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
	MHL071-034	A. BUILDING: _____ B. WING _____	R 10/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOTUS	224 ISLAND CREEK ROAD ROCKY POINT, NC 28457

(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, follow up, and complaint survey was completed October 16, 2018. The complaint was unsubstantiated (intake #NC00141848). 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		
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;	V 105	DHSR - Mental Health NOV 05 2018 Lic. & Cert. Section	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimberly Hill — TITLE: Executive Director — (X6) DATE: 10/31/18

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V 105	Continued From page 1 (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (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; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (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; This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to implement written policies for an admission assessment. The findings are:	V 105		

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V 105	Continued From page 2 Review on 10/15/18 of client #2's record revealed: -28 year old male admitted 7/9/18. -Diagnoses included autistic disorder; psychotic disorder, not otherwise specified; mild mental retardation. -No documentation of an admission assessment. Interview on 10/15/18 Qualified Professional #9 stated she did not document an admission assessment for client #2 when he was admitted to the group home. Interview on 10/15/18 the Executive Director/Qualified Professional stated: -Client #2 attended the day program owned/operated by the Licensee prior to his admission to the group home. -The policies were followed when first admitted to the day program services. Client #2's guardian had signed the "Notification of Receipt of Participants Rights" as part of this process. (Document had been signed and dated 3/12/17.) -Client #2 moved into the group home on 7/9/18. -There was no admission assessment done for his admission to the group home on 7/9/18.	V 105		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem;	V 111		

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V 111	Continued From page 3 (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to complete an admission assessment and strategies to address the client's presenting problems prior to the delivery of services for 1 of 3 clients audited (client #2). The findings are: Review on 10/15/18 of client #2's record revealed: -28 year old male admitted 7/9/18. -Diagnoses included autistic disorder; psychotic disorder, not otherwise specified; mild mental retardation.	V 111		

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V 111	Continued From page 4 -No documentation of an admission assessment. -"ISP (Individual Service Plan) Meeting Date: 07/25/18." -Short Range Goals/Interventions "Effective Date: 08/01/2018." -No documentation of strategies to address the client's presenting problems prior to the delivery of services in the facility. Interview on 10/15/18 the Qualified Professional #9 stated she did not document an admission assessment for client #2. Interview on 10/15/18 the Executive Director/Qualified Professional stated: -Client #2 attended the day program owned/operated by the Licensee prior to his admission to the group home. -There was no admission assessment done prior to his admission to the group home. -There was no documentation of strategies to address his presenting problems prior to the delivery of services as a new admission to the group home.	V 111		
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 reviews and interviews, the facility failed to ensure medications were administered as ordered by the physician, and recorded immediately after administration affecting 2 of 2 current clients and 1 of 1 former clients (FC) audited (client #1, client #2, FC #3). The findings are: Finding #1: Review on 10/12/18 and 10/15/18 of client #1's record revealed: -27 year old male admitted 1/1/10. -Diagnoses included autistic disorder and mild mental retardation. -Orders dated 6/19/18 included: -Magnesium Oxide Tab 250 mg (milligrams)	V 118		

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V 118	Continued From page 6 daily. (Supplement) -Vitamin Century with/lycop, 1 daily (Supplement) -Divalproex Sodium Extended Release 250 mg every morning (Mood Stabilizer, Anticonvulsant) -Vitamin D3 400 iu (international units), 2 Tablets daily (Supplement) -Ziprasidone 40 mg every morning (Antipsychotic) -Sea-Omega 30 mg twice daily (Fish oil, supplement) Review on 10/12/18 of client #1's October 2018 MAR revealed: -The following medications scheduled to be administered at 7 am had not been documented as administered on 10/8/18: -Magnesium Oxide Tab 250 mg daily. -Vitamin Century with/lycop, 1 daily -Divalproex Sodium Extended Release 250 mg every morning -Vitamin D3 400 Iu (international units), 2 Tablets daily -Ziprasidone 40 mg every morning -Sea-Omega 30 mg twice daily -Ziprasidone 40 mg, scheduled to be administered at 7 am, had not been documented as administered on 10/6/18. Finding #2: Review on 10/12/18 and 10/15/18 of client #2's record revealed: -28 year old male admitted 7/9/18. -Diagnoses included autistic disorder; psychotic disorder, not otherwise specified; and mild mental retardation. -Orders dated 7/12/18 and 8/22/18 for Clotrimazole-Betamethasone 1%-0.05% Cream (Lotrimin), apply topically on skin 4 times daily.	V 118		

