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
	MHL033-052	A. BUILDING: ___ B. WING ___	R 12/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMEONE DOES CARE	601 WEST WALNUT STREET TARBORO, NC 27886

(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 survey was completed on 12/7/18. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Developmental Disabled Adults	V 000		
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	DHSR-Mental Health DEC 2 7 2018 Lic. & Cert. Section	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE administrator (X6) DATE 12/24/2018

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMEONE DOES CARE	601 WEST WALNUT STREET TARBORO, NC 27886

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure one of three audited clients (#2) treatment plan was reviewed annually and revised. The findings are: Review on 12/7/18 of client #2's record revealed: - admitted 5/15/19 - diagnoses of Schizophrenia & Moderate Intelluctual Developmental Disability - last treatment plan was dated June 2017 - no current treatment plan to update his health status - a 11/20/18 physician consultation "urology colonscopy...5 pound weight gain...next study 2028...will continue to monitor..." During interview on 12/7/18 staff #1 reported: - client #2 has lost weight - his physicians are aware of his weight lost and client #2 being unstable - he has walked off balance for the last month - he has only fallen one time - she monitors client #2 at all times - he likes to go to his bedroom and pull clothes out of his closet...he fell yesterday in his bedroom - she currently worked with him on not pulling clothes out of his closet During interview on 12/7/18 the Licensee reported: - client #2 had lost some weight - he has a good appetite - his balance has been off since October 2018... he has fallen only one time and that was yesterday - his physician has ran several test and has not found anything healthwise - she will have the Qualified Professional	V 112	Someone Does Care administrator has attached Client #2 updated treatment plan to support the corrective action for the Plan of Correction. Client #2 is closely been monitered. His balance has improve, he is stronger, and he also has an appointment with his primary physician on 12/27/2018.	

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V 112	Continued From page 2 complete & revise client #2's treatment plan	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 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.	V 118		

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V 118	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure one of three audited clients (#2) medications were administered on the written order of a physician and failed to ensure medications administered were recorded immediately after administration for two of three audited clients (#1 & #5). The findings are: Review on 12/7/18 of client #1's record revealed: - admitted to the facility on 3/8/17 - diagnoses of Intermittent Explosive Disorder; Moderate Intellectual Developmental Disability & Anxiety Disorder - a physician's order dated 10/24/18: Ativan 1mg: 1 tab under the tongue three times (TID) a day (can treat seizure and anxiety disorder) Review on 12/7/18 of client #2's record revealed: - admitted 5/15/19 - diagnoses of Schizophrenia & Moderate Intellectual Developmental Disability - a FL2 dated 4/6/18: Diphenhydramine 50mg bedtime - a 10/9/18 physician consultation: discontinue Diphendydramine (can treat pain and itching caused by insect bites...insomnia) Review on 12/7/18 of client #5's record revealed: - admitted to the facility on 5/2/14 - diagnosis of Schizoaffective Disorder; Mild Intellectual Developmental Disability; Obesity; Hypertension and Obstructive Sleep Apnea - a physician order dated 5/29/18: Dicyclomine 20mg (can treat irritable syndrome) & a physician order dated Ativan .5mg TID (can treat seizure and anxiety disorder) 1. The following is an example of how a physician's order was not followed:	V 118	Someone Does Care administrator is sub mitting documents to support the corrective actions and traing from the nurse to support the correction. moving forward the individual that transport a consumes to their appointment will be the be the one to complete the paper trail from the beginning of the appointment until the end of the appointment. this will include the completion of any medication changes, obtaining the D/C order	

