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
	MHL031-039	A. BUILDING: _____ B. WING _____	R 08/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARSAW GROUP HOME	716 CURTIS ROAD WARSAW, NC 28398

(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 8/15/18. A deficiency was cited. This facillty is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
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	Strategies to be developed to support all health concerns in regards to diabetes Administration to monitor Strategies through documentation Communication between guardian medical provider & group home	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jaime Mcneill — TITLE: Executive Director — (X6) DATE: 8/30/18

DHSR-Mental Health
AUG 30 2018
Lic. & Cert. Section

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARSAW GROUP HOME	716 CURTIS ROAD WARSAW, NC 28398

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement strategies based on assessment affecting one of three clients (client #3). The findings are: Review on 8/15/18 of client #3's record revealed: - 37 year old female admitted on 7/16/13. - Diagnoses of Mild Intellectual Developmental Disabilities, Major Depressive Disorder, and Diabetes Type I. - Treatment plan dated 7/13/18. - No treatment plan strategies to address client #3's food preparation, education, or monitoring due to diagnosis of diabetes. Review on 8/15/18 of client #3's treatment plan revealed: - "...How Best to Support...[Client #3] has need of various medical and psychiatric interventions including BSL (blood sugar level) checks 4 times daily and insulin 4 times daily; [client #3] is monitored closely; staff should assist her to select more vegetables and protein, and less sugar and starch items at meals..." - "...What's not working:...[Client #3] continues to transition with her blood sugar levels and the insulin she takes for her Type I diabetes. Her BSL's are often irregular and high; it is known that [client #3] will eat foods when offered regardless of health risk and will often be 200 and much higher..." - "...Goal #1 Consumer has diabetes and is on insulin...Residential staff will: assist [client #3] with checking BSL, monitor BSL readings, document and report any abnormalities..." Review on 8/15/18 of client #3's FL-2 dated 6/28/18 revealed:	V 112		

Division of Health Service Regulation

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	MHL031-039	A. BUILDING: _____ B. WING _____	R 08/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARSAW GROUP HOME	716 CURTIS ROAD WARSAW, NC 28398

(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 112	Continued From page 2 - "...Nutritional Status: Diet No concentrated sweets..." - "...Personal Care Assistance: Feeding Food Prep..." Interview on 8/14/18 client #3 stated: - She did not like the staff attitudes at the home when they asked her to clean her room. - She had been told not to have food in her room and staff had found a diet soda and candy bar wrappers on 8/14/18. - She knew it was a house rule not to have food in the room or in the night stand drawers. She also knew it would affect her sugar level. - She said that if her sugar was too high she felt dizzy and would let the staff know. Interview on 8/14/18 the Facility Residential Service Coordinator stated: - When client #3's sugar level was higher than normal, we checked her room to see if she had any food items hidden that would be causing the increase in her sugar levels. - Client #3 has been present when staff helped her search in her room for food items that were harmful to her health. - We have found food items under her bed and in her nightstand drawer. - We have a menu for client #3's dietary needs; but there was no documentation of food intake for her at the home or at day program. Interview on 8/15/18 the Facility Executive Director stated: - There were no strategies regarding client #3's food and diabetic needs. - She would follow-up with the team and with the residential staff to correct the issue.	V 112		

204 Faison Hwy.
PO Box 1190 - mailing
Clinton, NC 28329
910-592-8395
910-596-0005 Fax
duplinsampsonhomes@earthlink.net

Duplin-Sampson Group Homes, Inc

Fax

To: Beth Phillips **From:** Jaime McNeill

Fax: **Pages:** (Includes cover) 7

Phone: **Date:** 8/30/18

Re: MHL 031-039 **cc:**

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**

• **Comments:**

Date Faxed: _____

Faxed by: _____

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NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

August 17, 2018

Jamie McNeill, Facility Director
Paula Becton, Contact Person
Duplin Sampson Group Homes, Inc.
PO Box 1190
Clinton, NC 28329

Re: Annual and Follow-Up Survey completed 8-15-18
Warsaw Group Home 716 Curtis Road, Warsaw, NC 28398
MHL # 031-039
E-mail Address: pbecton@earthlink.net & duplinsampsonhomes@earthlink.net

Dear Ms. McNeill & Ms. Becton:

Thank you for the cooperation and courtesy extended during the annual and follow-up survey completed 8/15/18.

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. A deficiency was 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
- The tag cited is a standard level deficiency.

Time Frames for Compliance
- A standard level deficiency must be corrected within 60 days from the exit of the survey, which is 10/13/18.

What to include in the Plan of Correction
- Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to prevent the problem from occurring again.
- Indicate who will monitor the situation to ensure it will not occur again.
- Indicate how often the monitoring will take place.

- Sign and date the bottom of the first page of the State Form.

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

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 Wendy Boone, Team Leader at 252-568-2744.

Sincerely,

Beth Phillips, MAEd.

Beth Phillips
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: Rob Robinson, Director, Alliance Behavioral Health LME/MCO
Wes Knepper, Quality Management Director, Alliance Behavioral Health LME/MCO
Leza Wainwright, Director, Trillium Health Resources LME/MCO
Kim Keehn, Quality Management Director, Trillium Health Resources LME/MCO
Sarah Stroud, Director, Eastpointe LME/MCO
Jeanette Jordan-Huffam, Quality Management Director, Eastpointe LME/MCO
File

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL031-039 Y1	A. Building B. Wing Y2	8/15/2018 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WARSAW GROUP HOME	716 CURTIS ROAD WARSAW, NC 28398

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 V0540 Reg. # 27F .0103 LSC	Correction Completed 08/15/2018	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
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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 Beth Phillips, MEd	DATE 8/15/18
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 3/22/2018	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: 5F8312