar checks: 6/6, 6/13, 6/20 and 6/27. <p>Interview on 8/2/18 with the Licensee revealed:</p> <ul style="list-style-type: none"> -She checked client #1's blood sugars once a week. -Client #1 was not capable of checking his own blood sugar. -She was not aware a CLIA waiver was required to check client #1's blood sugars. -She had been checking client #1's blood sugars for the last few years. -She had a survey last year and was not informed a CLIA waiver was required. -She confirmed the facility failed to have a CLIA waiver to check client #1's blood sugars. 	V 105			

**B and R Providers,
2445 Rogers Court, Graham, NC 27253
MHL # 001-245**

Annual survey completed August 2, 2018.

Plan of Correction

V 105 27G.0201

AUGUST 7TH 2018

The Licensee was initially unaware of the rule which requires AFL providers, whom support persons served that require glucose monitoring; to have the CLIA wavier. The Licensee, acquired information on the standards that ensured operational and programmatic performance meeting applicable standards of practice for the use of a Glucometer instrument Including the CLIA (Clinical Laboratory Improvement Amendments) waiver. The Licensee called the Division of Health Service Regulation/CLIA Certification to complete the CLIA application for certification wavier. The wavier was completed and sent on August, 7th 2018. The Licensee also consulted the State survey agency contact, Ms. Johnson, to ensure the CLIA was completed correctly. Once the wavier is processed the AFL home will be in compliance with the rule and have adoption of standards that assure operational and programmatic performance, meeting applicable standards of practice. This action is also a preventive measure to ensure that the site is ran accordingly to the applicable standards of practice. The Licensee and will monitor the Division of Health Service Regulation website and communication updates to ensure that standards of practice are followed. This will be completed a minimum of once per month.

Licensee signature:

Date:



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

ROY COOPER • Governor

MANDY COHEN, MD, MPH • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

August 6, 2018

Brenda W. Reese, Director
P.O. Box 2054
Burlington, NC 27216

DHSR - Mental Health

AUG 13 2018

Lic. & Cert. Section

Re: Annual Survey completed August 2, 2018
B and R Providers, 2445 Rogers Court, Graham, NC 27253
MHL # 001-245
E-mail Address: bandrproviders@gmail.com

Dear Ms. Brenda W. Reese:

Thank you for the cooperation and courtesy extended during the Annual survey completed August 2, 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

- 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 October 1, 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.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718
www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

August 6, 2018
Brenda W. Reese
B and R Providers.

- 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 Bryson Brown at (919) 855-3822.

Sincerely,



Kimberly R. Sauls
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: Trey Suttan, Director, Cardinal Innovations LME/MCO
Onika Wilson, Quality Management Director, Cardinal Innovations LME/MCO
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