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V 118	Continued From page 4 Review on 12/7/18 of client #2's October, November and December 2018 MARs revealed: - the Diphendydramine was administered daily all three months from 10/9/18 to current 2. The following are examples of how staff failed to record immediately after administration: A. Review on 12/7/18 of client #1's November 2018 MAR revealed: - Ativan was to be administered TID a day: 8am; 12pm and 8pm - the Ativan was initialed at 8am & 8pm but not at 12pm for the entire month Review on 12/7/18 of client #5's December 2018 MAR revealed: - Ativan was to be administered TID a day: 8am; 12pm and 8pm - the Ativan was initialed at 8am & 8pm but not at 12pm for the entire month - at 12:20pm the Dicyclomine had already been initialed by staff for the 4pm dose During interview on 12/7/18 staff #1 reported: - she reviewed the MARs daily - the MARs not being initialed was an oversight on her part During interview on 12/7/18 the Licensee reported: - she has a facility nurse that comes once a month to review the MARs - the nurse came last week - the staff are forgetting to sign the noon dose for the client's medications - staff that take the clients to their physician appointments are responsible for the updates - if a medication was discontinued at the	V 118	removing the old medication from the Mar, and adding the new medication to the MaR. There has also been a request for the nurse to review the doctor order sheet as well as the Mar, and the Medication	

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V 118	Continued From page 5 appointment, staff are suppose to write discontinue on the MARs - she usually reviewed any notes from the nurse's visits but she has not reviewed any notes for the month of December 2018 "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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
	[illegible]

Name:

Allen Crawford's **PERSON-CENTERED PROFILE**

Name:	**DOB:**	**Medicaid ID:**	**Record #:**
(Non - CAP-MR/DD Plans ONLY) **PCP Completed on:** 12/10/2018	(CAP-MR/DD Plans ONLY) **Plan Meeting Date:** / /	**Effective Date:** / /	

WHAT PEOPLE LIKE AND ADMIRE ABOUT….

"I like to help"

kes to help out with household chores"

WHAT'S IMPORTANT TO….

Being cared for and going into the community.

HOW BEST TO SUPPORT….

Keeping busy is very important. needs to feel that his is safe, cared for, and that others have his best interests in mind.

ADD WHAT'S WORKING / WHAT'S NOT WORKING

has been able to remain in the community setting and continues to reside in the group home, (Someone Does Care, LLC.

What's not working

has a history of intellectual disability and is treated for psychosis and mood dysregulations. He lacks independent living skills and resided in a residential group home with supervision due to challenges self-managing himself and caring for himself independently.

Name:

ACTION PLAN

The Action Plan should be based on information and recommendations from: **the Comprehensive Clinical Assessment (CCA), the One Page Profile, Characteristics/Observations/Justifications for Goals, and any other supporting documentation.**

Long Range Outcome: (Ensure that this is an outcome desired by the individual, and not a goal belonging to others).

I want to live on my own, and I want to go home.

Where am I now in the process of achieving this outcome? (Include progress on goals over the past years, as applicable).

mental health history, presenting problems and current assessment findings are congruent with individuals diagnosed with Schizophrenia and Other Psychotic Disorders. meets criteria for a Depressive Disorder based on their mental health history, presenting concerns and psychological assessment results, currently meets criteria for Mood Disorder based on their mental health history, presenting problems and the results of the psychological assessment. displays destructive outbursts, irritability, agitation, and unpredictable fluctuations in performance and relationships are common. is Unable at an age appropriate level to assist with chores, use money or budget appropriately, utilize community resources, requires and needs group home/special needs type living setting with 24-7 supervision.

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: Hygiene

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
1. will maintain a healthy hygiene and complete ADL's with promptings from staff daily, throughout the plan year.	Residential Staff – Someone Does Care, LLC.	Residential Services/ Personal Care

HOW (Support/Intervention)

Residential Home staff will assist and encourage to follow a structured daily routine with ADL's; bathing, cleaning, brushing hair, bruising teeth, using deodorant. Residential Home staff will assist and encourage in completing tasks in all setting. Staff will provide safety monitoring for behaviors and non-compliance in all settings. Staff will ensure that rights are protected at all time. Staff will supports in activities of his choice. Staff will model proper completion of chores and how to proper clean his immediate environment, such as but limited to, taking out personal trash, making his bed, folding laundry, washing dishes, preparing small snacks that do not require cooking, etc all within staff supervision.

