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
	MHL034-363	A. BUILDING: _____ B. WING _____	R 12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGWELL NETWORK, INC-INDEPENDENC	2001 INDEPENDENCE ROAD WINSTON-SALEM, NC 27106

(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 December 6, 2018. A deficiency was cited. This facility is licensed for the following service category: - 10A NCAC 27G .5600C: Supervised Living for Developmentally Disabled Adults	V 000	DHSR - Mental Health DEC 18 2018 Lic. & Cert. Section	
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 interview and record review, the facility staff failed to hold disaster drills at least quarterly, and repeated on each shift, under conditions that simulate an emergency. The findings are:	V 114	According to V 14 27G 0.0207 Emergency Plans and Supplies 10A NCAC 27G .0207 Emergency Plans and Supplies All group home facilities operated by Springwell Network, Inc. have developed a fire and disaster plan that will include such drills 1st, 2nd, and 3rd shifts during the week and weekend when residents are on site. These times will be include on the evacuation form. During the the week staff will conduct drills according to the following schedule. 1st shift during the week will be 6:00 am-9:00 am. 2nd shift 3:00 pm-9:30 pm and 3rd shift will 9:30 pm-6:00 am which will include deep sleep drills. On the weekend the staff will conduct drills 1st shift 6:00 am-3:00 pm; 2nd shift 3:00 pm-9:30 pm and 3rd shift 9:30 pm-6:00am which will also include	12/11/18

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V 114	Continued From page 1 Review on 12-5-18 of the folder that contained the drill logs revealed: - a form used by the facility with drill information that included: - blanks to indicate first, second and third shifts - no times delineating what hours constituted each drill shift - some drills were "unannounced" and some were "announced" - "announced" drills were not included in this survey - there was no disaster drill held on the: - first shift of the second, third or fourth quarter of 2018 - third shift of the second, third or fourth quarter of 2018 Interview on 12-4-18 with client #1, client #2 and client #3 revealed each remembered participating in drills, but could not remember when the last drill was held. Interview on 12-4-18 with the Group Home Manager/Supervisor (GHM/S) revealed: - she was responsible for insuring drills were held - more fire drills were held, than disaster drills Interview on 12-6-18 with the Qualified Professional (QP) revealed: - he was responsible for making sure each facility completed required drills - "They (GHM/S) all turn them (drill logs) in to me" - "I didn ' t look for what shift they were done,	V 114	a deep sleep drill. Supervisors of each group home facility will communicate with staff as to when drills will be conducted by written communication on calendar or through Therap electronic system on SCom. Supervisors will review evacuation form monthly to ensure all fire drills and disaster drills have been conducted. Qualified Professionals of group home facilities will include fire and disaster drills on monthly monitoring/ site visits to ensure such drills was conducted according to shifts.	12/11/18

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V 114	Continued From page 2 or the time" - "Now I know to ask them and record what shift" - " ...I ' ll have to add to my (Quality Assurance) report to capture all shifts; first, second and third" Interview on 12-6-18 with the Residential Director/Qualified Professional (RD/QP) revealed: - "we ' ll put the shift times on the forms, that ' s an easy fix" - "It ' s definitely the GHM/S ' s responsibility to make sure the drills are held" - "they should write it on the calendar -on the wall or the electronic communication." - "And the QP, when they go in for their site visits, that should be on their forms to insure that gets done during monthly monitoring."	V 114		

Springwell Network
Creating Pathways. Enriching Lives.

SPRINGWELL NETWORK, INC. SITE/ OBSERVATION CHECKLIST

Date of Visit: _____Time:_____ **Consumer: _____**

Services(s): _____ **Staff Present: _____**

Location: _____

Person conducting Site Visit: _____

SERVICE REVIEW	Excellent	Good	Fair	Poor	N/A
1. Are goals currently being monitored comparable to interventions outlined on PCP or ISP?					
2. Is there a current authorization for person served?					
3. Is the data being scored based on the service and frequency authorized?					
4. Has staff entered accurate data and comments when indicated for ISP Data/Tasks, T-Logs or S-Com, MAR, Personal Care Log, and that are relevant to PCP or ISP?					
5. Is the scoring method used accurately and comments useful in determining ability, progress, or lack of progress?					
6. Has fire drills and disaster drills been completed on appropriate shifts?					
7. Physician signature on all prescription orders?					
CONSUMER RELATIONS OBSERVATION					
1. Are consumer's privacy, space, and belongings respected?					
2. Are residents treated age-appropriately?					
STAFF OBSERVATION					
1. Are appropriate training materials used when needed? For medication administration, are appropriate procedures used?					
2. Does staff relate to consumers by using appropriate language and demonstrating good rapport, choice making and independence?					
3. Is cultural preference of the individual observed and utilized?					