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V 118	Continued From page 7 (Antifungal) Review on 10/12/15 of client #2's August, September, and October 2018 MARs revealed: -Clotrimazole had been transcribed monthly, and scheduled to be administered daily at 7 am, 12 pm, 5 pm, 7 pm. -No documentation Clotrimazole had been administered in October 2018. Finding #3: Review on 10/12/18 and 10/15/18 of FC#3's record revealed: -21 year old male admitted 10/22/16 and discharged 10/3/18 (discharge date given by Executive Director/Qualified Professional) -Diagnoses included autistic disorder and severe mental retardation. -Order dated 8/13/18 for Polytrim Ophthalmic Suspension OU (each eye) 4 times daily for 14 days. (Antibiotic eye drops) Review on 10/15/18 of FC#3's August and September 2018 MARs revealed: -Polytrim Ophthalmic Suspension had been transcribed to the August 2018 MAR to be administered at 7 am -12 pm - 6 pm - 8 pm. The medication was documented for 12 days starting on 8/20/18 (7 days after order was written) through 8/31/18. -Polytrim Ophthalmic Suspension had not been transcribed onto the September 2018 MAR and not documented as administered in September 2018 (should have been given for 2 days in September for a total of 14 days). Interview on 10/12/18 the Group Home Manager stated: -When staff fail to sign the MARs he would contact them and request they sign the MARs on	V 118		

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V 118	Continued From page 8 their next shift. There was no documentation to identify late entries from those that were documented immediately after a medication was administered. -He was aware client #2's Clotrimazole cream had not been documented on the October 2018 MAR. It was ordered as a routine medication for the client's dry skin. The cream had not been sent from the pharmacy with the batch medication refills and the facility had not requested it be filled. Interviews on 10/15/18 and 10/16/18 the Program Director stated: -He did not know why FC #3's antibiotic eye drops had been started 7 days after order had been written and not given 14 days as ordered. The eye doctor had written the order during a routine eye exam. -It was his understanding client #2's Clotrimazole cream had been discontinued. -He would contact the physician to obtain a copy of the discontinue order and send to surveyor via facsimile. Information received via facsimile at 9:16 pm on 10/16/18 did not include a discontinue order for client #2's Clotrimazole cream. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician.	V 118		
V 133	G.S. 122C-80 Criminal History Record Check G.S. §122C-80 CRIMINAL HISTORY RECORD CHECK REQUIRED FOR CERTAIN APPLICANTS FOR EMPLOYMENT.	V 133		

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V 133	Continued From page 9 (a) Definition. - As used in this section, the term "provider" applies to an area authority/county program and any provider of mental health, developmental disability, and substance abuse services that is licensable under Article 2 of this Chapter. (b) Requirement. - An offer of employment by a provider licensed under this Chapter to an applicant to fill a position that does not require the applicant to have an occupational license is conditioned on consent to a State and national criminal history record check of the applicant. If the applicant has been a resident of this State for less than five years, then the offer of employment is conditioned on consent to a State and national criminal history record check of the applicant. The national criminal history record check shall include a check of the applicant's fingerprints. If the applicant has been a resident of this State for five years or more, then the offer is conditioned on consent to a State criminal history record check of the applicant. A provider shall not employ an applicant who refuses to consent to a criminal history record check required by this section. Except as otherwise provided in this subsection, within five business days of making the conditional offer of employment, a provider shall submit a request to the Department of Justice under G.S. 114-19.10 to conduct a criminal history record check required by this section or shall submit a request to a private entity to conduct a State criminal history record check required by this section. Notwithstanding G.S. 114-19.10, the Department of Justice shall return the results of national criminal history record checks for employment positions not covered by Public Law 105-277 to the Department of Health and Human Services, Criminal Records Check Unit. Within five	V 133		

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V 133	Continued From page 10 business days of receipt of the national criminal history of the person, the Department of Health and Human Services, Criminal Records Check Unit, shall notify the provider as to whether the information received may affect the employability of the applicant. In no case shall the results of the national criminal history record check be shared with the provider. Providers shall make available upon request verification that a criminal history check has been completed on any staff covered by this section. A county that has adopted an appropriate local ordinance and has access to the Division of Criminal Information data bank may conduct on behalf of a provider a State criminal history record check required by this section without the provider having to submit a request to the Department of Justice. In such a case, the county shall commence with the State criminal history record check required by this section within five business days of the conditional offer of employment by the provider. All criminal history information received by the provider is confidential and may not be disclosed, except to the applicant as provided in subsection (c) of this section. For purposes of this subsection, the term "private entity" means a business regularly engaged in conducting criminal history record checks utilizing public records obtained from a State agency. (c) Action. - If an applicant's criminal history record check reveals one or more convictions of a relevant offense, the provider shall consider all of the following factors in determining whether to hire the applicant: (1) The level and seriousness of the crime. (2) The date of the crime. (3) The age of the person at the time of the conviction. (4) The circumstances surrounding the	V 133		

