STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL084-069	A. BUILDING: _____ B. WING _____	12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND STREET HOME	242 N SECOND STREET ALBEMARLE, NC 28001

(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 12/3/18. The complaint was substantiated (intake #NC145412). 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		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL084-069	A. BUILDING: _____ B. WING _____	12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND STREET HOME	242 N SECOND STREET ALBEMARLE, NC 28001

(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 109	Continued From page 1 plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on records review, observations and interviews, the facility failed to ensure 1 of 1 Qualified Professional demonstrated competency for the population served. The findings are: Cross Referenced: 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN V112 Based on records review, observations and interviews, the facility failed to ensure strategies were developed and implemented to address client needs affecting 1 of 3 clients (#1). Review on 11/20/18 of the Qualified Professional's personnel record revealed: -hire date of 10/8/09 with job title of Team Lead/Qualified Professional(TL/QP); -documentation of completed trainings in Overview in Mental Health dated 8/17/15, Trauma Informed Care 7/29/16, Coordination of Care 10/11/17, Getting It Right 11/20/18, Psychotropic Medications 8/17/15, Client Rights 6/22/18 and Confidentiality 6/21/17. Interview on 11/30/18 with the TL/QP revealed: -started as TL/QP for this facility in early 2/2018; -getting to know client #1; -Residential Manager(Res Mgr) was new when	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL084-069	A. BUILDING: _____ B. WING _____	12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND STREET HOME	242 N SECOND STREET ALBEMARLE, NC 28001

(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 109	Continued From page 2	V 109		

client #1 burnt himself in 9/2018;
-have 2 staff on second shift, one staff awake on third shift;
-third shift staff check on clients, if staff hear a noise, staff go knock on client's bedroom door and check;
-if client displays a deterioration in mental health status, take client to see psychiatrist or therapist;
-if client displaying "slew"of SIBs(self-injurious behaviors), put a safety plan in place;
-safety plan specific to client, notify staff, staff follow;
-held a meeting to plan client #1's discharge from the hospital on 5/22/18 after he burnt himself the first time;
-the treatment team met and discussed client #1's status;
-client #1 was less delusional, less disorganized, ready to return back to the facility;
-do not remember discussing client #1's SIBs;
-agreed at this meeting on 5/22/18 facility staff will continue to monitor and report any unusual behaviors to the Res Mgr or the TL/QP;
-decision was made not to update goals or crisis plan of treatment plan in place at time of client #1 discharge from hospital on 5/22/18;
-do not remember a conversation about "natural consequences;"
-current treatment plan effective in 8/2018, SIBs not identified as an issue;
-now that client #1's SIBs happened again, will be highlighted in next treatment plan;
-did not update goals and strategies to address client #1's SIBs.

Review on 11/30/18 of a Plan of Protection dated 11/30/18 and completed by the Director of Program Operations(DPO) revealed the following documented:
- "What will you immediately do to correct the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL084-069	A. BUILDING: _____ B. WING _____	12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND STREET HOME	242 N SECOND STREET ALBEMARLE, NC 28001

(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 109	Continued From page 3 above rule violations in order to protect clients from further risk or additional harm? On 11/30/18 the [TL/QP] received formal training on clinical follow up to address threats of and attempts of self harm which should be incorporated into the individual treatment plans, crisis plans, and re-assessments after hospitalizations. A review of all treatment plans and/or crisis plans will be completed by the DPO. By 12/2/18, staff will be trained in the event of evidence of unusual or self harming behaviors, staff will report behaviors to the supervisor immediately in order to ensure the safety of all individuals in the house. If self-harming behaviors are threatened or occur, enhanced staffing will be provided. The treatment plans and crisis plans will be reviewed and revised as necessary to include enhanced staffing, reporting of behaviors and ensuring health and safety;" -"Describe your plans to make sure the above happens. The [TL/QP] will review all residents treatment plans to ensure that the health, safety and services provided to all individuals are accurate and will addendum current treatment plans as needed. The [TL/QP] will review treatment plans through gathering person's specific behaviors and symptoms to be added to all plans for implementation. The [TL/QP] will develop strategies for crisis plans to address health and safety issues as well as issues of self harm behaviors as needed per individual. The crisis plan will also address the monitoring, support and prevention of any behaviors that would impact the health and safety of individuals. The [TL/QP] and/or [Res Mgr] will train support staff on the treatment plans and crisis plans for prevention of reoccurring that would impact the health and safety of individuals. Any need for increased staffing will be addressed in the treatment plans, addendums, and/or crisis plans	V 109		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL084-069	A. BUILDING: _____ B. WING _____	12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND STREET HOME	242 N SECOND STREET ALBEMARLE, NC 28001