Positive Observations/Comments:

_____

_____

_____

Corrections/Improvements Needed:

Recommendations:

Staff being Monitored Signature and Title Date

Supervisor/QP Signature and Title Date

Springwell Network, Inc.

EMERGENCY PREPAREDNESS DRILL

Name of Program/Group Home_____
Adress:_____

1st(6am-9am)____ weekend 1st shift (6am-3pm)____ 2nd shift (3pm-9:30pm)_____ 3rd shift (9:30pm-6am)___

Unannounced Announced

Check type of drill performed:

Fire Bomb Tornado Hurricane Power Outage Intruder Med. Emergency Violent Situations

Date:_____ **Time**_____ **AM or PM (Circle one)**

Names of Staff Present_____

Names of Individuals Present(First name &Last initial only)

Time of Drill concluded_____ **Total drill time**_____

Descriptions of Process(i.e. problems, concerns etc)_____

Signature of staff member implementing drill_____

Name of Program/Group Home_____
Adress:_____

1st(6am-9am)____ weekend 1st shift (6am-3pm)____ 2nd shift (3pm-9:30pm)_____ 3rd shift (9:30pm-6am)___

Unannounced Announced

Check type of drill performed:
Fire Bomb Tornado Hurricane Power Outage Intruder Med. Emergency
Violent Situations

Date:_____ **Time**_____ **AM or PM (Circle one)**

Names of Staff Present_____

Names of Individuals Present(First name &Last initial only)

Time of Drill concluded_____ **Total drill time**_____

Descriptions of Process (i.e. problems, concerns etc)_____

Signature of staff member implementing drill_____

Rev. 12/18

Springwell Network, Inc.

EMERGENCY PREPAREDNESS DRILL

Name of Program/Group Home_____
Adress:_____

1st(6am-9am)____ weekend 1st shift (6am-3pm)____ 2nd shift (3pm-9:30pm)_____ 3rd shift (9:30pm-6am)___

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Names of Individuals Present(First name &Last initial only)

Time of Drill concluded_____ **Total drill time**_____

Descriptions of Process(i.e. problems, concerns etc)_____
_____

Signature of staff member implementing drill_____

Name of Program/Group Home_____
Adress:_____

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Violent Situations

Date:_____ Time_____ AM or PM (Circle one)

Names of Staff Present_____

Names of Individuals Present(First name &Last initial only)

Time of Drill concluded_____ **Total drill time**_____

Descriptions of Process (i.e. problems, concerns etc)_____
_____

Signature of staff member implementing drill_____

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL034-363 (Y1)	A. Building B. Wing (Y2)	12/6/2018 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGWELL NETWORK, INC-INDEPENDENCE ROAD GROUP HO	2001 INDEPENDENCE ROAD WINSTON-SALEM, NC 27106

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 V0108 Reg. # 27G .0202 (F-I) LSC	Correction Completed 12/06/2018	ID Prefix V0110 Reg. # 27G .0204 LSC	Correction Completed 12/06/2018	ID Prefix V0112 Reg. # 27G .0205 (C-D) LSC	Correction Completed 12/06/2018
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE 12-6-18
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/16/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: TNH112

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

December 11, 2018

Charlene Warren
Springwell Network, Inc.
3820 North Patterson Avenue
Winston-Salem, North Carolina, 27105

Re: Annual and Follow-Up Survey Completed December 6, 2018
Springwell Network, Inc.-Independence Road Group Home, 2001 Independence Rd. Winston-Salem, NC. 27106
MHL# 034-363
E-mail Address: cwarren@grphms.com
rrolle@grphms.com

Dear Ms. Warren:

Thank you for the cooperation and courtesy extended during the Annual and Follow-Up Survey Completed December 6, 2018.

As a result of the Follow-Up Survey, it was determined that all of the previous deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. An additional deficiency was cited during the survey.

Enclosed you will find the deficiency 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 the 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 deficiency found, the time frames for compliance, plus what to include in the Plan of Correction.

Type of Deficiencies Found

- The tag cited was a standard level deficiency.

Time Frames for Compliance

- The standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is February 4, 2019.

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 Barbara Perdue at (336) 861-6283.

Sincerely,

Scott M. Walton, LCSW, CI/I
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: Trey Sutten, Interim Director, Cardinal Innovations LME/MCO
Onika Wilson, Quality Management Director, Cardinal Innovations LME/MCO
File