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
	MHL026-857	A. BUILDING: _____ B. WING _____	R 11/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELITE CARE SERVICES AT MIDDLE RD	711 MIDDLE ROAD FAYETTEVILLE, NC 28302

(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 November 27, 2018. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.	V 000	RECEIVED By DHSR - Mental Health Lic. & Cert. Section at 8:14 am, Dec 14, 2018	
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.	V112	**Corrective Action** Consumer #4's PCP will be reviewed and updated to specifically address strategies to prevent the client from having further elopements. To prevent further elopements, staff will be trained on the revision and monitored for implementation by the Home Manager and QP on a weekly basis.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature], BS, CPSS, CSAC-R, QMHP — TITLE: Qualified Professional — (X6) DATE: 12/13/18

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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 audited clients (#4). The findings are: Review on 11/27/18 of client #4's record revealed: - 31 year old male. - Admission date of 02/28/17. - Diagnoses of Schizophrenia, Autism Spectrum Disorder, Cannabis Use Disorder and Alcohol Use Disorder. Review on 11/27/18 of client #4's Person-Centered Profile (PCP) dates 03/01/18 revealed: - "How Best To Support...Redirect [Client #4] when he talks about eloping from the facility and assist him in resolving the concerns that he expresses." - "Strategies for crisis response and stabilization...If [Client #4] elopes, walk with him and encourage his return. If he refused to accept staff's support and is away from the facility for 3 hours, call 911 to report him missing." - The PCP did not include any specific goals or strategies to address client #4's continued elopement from the day program or group home. Review on 11/27/18 of a level I facility incident report for client #4 dated 11/20/18 revealed: - He eloped from the day program. - Client #4 went to a local department store and called his mother. Review on 11/27/18 of facility communication logs revealed: - 11/07/18 - Client #4 eloped from the facility and was returned by the local police department.	V 112		

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V 112	Continued From page 2 - 11/08/18 - Client #4 eloped from the facility and was returned by the local police department. Interview on 11/26/18 client #4 stated: - He had resided at the group home for approximately 1 year. - He sometimes felt excluded from the other clients and would walk off from the group home. - He was not able to state any specific dates he eloped from the facility. Interview on 11/26/18 staff #1 stated: - He had worked at the facility for approximately 3 years. - Client #4 had a history of walking away from the facility. - Client #4 walked off about 2 weeks ago and the local police were involved. - Clients can leave for 3 hours and then police are called. - The local police seemed to request contact to their agency as soon as client #4 walked off. Interview on 11/26/18 staff #2 stated: - He had worked at the facility for approximately 3 years. - He provided 1:1 for client #4 at times. - Client #4 walked off from the facility at times. - The last two walk offs related to client #4 required police involvement. - The police would be called after client #4 was gone for 3 hours. - The police said they could not make client #4 return to the facility since he was his own guardian. Interview on 11/27/18 the Qualified Professional stated: - Client #4 had walked off from the facility. - He was aware the PCP needed to include	V 112		

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V 112	Continued From page 3 current and ongoing goals and strategies to address client #4's elopements. This deficiency constitutes a recited deficiency and must be corrected within 30 days.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to have fire and disaster drills held at least quarterly and repeated on each shift. The findings are: Review on 11/27/18 of facility records for 2018 revealed: - No documented fire or disaster drills from January 2018 thru June 2018. - No 3rd shift fire or disaster drills from July 2018 thru September 2018.	V114 **Corrective Action** It is the Policy of Elite Care Services to conduct Fire and Disaster Drills once a month on each shift. The documentation of the drills will be kept at the main office and a copy will be kept at the facility. The compliance and completion of the drills will be monitored by the home manager on a monthly basis and reviewed by the QP on a quarterly basis.		

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V 114	Continued From page 4 Interview on 11/26/18 client #1, #3 and #4 stated they had participated in fire and disaster drills at the facility. Interview on 11/27/18 the Qualified Professional stated: - 1st shift - 8am-4pm. - 2nd shift - 4pm-12 midnight. - 3rd shift - 12 midnight-8am. - He would obtain the documented fire and disaster drills from January 2018 thru June 2018. No additional documentation was received prior to end of survey.	V 114		
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 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;	**V118** **Corrective Action** By December 27th, 2018, Elite Care Services will ensure that going forward all medications will have a physicians' order in the consumer's chart to accompany prescribed medications as written. All staff will be trained on reading Physicians' Orders, Documentation, and MAR Reconciliation. MAR's, Documentation, and Administering medication will be monitored weekly by home manager and monthly by QP.		