(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 109	Continued From page 4	V 109		

for each individual to allow support for any unusual precursor behaviors that are being identified to lessen further decompensation of each individual. The [TL/QP] or the [Res Mgr] will in-service all staff on addendums of individuals' plans and strategies for the crisis plans through delivery of services as well as meet the competency and practice of service delivery of DHHS."

Client #1 has a diagnoses of Schizophrenia with delusions, auditory hallucinations, paranoia, disorganized thinking, social withdrawal and history of banging his head resulting in head trauma. A treatment plan and crisis plan dated 9/27/18 did not document self injurious behaviors (SIBs) as an identified need. On 4/27/18, client #1 burnt his left forearm with a cigarette lighter he had in his possession and expressed suicidal ideation. This incident resulted in first and second degree burns on client #1's left arm and an inpatient hospitalization from 4/27/18 until 5/22/18. Upon discharge back to the facility on 5/22/18, the treatment plan and crisis plan dated 9/27/18 were not updated with strategies to address client #1's SIBs. Client #1 continued to maintain possession of his cigarette lighters in his room. A new treatment plan dated 8/30/18 again did not document any strategies for client #1's SIBs. During the months of August 2018 and September 2018, client #1 exhibited increased mental health symptoms and residential staff documented their concerns as well as expressed their concerns to the TL/QP. On 9/17/18, client #1 burnt both forearms with his cigarette lighter while at the facility and as a result, was hospitalized where he remained as of 11/30/18. Client #1's burns were severe second degree, became infected, required ongoing wound care and had not healed as of 11/28/18. The poor decision

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL084-069	A. BUILDING: _____ B. WING _____	12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND STREET HOME	242 N SECOND STREET ALBEMARLE, NC 28001

(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 109	Continued From page 5 making by the TL/QP to not develop and implement strategies to address SIBs resulted in serious harm and neglect of client #1. This constitutes a Type A1 rule violation and must be corrected within 23 days. An administrative penalty of $5,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance.	V 109		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL084-069	A. BUILDING: _____ B. WING _____	12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND STREET HOME	242 N SECOND STREET ALBEMARLE, NC 28001

(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 112	Continued From page 6 This Rule is not met as evidenced by: Based on records review, observations and interviews, the facility failed to ensure strategies were developed and implemented to address client needs affecting 1 of 3 clients (#1). The findings are: Review on 11/19/18 of client #1's record revealed: -admission date of 10/5/17 with diagnosis of Schizophrenia, Hyperlipidemia, Hypertriglyceridemia, Hypertension, Type 2 Diabetes, Gastroesophageal Reflux, Vitamin D deficiency and Chronic Back Pain; -legal guardian(LG) is Department of Social Services -discharge summary from a state psychiatric hospital dated 10/4/17 documented client #1 was admitted on 9/18/15, had 16 prior inpatient psychiatric hospitalizations, was paranoid, had delusions, was confused a lot, paces a lot, has a history of alcohol use and smoking cigarettes; -Comprehensive Clinical Assessment dated 10/25/17 documented client #1 had been in state hospitals a total of 8 years, was easily distracted, had difficulty completing tasks, disorganized, depressed mood, social withdrawal, agoraphobia, compulsive behaviors, hit head which resulted in head trauma, pressured speech, passive, distractible thoughts, attempted to cheek his medications, impaired judgement; -treatment plan dated 9/28/17 documented the following goals: adapt to living in the community by following house guidelines and completed household chores, take all medications as prescribed and meet with his psychiatrist as	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL084-069	A. BUILDING: _____ B. WING _____	12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND STREET HOME	242 N SECOND STREET ALBEMARLE, NC 28001

(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 112	Continued From page 7	V 112		

needed to monitor mental health;
-staff strategies documented in treatment plan dated 9/28/17 included providing assistance and guidance as needed for independent living skills, provide at least one opportunity per day to discuss any issues or concerns, provide redirection as needed, ensure client #1 attends all his appointments, provide support at appointments, order and maintain adequate supply of medications, provide supervision and guidance during medications administration, provide information to doctors for medication consistency.