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V 133	Continued From page 11 commission of the crime, if known. (5) The nexus between the criminal conduct of the person and the job duties of the position to be filled. (6) The prison, jail, probation, parole, rehabilitation, and employment records of the person since the date the crime was committed. (7) The subsequent commission by the person of a relevant offense. The fact of conviction of a relevant offense alone shall not be a bar to employment; however, the listed factors shall be considered by the provider. If the provider disqualifies an applicant after consideration of the relevant factors, then the provider may disclose information contained in the criminal history record check that is relevant to the disqualification, but may not provide a copy of the criminal history record check to the applicant. (d) Limited Immunity. - A provider and an officer or employee of a provider that, in good faith, complies with this section shall be immune from civil liability for: (1) The failure of the provider to employ an individual on the basis of information provided in the criminal history record check of the individual. (2) Failure to check an employee's history of criminal offenses if the employee's criminal history record check is requested and received in compliance with this section. (e) Relevant Offense. - As used in this section, "relevant offense" means a county, state, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or felony, that bears upon an individual's fitness to have responsibility for the safety and well-being of persons needing mental health, developmental disabilities, or substance abuse services. These crimes include the criminal offenses set forth in	V 133		

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V 133	Continued From page 12 any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7A, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots and Civil Disorders; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. These crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes, and alcohol-related offenses such as sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. (f) Penalty for Furnishing False Information. - Any applicant for employment who willfully furnishes, supplies, or otherwise gives false information on an employment application that is the basis for a criminal history record check under this section	V 133		

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V 133	Continued From page 13 shall be guilty of a Class A1 misdemeanor. (g) Conditional Employment. - A provider may employ an applicant conditionally prior to obtaining the results of a criminal history record check regarding the applicant if both of the following requirements are met: (1) The provider shall not employ an applicant prior to obtaining the applicant's consent for criminal history record check as required in subsection (b) of this section or the completed fingerprint cards as required in G.S. 114-19.10. (2) The provider shall submit the request for a criminal history record check not later than five business days after the individual begins conditional employment. (2000-154, s. 4; 2001-155, s. 1; 2004-124, ss. 10.19D(c), (h); 2005-4, ss. 1, 2, 3, 4, 5(a); 2007-444, s. 3.) This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to request within 5 business days national criminal history record checks, to include a check of the applicant's fingerprints, for 2 of 2 staff audited who had been a resident of this State for less than five years prior to hire (Group Home Manager, Program Director). The findings are: Finding #1: Review on 10/16/18 of the Program Director's personnel file revealed: -Hired on 1/30/17. -Work history documented employment/residence in another state 1998-2000. -No documentation the fingerprints had been submitted with the national criminal background	V 133		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL071-034	A. BUILDING: _____ B. WING _____	R 10/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOTUS	224 ISLAND CREEK ROAD ROCKY POINT, NC 28457

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V 133	Continued From page 14 check. Finding #2: Review on 10/16/18 of the Group Home Manager's personnel file revealed: -Hired on 10/30/15. -Resident of another state in 2014. -No documentation the fingerprints had been submitted with the national criminal background check. Interview on 10/16/18 the Executive Director/Qualified Professional and Program Director stated: -Following the annual survey finding in 2017 "nation wide" criminal background searches had been requested for those staff who had been a resident of this state for less than 5 years at the time of employment. -Fingerprints were obtained and filed in the personnel records for those staff who had been a resident of this state for less than 5 years at the time of employment. -The fingerprints had not been included with the requests for nation wide criminal background requests. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 133		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by:	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 366	Continued From page 15 (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal	V 366		

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V 366	Continued From page 16 review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different;	V 366		