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V 118	Continued From page 5 (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 review, observation and interview, the facility failed to administer medications on the written order of a physician and failed to keep the MARs current affecting three of three clients (#1, #3 and #5). The findings are: Finding #1: Review on 11/27/18 of client #1's record revealed: - 26 year old male. - Admission date of 12/18/17. - Diagnoses of Schizophrenia, Cannabis Use Disorder and Cocaine Use Disorder. Review on 11/27/18 of a phone order for client #1 dated 11/14/18 revealed: - Chlorhexadine 0.12% Rinse (antiseptic) - swish 1 capful by mouth twice daily. Review on 11/27/18 of client #1's physician orders revealed no signed order for Amoxicillin (antibiotic). Review on 11/27/18 of client #1's November 2018 MAR revealed:	V 118		

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V 118	Continued From page 6 - No transcribed entry for Chlorhexadine. - Administer Amoxicillin 500 milligrams (mg) - take 1 capsule every 8 hours (3 times a day). - Staff initials to indicate the Amoxicillin was administered every 12 hours (twice daily). Observation on 11/27/18 of client #1's medications at approximately 9:50am revealed: - One blister pack of Amoxicillin 500mg dispensed on 11/15/18. - 10 capsules left in the package. - Directions for administration-One capsule every 8 hours. Interview on 11/26/18 client #1 stated he received his medications daily as ordered. Finding #2: Review on 11/27/18 of client #3's record revealed: - 29 year old male. - Admission date of 09/11/17. - Diagnoses of Schizoaffective Disorder, Major Depressive Disorder, Mild Intellectual Developmental Disability and Gilbert Disease. - No order for Amitiza (treats chronic constipation) 24 micrograms - take 1 capsule twice daily. Review on 11/27/18 of a signed FL-2 for client #3 dated 11/6/18 revealed the following medications ordered: - Metoprolol (treats high blood pressure) 25 milligrams (mg) - take 1/2 tablet (12.5mg) twice daily. - Hydroxyzine (antianxiety) 25mg - one tablet daily at 3pm. Review on 11/27/18 of client #3's November 2018 MAR revealed: - Amitiza 24 micrograms - take 1 capsule twice daily. "DC (discontinue) handwritten and no staff	V 118		

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V 118	Continued From page 7 initials to indicate Amitiza was administered. - Metoprolol 25mg - take 1/2 tablet (12.5mg) twice daily. - Hydroxyzine (antianxiety) 25mg - one tablet daily at 3pm. "PRN (as needed)" handwritten on the transcribed entry. No staff initials to indicate the Hydroxyzine was administered. Interview on 11/26/18 client #3 stated: - He received his medications daily as ordered. Finding #3: Review on 11/27/18 of client #4's record revealed: - 31 year old male. - Admission date of 02/28/17. - Diagnoses of Schizophrenia, Autism Spectrum Disorder, Cannabis Use Disorder and Alcohol Use Disorder. - No signed physician order for Topamax (treats seizures) - 200mg - take one tablet daily. Review on 11/27/18 of client #4's September 2018 thru November 2018 MARs revealed the following transcribed entry: - Topamax - 200mg - take one tablet daily. - No staff initials to indicate the medication was administered. - No documentation the Topamax was discontinued Interview on 11/26/18 client #4 stated he received his medication as ordered. Interview on 11/27/18 the Qualified Professional stated: - He had requested medication orders from the pharmacy. - The facility had changed pharmacy's several months ago. - Staff #2 was currently responsible for the	V 118		

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V 118	Continued From page 8 medications at the facility. - He would follow up to ensure the MARs were reconciled with the current medication orders. 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 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court	**V291** **Corrective Action** By December 27th, 2018 Elite Care Services will inservice all staff & all consumers prescribed medication and availability. The home manager will monitor weekly and the QP monthly for compliance		