Review on 11/19/18 of incident reports revealed an incident report dated 4/27/18 regarding client #1 documented the following:
-client #1 went downstairs to smoke on the porch;
-was outside longer than normal, staff went outside to check on client #1;
-client #1 had burnt his left lower arm with his cigarette lighter;
-client #1 reported he burnt himself because he wanted to leave the group home;
-EMS(emergency medical services) were called and client #1 was transported to the local emergency room(ER);
-client #1 was admitted for inpatient psychiatric treatment;
-client #1 was discharged on 5/22/18 back to the facility.

Review on 11/20/18 of a support summary for the month of May 2018 completed by the Team Lead/Qualified Professional (TL/QP) dated 6/7/18 revealed the following documented:
-client #1 was hospitalized for psychiatric treatment after burning his left forearm on 4/27/18;
-was released on 5/22/18;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL084-069	A. BUILDING: _____ B. WING _____	12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND STREET HOME	242 N SECOND STREET ALBEMARLE, NC 28001

(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 112	Continued From page 8 -appeared somewhat stable upon discharge; -after being home a couple of days, he went back to the ER for threats to harm himself again; -he was released back home after a tele-evaluation; -while at the ER he did not express or show any signs of harming himself; -his goals will continue to be implemented (no changes/updates noted to include self injurious behaviors). Review on 11/19/18 of a treatment plan dated 8/30/18 revealed the following documented: -goals included work on completion of chores independently, with supervision take medications daily and increase vocational skills by participating in work assignments at his day program; -staff strategies included providing guidance and assistance, provide opportunities at least once a day to discuss any issues or concerns, provide redirection as needed, ensure he attends all appointments, provide supervision with medication administration, assist in identifying possible appropriate activities, provide transportation; -crisis plan addressed increase in symptoms, self isolation, loss of focus, laughs inappropriately, becomes more disorganized; -no documentation of any strategies to address self harm such as burning himself. Review on 11/19/18 of progress notes and medication management documentation for client #1 from 8/1/18 through 9/17/18 revealed the following: -8/16/18 medication management note completed by client #1's psychiatrist documented staff expressed concerns about client #1's behaviors, not sleeping, increase in hallucinations, awake for	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL084-069	A. BUILDING: _____ B. WING _____	12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND STREET HOME	242 N SECOND STREET ALBEMARLE, NC 28001

(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 112	Continued From page 9	V 112		

days, somatic concerns, increased one of his medication;
-9/8/18 progress note client #1 up and down all night, paced inside and outside, yelled at staff, said hearing voices, staff concerned;
-9/9/18 progress note client #1 reporting hearing voices a lot, hallucinations also, expressed concern about being harmed, staff expressed all concerns to immediate supervisor;
-9/10/18 progress note client #1 said he wanted to go to the hospital, in a rage, Residential Manager(Res Mgr) came, took client #1 to hospital at 1:00am, returned to facility at 7:20am;
-9/11/18 medications management note completed by client #1's psychiatrist documented staff reported client #1 not sleeping, at times aggressive, paranoid, auditory hallucinations, did not want to leave with staff, accused staff of having a snake in her private area, increased a second medication;
-9/14/18 progress note 11pm-8am client #1 smoking, pacing a lot, clutching chest, complaining of chest pain, said going to pour scalding water over his head, taken to the ER, evaluation and released back to the facility;
-9/15/18 progress note client #1 caught trying to cheek his medications.

