STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL043059	A. BUILDING: _____ B. WING _____	07/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROFESSIONAL FAMILY CARE HOME #5	19 SUSIE CIRCLE CAMERON, NC 28326

(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 complaint survey was completed on July 27, 2018. Deficiencies were cited. The complaint was unsubstantiated. (Complaint ID # NC 00140870) This facility is licensed for the following service category 10A NCAC 27G.5600C Supervised Living for Adults with Developmental Disabilities.	V 000	DHSR - Mental Health SEP 25 2018 Lic. & Cert. Section	
V 106	27G .0201 (A) (8-18) (B) 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: (8) use of medications by clients in accordance with the rules in this Section; (9) reporting of any incident, unusual occurrence or medication error; (10) voluntary non-compensated work performed by a client; (11) client fee assessment and collection practices; (12) medical preparedness plan to be utilized in a medical emergency; (13) authorization for and follow up of lab tests; (14) transportation, including the accessibility of emergency information for a client; (15) services of volunteers, including supervision and requirements for maintaining client confidentiality; (16) areas in which staff, including nonprofessional staff, receive training and continuing education; (17) safety precautions and requirements for facility areas including special client activity areas; and	V 106		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Theresa D Shaw, LPC — TITLE: Director of Clinical Services — (X6) DATE: 9.19.18

Division of Health Service Regulation

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V 106	Continued From page 1 (18) client grievance policy, including procedures for review and disposition of client grievances. (b) Minutes of the governing body shall be permanently maintained. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility management failed to implement written policies for staff reporting of incidents and/or unusual occurrences affecting 1 of 3 clients (#1.) The findings are: Cross Reference: 10A NCAC 27G .0604, INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS. Based on record reviews and interviews, the facility failed to report all level II and/or III incidents within 72 hours of becoming aware of the incident. Review on 7/25/18 of the facility's policy on incident reporting revealed the policy required staff to complete the following actions: - monitor, evaluate and investigate incidents to determine the root cause and identify opportunities for improvement - complete an incident report and notify appropriate management staff - recognize "emergency or unusual incidents" as including: 1. "physical injury to client (bruises, sprains, cuts, burns, falls, etc)" 2. reports of alleged client abuse 3. "other incidents that could potentially have adverse effects on a client, staff and/or the company" - notify group home manager/immediate	V 106		

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V 106	Continued From page 2 supervisor or Qualified Professional (QP) or "appointed designee on call" immediately after the incident - Level I - to be written report; Level II to be completed "on-line." - staff with best and most knowledge remain on duty to "thoroughly document(ed) and complete(d) the incident report "as soon as possible" after the incident. - turn in written report of Level I incident or email completed on-line copy of Level II incident to group home manager/immediate supervisor within 24 hours for review and forwarding on to QP within 24 hours. - QP to notify host/home LME, guardian, case manager and other appropriate entities within 24 hours of incident. During on 7/24/18, the Director of Residential Services reported: - The facility did not currently have a Qualified Professional. - He is responsible for QP duties until the position could be filled. - He confirmed a Level II incident reports should have been submitted to the state as required for the incident the facility staff and nurse reported on 7/2/18 and 7/6/18 for Client #1. - He further confirmed staff reported Level II incidents on 6/22/28 and 7/2/18 for Client #2 which were not reported to the State as required.	V 106		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during	V 367		

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V 367	Continued From page 3 the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and	V 367		

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V 367	Continued From page 4 (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by:	V 367		

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V 367	Continued From page 5 Based on record reviews and interviews, the facility failed to report all level II and/or III incidents within 72 hours of becoming aware of the incident. The findings are: A. Review on 7/20/18 of Client #1's record revealed: - Admission date of 5/3/15 - Diagnoses of Autistic Disorder; Profound Mental Retardation; Mild Cerebral Palsy; Mood Disorder, Not Otherwise Specified; Hypothyroidism; Hypertension; Elevated Cholesterol - Assessment updated 5/2016 documenting the client: 1) is non-verbal 2) "displays self-injurious behaviors of hitting and throwing self to floor. 3) hits herself "quite hard" and behavior "may last for hours." 4) "does not like new people" and reacts to changes by engaging in self-injurious behavior. Review on 7/20/18 of the facility's incident reports revealed staff documented the following for Client #1: - "7/2/18 - Staff noticed when giving consumer a shower that there was a suspicious looking bruise on the left side abdominal area. Consumer has not had any issues of self harming herself since she returned home from school (day program.)" Interview on 7/20/18 of Staff #1 revealed: - Staff completed daily body checks and document any bruises identified on Client #1 every morning and evening. - Client #1 began a new day program on 6/25/18. - The new day program also changed the client's one-on-one staff. - Staff noticed an increase in Client #1's self injurious behavior after the changes.	V 367		