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V 291	Continued From page 9 or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record reviews, observation and interview, the facility failed to maintain coordination between the facility operator and the professionals who are responsible for the client's treatment, affecting one of three audited clients (#4). The findings are: Review on 11/27/18 of client #4's record revealed: - 31 year old male. - Admission date of 02/28/17. - Diagnoses of Schizophrenia, Autism Spectrum Disorder, Cannabis Use Disorder and Alcohol Use Disorder. Review on 11/27/18 of an electronic physician order for client #4 dated 04/28/18 revealed: - Albuterol Sulfate (Ventolin-treats bronchospasm) - inhale one puff every 4 hours as needed for wheezing or shortness of breath. Observation on 11/27/18 at approximately 11:00am revealed: - Client #4's medications revealed Ventolin inhaler with directions to administer every 4 hours as needed for wheezing or shortness of breath. - Client #4 did not have has Ventolin inhaler while he was out in the community. Interview on 11/27/18 the Qualified Professional stated: - Client #4 did not have the Ventolin inhaler with him while in the community. - He would follow up to ensure client #4 had his rescue inhaler in the event of shortness of breath	V 291		

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V 291	Continued From page 10 or wheezing.	V 291		
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 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	V367 **Corrective Action** By December 27th, 2018 Elite Care Services will inservice all staff IRIS reporting and documentation. All incidents will be reported required. Reporting will monitored by QP on a weekly basis.		

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V 367	Continued From page 11 (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 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	V 367		

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V 367	Continued From page 12 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) within 72 hours as required. The findings are. Review on 11/26/18 of the North Carolina Incident Response Improvement System revealed: - No documented level II incident reports for the past 3 months (September 2018 thru November 2018.) Review on 11/27/18 of client #4's record revealed: - 31 year old male. - Admission date of 02/28/17. - Diagnoses of Schizophrenia, Autism Spectrum Disorder, Cannabis Use Disorder and Alcohol Use Disorder. Review on 11/27/18 of a level I facility incident report for client #4 dated 11/20/18 revealed: - He eloped from the day program. - Client #4 went to a local department store and called his mother. Review on 11/27/18 of facility communication logs revealed: - 11/07/18 - Client #4 eloped from the facility and was returned by the local police department. - 11/08/18 - Client #4 eloped from the facility and	V 367		

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V 367	Continued From page 13 was returned by the local police department. Interview on 11/26/18 client #4 stated: - He had resided at the group home for approximately 1 year. - He sometimes felt excluded from the other clients and would walk off from the group home. - He was not able to state any specific dates he eloped from the facility. Interview on 11/26/18 staff #1 stated: - He had worked at the facility for approximately 3 years. - Client #4 had a history of walking away from the facility. - Client #4 walked off about 2 weeks ago and the local police were involved. - Clients can leave for 3 hours and then police are called. Interview on 11/26/18 staff #2 stated: - He had worked at the facility for approximately 3 years. - He provided 1:1 for client #4 at times. - Client #4 walked off from the facility at times. - The last two walk offs related to client #4 required police involvement. - The police would be called after client #4 was gone for 3 hours. Interview on 11/27/18 the Qualified Professional stated: - Client #4 had walked off from the facility. - He understood a Level II incident report should be generated when there was police involvement with clients at the facility. This deficiency constitutes a recited deficiency and must be corrected within 30 days.	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-857	A. BUILDING: _____ B. WING _____	R 11/27/2018

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V 736	Continued From page 14	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 observation and interview, the facility was not maintained in a clean, attractive and orderly manner. The findings are: Observation on 11/26/18 at approximately 5:00pm revealed: - The kitchen revealed a broken drawer and a cabinet door which would not close. - Client #1 and #2's bedroom revealed debris scattered throughout the carpet. A missing floor vent. A window blind bracket was broken and two broken slats. - Bathroom #1 had 3 of 6 light bulbs which worked. - The hallway carpet had bits of debris and trash on the carpet. - The living room revealed one of four lights which worked. A small bleach type stain on the carpet. - Client #5's bedroom revealed 2 broken dresser drawers. The mirror was not attached to the dresser. - The 2nd bathroom revealed 3 of 6 light bulbs worked. - Client #3's bedroom revealed 3 broken window slats. - The door frame leading to the office was broken.		**Corrective Action** By January 26th, all repairs as noted but limited to will be repaired and items replaced. The maintenance of the facility will be monitored by the home manager on weekly basis and by the QP on a monthly basis.	

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 736	Continued From page 15 Interview on 11/27/18 the Qualified Professional stated he had no questions regarding facility items discussed at exit of the survey.	V 736		