Review on 11/20/18 of an incident report dated 9/17/18 regarding client #1 revealed the following documented:
-client #1 came downstairs and reported to staff his lungs collapsed during the night;
-he then showed staff his right forearm with a burn down the middle, reported he did this with his personal cigarette lighter;
-staff notified Res Mgr and client #1 transported to local ER;
-client #1 was admitted on 9/17/18 to the hospital to be evaluated for his psychosis and medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL084-069	A. BUILDING: _____ B. WING _____	12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND STREET HOME	242 N SECOND STREET ALBEMARLE, NC 28001

(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 112	Continued From page 10 review. Interview on 11/20/18 with client #1's LG revealed: -has concerns with the supervision client #1 received at the facility; -he burnt both arms this time; -after first time he burnt his arm, there was discussion about taking away his lighters and cigarettes; -decided to not take these things away as everyone felt he would not do it again, a better alternative was "natural consequences;" -not aware of any strategies or interventions added to client #1's treatment plan to address self-harm; -do not remember any kind of safety plan or crisis plan addressing self-harm; -the Res Mgr was new and came 2 weeks before client #1 burned himself the most recent time; -this time, the burns got infected and required more treatment; -client #1 still in the hospital. Interview on 11/20/18 with staff #2 revealed: -works third shift on the weekends Friday and Saturday night; -sent client #1 out to the ER on the night of 9/15/18 for making statements he was going to hurt himself, pour scalding water over his head; -this was right before he burnt himself this last time on 9/17/18; -client #1 was also talking about his insides were trying to come out on the outside; -very concerned about client #1's behaviors; -expressed her concerns to the TL/QP; -"Any time any one of them threaten self-harm, I will act, send them out, I am not going to wait around to see if things get better;" -not aware of any strategies or interventions to	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL084-069	A. BUILDING: _____ B. WING _____	12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND STREET HOME	242 N SECOND STREET ALBEMARLE, NC 28001

(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 112	Continued From page 11	V 112		

address his self-harm;
-client #1 did not return to the facility during her shift.

Interview on 11/20/18 with staff #1 revealed:
-work second shift from 2pm-12am;
-on the night client #1 most recently burnt himself, worked a double shift and worked third also;
-client #1 burnt himself in April and spent time in the hospital;
-burnt himself again in September with his lighter;
-client #1 smokes, keeps his own lighters;
-not aware of any time he was not able to keep his own lighters;
-it was early in the morning between 4am-5am client #1 came downstairs and showed her his arm;
-she was in shock, called Res Mgr and their on-call staff, taken to ER;
-not aware of any strategies or interventions addressing client #1's self-harm;
-was not told how often to check on clients at night;
-put in her progress notes about client #1's delusions and paranoia;
-client #1 still in hospital.

Interview on 11/30/18 with the Res Mgr revealed:
-was hired on 8/27/18;
-had a week of training then started at the facility;
-had been on the job for two weeks and client #1 burned himself;
-not aware of any strategies to deal with client #1's self-harm;
-client #1's symptoms appeared to be increasing, "worse in his psychosis."

Review on 11/28/18 of hospital medical records for client #1 from the local ER dated 4/27/18 revealed the following documented:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL084-069	A. BUILDING: _____ B. WING _____	12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND STREET HOME	242 N SECOND STREET ALBEMARLE, NC 28001

(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 112	Continued From page 12 -second degree burn of left forearm, thoughts of self-harm; -"EMS called out to group home facility d/t(due to) self inflicted burn to left forearm by a lighter;" -"He told staff he was trying to burn his genitals. He told [hospital physician] that he was trying to set himself on fire due to not liking his medications;" -"He states he continues to have thoughts of harming himself. 'I have problems being self harmful';" -"patient stated that he was still feeling suicidal and did not feel comfortable returning to the group home because he thought he would still attempt to hurt himself;" -"It was then determined that patient should continue involuntary committal..." Review on 11/28/18 of hospital medical records for client #1 from the local ER dated 9/17/18 revealed the following documented: -"...presents to the emergency room with a staff member from [parent agency] with complaints of suicidal ideation. [Client #1] inflicted burns to bilateral arms utilizing his lighter. [Client #1] states 'I wanted to burn my arms off;" -"first to second degree burns noted to left and right arms. [Client #1] has a cross-like appearance burn to the left medial arm. [Client #1] has a vertical burn to the posterior aspect of the left arm. [Client #1] also has an anterior to medial right first to second degree burn to the right arm;" "After evaluation [client #1] from a clinical standpoint due to self-inflicted injury and reports of wanting to harm himself or kill himself [physician] will place [client #1] under IVC paperwork...will irrigate the wounds apply antibiotic ointment and place a moist to dry dressing."	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL084-069	A. BUILDING: _____ B. WING _____	12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND STREET HOME	242 N SECOND STREET ALBEMARLE, NC 28001

