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
	MHL064-107	A. BUILDING: _____ B. WING _____	R 08/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
T Y L (THANK YOU LORD)	2612 WINSTEAD ROAD ROCKY MOUNT, NC 27804

(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 8/14/18. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600F Supervised Living/Alternative Family Living	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	DHSR - Mental Health SEP 18 2018 Lic. & Cert. Section	

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 1 of 3 clients (#2) treatment plan was revised. The findings are: Review on 8/9/18 of client #2's record revealed: - admitted to the facility on 12/1/11 - diagnoses of Schizophrenia; Psychotic Disorder; Hypertension; Seizure Disorder; Diabetes Mellitus II and High Cholesterol Review on 8/9/18 of a 9/28/17 treatment plan for client #2 revealed: - no goals in regards to drinking alcohol - no documentation throughout the treatment plan about drinking alcohol During interview on 8/9/18 client #2 reported: - he will drink a 40 oz beer every once in awhile - he rode his bike to the store to get the beer - he would drink the beer at the facility During interview on 8/9/18 the Licensee reported: - he has found empty alcoholic beverages in the yard and in client #2's bedroom - sometimes after drinking client #2 would fall down...which concerned him because he has seizures and it was difficult to tell if he was having a seizure or intoxicated - the last diagnosed seizure was 2 years ago - he does not exhibit any verbal or physical behaviors when he drinks - he explain/counsel client#2 about drinking alcohol with his medications - his physicians are aware of his drinking - client #2 drinks maybe 1 - 2 times a month During interview on 8/10/18 the Program	V 112		

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V 112	Continued From page 2 Manager reported: - she was filling in until the Qualified Professional was trained - she has filled in for the last month - she was not aware client #2 drink but his drinking was discussed in 2017 - as she recalled he did not drink often and exhibited no behaviors when he drink - client #2 still needed to be educated on the affects of alcohol and how it relates to his medications	V 112	**V112** **A treatment team meeting has been scheduled for 9/10/18. This date was determined based upon the quarterly review. During this time, the treatment team will discuss client's progress and address concerns. The information discussed during the treatment team meeting will be used to update and revise the client's Personal Centered Plan. New agenda to be discussed during the treatment team meeting will be incorporating goals in the client's plan relating to his alcohol usage and education on the effects of alcohol and how relates to the client's medication. The treatment team will be comprised of the client, QP, licensee, other professionals, nature supports, and other supportive staff. The new updates and revisions to plan will be monitored quarterly by the overseeing QP. The treatment team will continue meet quarterly to assess information concerning the client's needs, interest, preference, strengths, and goal progress.**	
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by	V 290		

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V 290	Continued From page 3 the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure a minimum of one staff member was present at all time except when the client's treatment plan documented the client was capable of remaining in the home or community for 2 of 3 clients (#2 & #3). The findings are: A. Cross reference tag (V112). 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN. Based on record review and interview the facility failed to ensure 1 of 3 clients (#2) treatment plan was revised. Review on 8/9/18 of client #2's record revealed: - admitted to the facility on 12/1/11	V 290		

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V 290	Continued From page 4 - diagnoses of Schizophrenia; Psychotic Disorder; Hypertension; Seizure Disorder; Diabetes Mellitus II and High Cholesterol - a treatment plan dated 9/8/17 with no documentation of unsupervised time in home/community During interview on 8/9/18 client #2 reported: - he will drink a 40 oz beer every once in awhile - he rode his bike to the store to get the beer - he would drink the beer at the facility - he has unsupervised time in the facility and community During interview on 8/10/18 the Program Manager reported: - client #2 only has 2 hours of unsupervised time - 1 hour in the community and 1 hour in the facility During interview on 8/8/18 & 8/14/18 the Licensee reported: - client #2's unsupervised time was reduced to 2 hours daily - the Local Managed Entity/Managed Care Organization reduced it last year due to concerns of his drinking B. Review on 8/9/18 of client #3's record revealed: - admitted to the facility on 12/13/17 - diagnoses of Mild Mental Retardation; Autism and Hypercholestorlemia - a treatment plan dated 12/12/17 with no goals of unsupervised time During interview on 8/9/18 client #3 reported: - he walked to the local gas station without	V 290		

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V 290	Continued From page 5 staff - he will walk on the local natural trail - he does not go out in the community often During interview on 8/14/18 the Licensee reported: - client #3 has unsupervised time in the home and community	V 290	**V 290** **A treatment team meeting has been scheduled for 9/10/18. This date was determined based upon the quarterly review. During this time, an "Unsupervised Time Assessment" will be completed by members of the treatment to assist with determining the appropriate amount of unsupervised time the client should have in the home and the community. The overseeing will update the client's "Personal Centered Plan" to include information relating to member' unsupervised time.** **The QP will continue to monitor the Licensee's facility and complete monthly supervisions. In addition to monthly supervisions, the QP will complete unannounced visits at the facility.**	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL064-107 Y1	A. Building B. Wing Y2	8/14/2018 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
T Y L (THANK YOU LORD)	2612 WINSTEAD ROAD ROCKY MOUNT, NC 27804

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 V0118 Reg. # 27G .0209 (C) LSC	Correction Completed 08/14/2018	ID Prefix V0291 Reg. # 27G .5603 LSC	Correction Completed 08/14/2018	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	DATE
			Rhonda Smith	8-14-18
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
7/18/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

August 15, 2018

DHSR - Mental Health
SEP 18 2018
Lic. & Cert. Section

Darrell Johnson II, AFL Provider
2612 Winstead Road
Rocky Mount, NC 27804

Re: Annual & Follow up survey completed August 14, 2018
T.Y.L. (Thank You Lord) 2612 Winstead Road, Rocky Mount, NC 27804
MHL #064-107
E-mail Address: dukeblue92@outlook.com

Dear Mr. Johnson II:

Thank you for the cooperation and courtesy extended during the Annual & Follow up survey completed August 14, 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 October 13, 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 Ames at (919) 552-6847.

Sincerely,

Rhonda Smith
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: 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