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V 367	Continued From page 6 - Staff did not identify similar concerns about Client #1's bruises while in the previous day program. - Staff reported they noticed "little things at first" and suspected Client #1 was possibly displaying self-injurious behavior in response to the changes in day program and change in her one-on-one staff of several years. - All bruises were documented for review by the nurse, House Manager and/or Qualified Professional. - She identified what appeared to be "suspicious" bruises on Client #1 on 7/2/18. "suspicious" because: a) it was located on her body in an area that was unlikely the client could have inflicted self-injury and b) the client did not have the bruise when staff completed a body check in the morning prior to leaving for the day program. - She contacted the nurse who came to the facility to check the condition of Client #1's bruise. - She delivered the completed 7/2/18 incident report to the office for review by the QP on 7/3/18. - Staff continued to notice and document additional unusual bruises and some that appeared to be "fingerprints on her arm." Interview on 7/24/18 of the facility's Registered Nurse (RN) revealed: - She visited the facility at least twice a month as well as upon request by staff. - On 7/2/18 staff contacted her about the "suspicious" bruises on Client #1. - She checked Client #1 and determined the injuries "concerned her" because they did not appear to be injuries caused by self-injurious behaviors. - She was not aware Client #1 had begun a new day program with a new one-on-one staff. - Staff contacted her again to check Client #1 because of additional unusual bruises on 7/5/18	V 367		

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V 367	Continued From page 7 which were identified during the evening body check upon the client's return from the day program. - She observed and documented a bruise on Client #1's right hip, leg, foot and right and left back area. - Due to her increased suspicion, she checked Client #1 again on 7/6/18 after she returned from the day program and found new bruises and additional bruising on top of the previous bruises. - On 7/6/18 she, reported her concerns to the Director of Residential Services and requested the incident be reported to the State authority and a meeting be held with the day program personnel. - She also informed the agency's Compliance Officer/Manager (supervisor of Director of Residential Services) because her "sense of alarm" had been "raised even more." During interview on 7/24/18, the Director of Residential Services reported: - On 7/6/18, staff documented Client #1 had sustained new injuries as well as some second injuries which overlapped the injuries first documented on 7/2/18. - Staff noted the injuries "appeared to be different from what client has historically inflicted." - He met with day program staff on 7/9/18 to discuss the incidents, request copies of body checks they said they completed and develop a plan for addressing the concerns. - Two days later, on 7/11/18, he received copies of documentation on body checks completed for Client #1 from the day program management. Day program forms documenting body checks were dated 7/2, 7/3; 7/5; 7/6; 7/9 and 7/11. - He confirmed staff submitted a Level II incident report for the injuries Client #1 sustained: a) from an unknown source and b) documented the	V 367		

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V 367	Continued From page 8 bruises as "suspicious." - He further confirmed he did not submitted the report to IRIS on any of the Level II incidents for Client #1: a. within 72 hours of becoming aware of the incidents b. as per the facility's policy c. and until after he the above information was received from the day program. B. Review on 7/20/18 of Client #2's record revealed: - Admission date of 8/18/17 - Diagnoses of Mild Intellectual Disability; Unspecified Schizophrenia Spectrum and other psychotic Disorder; Attention Deficit Disorder - Combined Type; Hypothyroidism; Asthma and Chronic Pain. Additional review on 7/20/18 of the facility's incident reports revealed staff documented the following incidents for Client #2: 1. 6/22/18: - The client displayed "disrespectful" and "combative" behavior towards staff. - Client #2 "swung on staff and had to be put in a restraint hold." - The client was released and continued to be combative and "swung on staff and kicked staff." - Client was again restrained by two staff as she was "kicking staff and scratching, as well as attempting to bite." - Hold was released and the client "grabbed other staff's hair and refused to let go." She was again restrained then released and told to "calm down and comply with household rules." - "After about 20 minutes passed staff was outside on the porch with other consumers and said consumer (Client #2) asked can she come outside on the porch with other consumers and	V 367		