(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 112	Continued From page 13 Review on 11/28/18 of local hospital medical records for client #1 from 9/17/18-9/26/18 revealed: -admission date of 9/17/18 with discharge date of 9/26/18 to behavioral health hospital; -9/22 noticed to have a large amount of swelling and some redness to left arm, burns to left arm not draining, reported pain in left arm; -9/25 4:10am increased swelling in left upper extremity from elbow to hand, will start on antibiotics. Review on 11/28/18 of behavioral health hospital records for client #1 from 9/26/18-11/1/18 revealed: -admission date of 9/26/18 with discharge date of 11/1/18 to medical hospital for wound care; -burns: left outer arm measured at 18.5 cm(centimeters) X 4cm, area has pink edges with red and yellow drainage, left inner arm measured at 13cm X 7cm with yellow drainage and pink edges, right arm measured at 14cm X 3cm with yellow drainage; -[client #1] reported bilateral arm pain 5/10; -on 11/1/18 client #1 was observed having unsteady gait, slow response to questions, difficulty staying alert; -stated feeling sick, wanting to lay down, had diarrhea and vomited; -sent client #1 to main medical hospital for evaluation. Review on 11/28/18 of main medical hospital records for client #1 from 11/1/18-11/7/18 revealed: -admission date of 11/1/18 with discharge date of 11/17/18 back to behavioral health hospital; -principal diagnosis: Sepsis, may be spread of arm wound infections as no other source or	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL084-069	A. BUILDING: _____ B. WING _____	12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND STREET HOME	242 N SECOND STREET ALBEMARLE, NC 28001

(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 112	Continued From page 14	V 112		

cause identified;
-bilateral arm pain, cellulitis of left arm, cellulitis of right arm;
-given several antibiotics and continued dressing of wounds and ointment.

Review on 11/28/18 of medical records from the wound care clinic for client #1 from 10/12/18-11/16/18 revealed:
-burn wounds to both arms self inflicted, burns one month old;
-presents with 3 open wounds that have been present for approximately one month;
-wound #1 is open,second degree burn, located right forearm, large amount of serosanguineous(blood and liquid) drainage noted, large amount of necrotic(premature death of cells) tissue within the wound bed, surrounding wound skin color noted with erythema (reddening of skin);
-wound #2 is open, second degree burn, located left forearm, large amount of serosanguineous drainage noted, large amount of necrotic tissue within the wound bed, surrounding wound skin color noted with erythema;
-wound #3 is open, second degree burn, located on left medial forearm, large amount of serosanguineous drainage noted, large amount of necrotic tissue within the wound bed;
-"There appears to be deep second-degree burns;"
-10/12/18: small burn debridement procedures completed on all three wounds;
-10/19/18: open debridement done on both arms after topical anesthesia on all wounds, removed slough from the burn wounds on both forearms;
-10/26/18: open wounds, ulcer cleansing, topical anesthetic applied, silvadene cream, dressings;
-11/9/18: open wounds, ulcer cleansing, topical anesthetic applied, silvadene cream, dressings;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL084-069	A. BUILDING: _____ B. WING _____	12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND STREET HOME	242 N SECOND STREET ALBEMARLE, NC 28001