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V 366	Continued From page 17 (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to implement policy for level II incident response. The findings are: Review on 10/15/18 of former client (FC) #3's record revealed: -21 year old admitted 10/22/16 and discharged 10/3/18. -Diagnoses included autism and severe mental retardation. -6/7/18 FC #3 was seen at the local Emergency Department (ED) for "human bite." Physician ordered antibiotic therapy with amoxicillin-clavulanate 875-125mg 1 tab every 12 hours -7/30/18 was seen at the local ED for "human bite." Physician ordered antibiotic therapy with amoxicillin-clavulanate 875-125mg 1 tab every 12 hours for 7 days. Review on 10/15/18 of facility incident reports from June 2018 - October 2018 revealed no level II incident reports for FC#3's bite wound injuries in June and July 2018 that required more than	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 366	Continued From page 18 first aid. Interview on 10/15/18 the Executive Director/Qualified Professional stated: -No level II incident reports had been completed for FC #3's injuries sustained when client #1 had bitten FC #3 in June and July 2018. -The incident reports had been completed for the restrictive interventions of client #1 when he bit FC#3.	V 366		
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 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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 367	Continued From page 19 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 (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	V 367		

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V 367	Continued From page 20 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: Based on record reviews and interviews the facility failed to ensure critical incident reports were submitted to the Local Management Entity (LME)/Managed Care Organization (MCO) within 72 hours as required. The findings are. Review on 10/15/18 of former client (FC) #3's record revealed: -21 year old admitted 10/22/16 and discharged 10/3/18. -Diagnoses included autism and severe mental retardation. -6/7/18 FC #3 was seen at the local Emergency Department (ED) for "human bite." Physician ordered antibiotic therapy with amoxicillin-clavulanate 875-125mg 1 tab every 12 hours -7/30/18 was seen at the local ED for "human bite." Physician ordered antibiotic therapy with amoxicillin-clavulanate 875-125mg 1 tab every 12 hours for 7 days.	V 367		

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V 367	Continued From page 21 Review on 10/15/18 of facility incident reports from June 2018 - October 2018 revealed no level II incident reports for FC#3's bite wound injuries in June and July 2018 that required more than first aid. Refer to V366 for additional information.	V 367		
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 observation and interview, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observations on 10/12/18 between 9:20 am and 10:30 am revealed: -Kitchen: -Bottom of sink base cabinet warped, discolored black, with a visible penetration through the surface. -Floor covering split in multiple areas across the kitchen floor. -Cracks approximately 6 inches in length on the wall by utility closet and above the adjacent cabinets. -Light cover above kitchen island separated from frame with particles inside. -Inside oven black baked on substance under	V 736		

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V 736	Continued From page 22 baking racks. Oven door glass covered with rust colored baked on splatter. -Bottom stove drawer covered with debris particles on top edge and inside the drawer. -Door to cabinet above microwave secured with tape; part of frame was missing. -Build up of food particles inside microwave. -Living areas: -Surface of exercise bench split exposing foam padding. -Carpet stains visible in front of entry door and in front of sofa in front living room. -Upholstery torn on the arms and seat cushion of the wing back chair in den. -Light fixture covers removed in front living room, kitchen, and den. -Client #1's room and bathroom: -Gray ring around water in toilet. -Rust colored stains on all water fixtures. -Multiple areas of unfinished/unpainted wall patches. -Hall bath -Rust colored stains on all water fixtures. -No bulbs in light fixture above sink. -No base board by sink, next to door. Interview on 10/12/18 the Group Home Manager stated: -The damage to walls in kitchen and client #1's room were a result of client #1's behaviors. The damage in the kitchen occurred a few months prior. -Fixtures have been removed from overhead lights to prevent clients from using them as "projectiles" when they have behaviors. -The rust staining is a result of the well water. The facility uses a gel product approximately every month to remove stains. -He would make sure the stove is cleaned. -They will obtain the product to remove stains on	V 736		

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V 736	Continued From page 23 bathroom surfaces.	V 736		
V 738	27G .0303(d) Pest Control 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (d) Buildings shall be kept free from insects and rodents. This Rule is not met as evidenced by: Based on observation and interview, the facility was not free from rodents. The findings are: Observations on 10/12/18 between 9:20 am and 10:30 am revealed: -Black pellets approximately ¼ inch or less in length, and similar in size and shape to a grain of rice were observed in the following kitchen areas: -Bottom of sink base cabinet -3 base cabinet drawers to the right of the sink used for storage of cooking utensils -Utility closet perimeter along the base boards -Inside the kitchen island Interview on 10/12/18 the Group Home Manager Stated: -Overnight staff had reported seeing a mouse in the living room a couple of nights prior. -He had plans to purchase mouse traps on 10/12/18.	V 738		

ASAP
AUTISM SUPPORT AND PROGRAMS

Plan of Correction:
DHSR- Annual Survey 10/16/18
MHL # 071-034 (Lotus)

1. V105 27 G .0201 (A) (1-7): Governing Body Policies

- QP has completed an admission assessment on the resident who moved in, but had been strictly a day program participant.