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V 367	Continued From page 9 said consumer asked can she come and again became combative with staff, she again had to be restrained." - Client #2 informed staff she was "hearing voices, telling her to do things, she didn't know why." 2. 7/02/18: - "Consumer made (4) cuts on her neck. Consumer (Client #2) was in her room at the time she did this. Staff did not see her do this." - Staff question Client #2 and was informed she used a piece of glass she found on her dresser to cut herself and subsequently threw the glass into the trash can. - Staff searched the room for other items the client could use for self harm, however no other items were found. - The client was instructed to take the trash can outside and empty it. Additional interview on 7/20/18 with Staff #1 revealed: - She completed the above Level II incident reports and delivered copies to the management office the day following each incidents. During additional interview on 7/24/18, the Director of Residential Services reported: - Client #2 was admitted to the hospital after the self-harming incident. - Upon discharge, staff implemented the following strategies to address Client #2's behavior: a. "suicide watch" and room search for 24 hours. b. removal of footwear requiring shoe strings c. weekly therapy - Confirmed Level II incident reports were not submitted to the state as required.	V 367		

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V 736	Continued From page 10	V 736		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the management of the facility failed to assure its grounds were maintained in a safe, attractive and orderly manner. The findings are: Observation during the survey from 2:30 PM - 7:30 PM on 7/23 - 7/27/18 revealed the following maintenance issues in the facility: - Brown fabric couch in the client living room/common area was dirty and broken. The end section of the couch where clients sat to watch television was sunken into the couch frame and propped up with blankets, towels and other assorted cushions. - Carpet contained large, unidentifiable stained sections. - Linoleum in dining room contained missing and broken sections throughout. - Windows in all client rooms were without screens and contained dead insects, mold and debris on the external frames. - Windows did not have curtains and were covered by blankets or sheets. - Dressers in client rooms had broken drawers and/or drawers without front sections and could not be used for access to clothing and/or storage in safe manner. - Walls in client rooms had holes in the sheet rock	V 736		

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V 736	Continued From page 11 as well as patched and unpainted areas. - Front entry door would not remain closed and had no screen. The door issue was repaired during the survey by the Director of Residential Services. However, there is no screen for the front entrance doorway (frequently used by clients to stand or sit on the front porch) and thus provide effective staff observation of clients using the area. During interview on 7/25/18, the Director of Residential Services confirmed the above observations.	V 736		

PROFESSIONAL FAMILY CARE SERVICES, INC.
1012 Pamalee Drive
Fayetteville, North Carolina 28303
Telephone: (910) 485-0085 Fax: (910) 485-0334

Re: Annual and Complaint Survey
Deficiencies and Plans of Correction
MHL043-059 surveyed on 07.27.2018

10A NCAC 27G .0604 (Incident reporting requirements for category A and B providers)

- Staff was trained on PFCS policy 320 for reporting incidents, the various levels of incidences, and how to accurately complete an incident report. All trainings were completed by September 12, 2018.
- Quality Management team has implemented monthly review of all incidences reported to verify staff are following the policy and procedure and to identify trends.
- PFCS has reduced the responsibilities of the Residential Manager to afford more time to focus on the residential facilities, clients, and staff

10A NCAC 27G .0303 (Location and exterior requirements) – SEE ATTACHED IMAGES

- The furniture in client living room/common area was replaced
- Common area carpet has been replaced
- Dining room linoleum has been replaced
- Windows in client rooms have been have been cleaned and painted. All screens will be replace by September 24, 2018 (note: storm weather (Hurricane Florence) has prevented maintenance
- Windows in client rooms have been covered with curtains
- Broken dressers have been removed and replaced
- Walls with holes have been repaired and painted
- Front entry door remains fixed and a screen door will be installed by September 24, 2018 (note: storm weather (Hurricane Florence) has prevented maintenance

In an effort to prevent these and other problems from reoccurring PFCS has reduced the responsibilities of the Residential Manager, so that closer monitoring of the clients, facilities, and staff can occur.


EXIT


Dad


DOGS
FOR DC.
DAY


* Staff sign daily


EXIT