(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 112	Continued From page 15 -11/16/18 open wounds, ulcer cleansing, topical anesthetic applied, silvadene cream, dressings. Observation on 11/28/18 at approximately 2:00pm of client #1 at the behavioral health hospital revealed: -hospital staff in process of changing client #1's dressings on his arms; -both arms bandaged from wrists to elbows. Interview on 11/28/18 with client #1's physician revealed: -first and second degree burns on both arms; -per client #1, did with the flame from a lighter; -client #1 reported he had lighters in his possession; -client #1 reported he wanted to burn himself on his arms, chest and penis; -reported to hospital staff he stopped burning himself because he ran out of lighter fluid; -concerns with supervision at the facility; -had to send to main hospital due to burns becoming infected; -burns are still weeks away from healing; -"pretty awful burns...amazing didn't need grafting." Interview on 11/28/18 with client #1 revealed; -burned his arms with cigarette lighters; -had three lighters in his possession; -kept lighters in his dresser drawer in his room; -"always kept" his lighters there; -staff never took his lighters from him; -does not remember burning himself before; -he was in his room when he burned himself with his lighter this time; -took two hours to burn his arms; -nobody checks on him once he goes to his room at night; -nobody came upstairs to check in him the night	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL084-069	A. BUILDING: _____ B. WING _____	12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND STREET HOME	242 N SECOND STREET ALBEMARLE, NC 28001

(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 112	Continued From page 16 he burnt himself; -staff was downstairs in the living room; -went downstairs and showed staff his arms; -did not burn any other part of his body. This deficiency is cross referenced into 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS V109 for a Type A1 rule violation and must be corrected within 23 days.	V 112		
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; (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	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL084-069	A. BUILDING: _____ B. WING _____	12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND STREET HOME	242 N SECOND STREET ALBEMARLE, NC 28001

(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 118	Continued From page 17 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 records review, observations and interviews, the facility failed to ensure medications were administered on the on the written order of a person authorized by law to prescribe drugs and failed to ensure the MARs were kept current affecting 1 of 3 clients (#3). The findings are:] Review on 11/19/18 of client #3's record revealed: -admission date of 7/15/14 with diagnosis of Schizophrenia, Antisocial Personality Disorder and Borderline Intellectual Functioning; -admitted to inpatient hospital on 9/1/18 and then discharged back to the facility on 9/23/18; -physicians' orders dated 2/19/18 for Ipratropium spray under tongue for drooling and discontinue (D/C) order dated 9/24/18; -physicians' orders dated 2/19/18 and 9/28/18 for Polyethylene Glycol once as day as needed; -physicians' orders dated 2/19/18 and 10/4/18 for Lumigan eye drops each eye twice daily; -physician's order dated 10/3/18 for Visine Eye Drops as needed; -physician's order dated 9/24/18 for Timolol maleate eye drops each eye twice daily. Observation on 11/20/18 at 1:30pm of client #3's medications on site revealed: -Ipratropium spray under tongue for drooling not	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL084-069	A. BUILDING: _____ B. WING _____	12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND STREET HOME	242 N SECOND STREET ALBEMARLE, NC 28001

(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 118	Continued From page 18 on site; -Polyethylene Glycol once as day as needed dispensed 11/6/18; -Lumigan eye drops each eye twice daily not on site; -Visine Eye Drops as needed dispensed 10/3/18; -Timolol maleate eye drops each eye twice daily dispensed 11/13/18. Review on 11/20/18 of client #3's MARs from 9/1/18-11/20/18 revealed: -Ipratropium spray under tongue for drooling not listed on 9/2018 and 10/2018 MARs; -Polyethylene Glycol once as day as needed not listed on 9/2018 and 10/2018 MARs; -Lumigan eye drops each eye twice daily not not listed on 9/2018 and 10/2018 MARs; -Visine Eye Drops as needed not listed on 10/2018 MAR; -Timolol maleate eye drops each eye twice daily not listed on 9/2018 and 10/2018 MARs. Interview on 11/20/18 with Residential Manager revealed: -Ipratropium last does used this am, refill being delivered this pm; -unsure why as needed medications not listed on 9/2018 and 10/2018 MARs. Interview on 11/20/18 with staff #1 revealed: -client #3 was discharged from hospital on 9/23/18; -handwrote new MAR to reflect all medication changes made in hospital; -not sure why as needed medications and other medications were left off of MARs; -went by D/C summary from the hospital to get current medications; -client #3 got all his medications.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL084-069	A. BUILDING: _____ B. WING _____	12/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECOND STREET HOME	242 N SECOND STREET ALBEMARLE, NC 28001

(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 118	Continued From page 19 Interview on 11/20/18 with the Team Lead/Qualified Professional revealed: -not sure why as needed medications did not make it on the MARs; -will ensure when clients get back from hospital stays, medications are correctly changed and transcribed on MARs.	V 118		