2. V111 27 G .0205 (A-B): Assessment/Treatment/Habilitation Plan

- The day following the exit interview, QP looked through the individual's file and there were goals implemented on the day that he moved in which include residential goals for the individual's new placement. These goals were behind the most recent, updated goals and were not noticed. We are more than happy to send those.

3. V118 27 G .0209 (c): Medication Requirements

- Administration Assistant will file all discontinued orders from the physician, once received.
- Group Home Manager and assigned direct care staff will ensure MARs have been completed each shift.
- Group Home Manager and assigned direct care staff will ensure routine and non-routine medications will be given as prescribed by the physician.
- If the medication is a non-routine medication, the Group Home Manager will verbally tell direct care staff and will also send an email out to the staff team.

4. V133 G.S. 122C-80: Criminal History Check

- Documentation was emailed to the SBI 10/30/18 and will also be certified mailed by our Programs Director to begin the process of obtaining an official agreement with the SBI and FBI to process fingerprints with national background checks for staff who have not lived in N.C. for the last five years. Moving forward, the complete process will be conducted by the Programs Director.

5. V366 27 G .0603: Incident Response Requirements

- The QP and Executive Director will see that a Level II IRIS report is completed for any injury a participant gets that requires more than 1st Aid at the residence.

6. V367 27 G .0604: Incident Reporting Requirements

- The QP and Executive Director will see that all levels of IRIS reports are submitted within the 72hr timeframe.

7. V736 27 G .0303 (c): Facility and Grounds Maintenance

- Programs Director and Executive Director have met and are actively beginning needed improvements/replacements in the residence.

8. V738 27 G .0303 (d): Pest Control

- Programs Director set up a contract with a new pest control agency on 10/24/18. On 10/30/18 an employee of that new agency came to the property to assess the mouse situation, located where it/they were more than likely to enter the home, and set bait and traps to rid of any unwanted pests. We will continue to utilize this agency for our quarterly pest control and also if any other "pests" are seen/suspected.

Kimberly Hill, Executive Director

Kimberly Hill, Executive Director

Supporting people with Autism in Southeast N. Carolina

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

October 22, 2018

Kimberly Hill, Executive Director
Autism Support and Programs, Inc.
200 Island Creek Road
Rocky Point, NC 28457

Re: Annual, Complaint, and Follow up Survey completed October 16, 2018
Lotus, 224 Island Creek Road, Rocky Point, NC 28457
MHL # 071-034
E-mail Address: asap.kimberlyh@gmail.com
Intake #NC00141848

Dear Ms. Hill:

Thank you for the cooperation and courtesy extended during the annual, complaint, and follow up survey completed October 16, 2018. The complaint was unsubstantiated.

As a result of the follow up survey, it was determined that some 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

- Re-cited standard level deficiency.
- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Re-cited standard level deficiency must be ***corrected*** within 30 days from the exit of the survey, which is November 15, 2018.
- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is December 16, 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 Wendy Boone at 252-568-2744.

Sincerely,

Betty Godwin

Betty Godwin, RN, MSN
Nurse Consultant
Mental Health Licensure & Certification Section

Cc: Leza Wainwright, Director, Trillium Health Resources LME/MCO
Kim Keehn, Quality Management Director, Trillium Health Resources LME/MCO
File

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL071-034 Y1	A. Building B. Wing Y2	10/16/2018 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LOTUS	224 ISLAND CREEK ROAD ROCKY POINT, NC 28457

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 V0107	Correction	ID Prefix V0110	Correction	ID Prefix V0291	Correction
Reg. # 27G .0202 (A-E)	Completed	Reg. # 27G .0204	Completed	Reg. # 27G .5603	Completed
LSC	10/16/2018	LSC	12/18/2017	LSC	10/16/2018
ID Prefix V0521	Correction	ID Prefix V0525	Correction	ID Prefix	Correction
Reg. # 27E .0104(e9)	Completed	Reg. # 27E .0104(e17)	Completed	Reg. #	Completed
LSC	10/16/2018	LSC	10/16/2018	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
			Rick Adkins	10/19/18
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	☒ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/11/2017	☒ YES ☐ NO