QP (Someone Does Care, LLC.), will be responsible for the following:

1. Discharge planning when needed
2. Facilitate and arrange treatment team meetings
3. Serve as a liaison between community agencies
4. Coordination and oversight of assessment and reassessment of level of care, need for service nd supports

Name: [redacted]

5. Development of the Person Centered plan
6. Monitoring of service delivery to assure quality of care

Medication Management MD, DO, PA, FNP will:

1. Assess, document, and monitor effectiveness of medication prescribed.
2. Psychiatric evaluation.-Psychiatrist

Target Date (Not to exceed 12 months)	Date Goal was reviewed	Status Codes	Progress toward goal and justification for continuation or discontinuation of goal.
12/09/2019			
/ /	/ /		
/ /	/ /		

Status Codes: R=Revised O=Ongoing A=Achieved D=Discontinued

Name:

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: will remain safe and stable in his current placement		
WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
2. will have his basic needs met in the area of safety, food, medication (taking his medication as prescribed) and safe/sanitary shelter as evidenced by maintaining residency in residential group home and decreasing hospitalization during the plan year,	Residential Staff – Someone Does Care, LLC.	Residential Services/ Personal Care

HOW(Support/Intervention)

and Group Home Staff

Residential Home staff will assist and encourage to follow a structured daily routine. Residential Home staff will assist and encourage n completing tasks in all setting. Staff will provide safety monitoring for behaviors and non-compliance in all settings. Staff will ensure that rights are protected at all time. Staff will supports in activities of his choice. Staff will model proper completion of chores and how to proper clean his immediate environment, such as but limited to, taking out personal trash, making his bed, folding laundry, washing dishes, preparing small snacks that do not require cooking, etc all within staff supervision.

- Participate in medication management tools to support him with being medication compliant such as using Pill Containers, telephone alerts, etc.
- Attend scheduled appointments with therapist, psychiatrist, primary care doctor and other identified supports
- Follow cleaning schedule to support the consumer with maintaining a clean apartment (sweeping and mop floors, putting out trash, dust furniture, make the bed, wipe down bathroom fixtures, etc.)
- Receive and review mail by checking mail daily and responding to request and informing his guardian of received mail
- Utilize public transportation to participate in once loved activities and resources
- Utilize the Collaboration Board to keep up with activities and appointments
- Report all safety hazards to support team
- Staff will educate Allen of the correct usages and safety of handling of razor while shaving and other grooming
- Allen will learn to prepare and cook foods complementary to his diet and overall health maintenance

Medication Management MD, DO, PA, FNP will:

1. Assess, document, and monitor effectiveness of medication prescribed.
2. Psychiatric evaluation.-Psychiatrist

Target Date (Not to exceed 12 months)	Date Goal was reviewed	Status Codes	Progress toward goal and justification for continuation or discontinuation of goal.
12/09/2019			

Name: [redacted]

/ /	/ /		
/ /	/ /		
Status Codes: R=Revised	O=Ongoing	A=Achieved	D=Discontinued

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: Peer Relations

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
3. [redacted] will decrease social inappropriate and aggressive behaviors with prompting from group home staff, daily, throughout the plan year.	Residential Staff – Someone Does Care, LLC.	Residential Services/ Personal Care

HOW(Support/Intervention)

Residential Home staff will assist and encourage [redacted] to follow a structured daily routine. Residential Home staff will assist and encourage [redacted] in completing tasks in all setting. Staff will provide safety monitoring for behaviors and non-compliance in all settings. Staff will ensure that [redacted] rights are protected at all time. Staff will support [redacted] in activities of his choice. Staff will assist [redacted] in scheduling and attending all medical and mental health appointments. Staff will assist [redacted] in improving his knowledge of the medications he's prescribed, why he's taken them, and what changes have taken place if any. Residential staff will promote and provide opportunities for positive peer relations and social interaction in the community.

QP (Someone Does Care, LLC.), will be responsible for the following:

1. Discharge planning when needed
2. Facilitate and arrange treatment team meetings
3. Serve as a liaison between community agencies
4. Coordination and oversight of assessment and reassessment of level of care, need for service and supports
5. Development of the Person Centered plan
6. Monitoring of service delivery to assure quality of care

Medication Management MD, DO, PA, FNP will:

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2. Psychiatric evaluation.-Psychiatrist

Target Date (Not to exceed 12 months)	**Date Goal was reviewed**	**Status Codes**	**Progress toward goal and justification for continuation or discontinuation of goal.**
12/09/2019			
/ /	/ /		

Name: [redacted]

/ /	/ /		

Status Codes:	R=Revised	O=Ongoing	A=Achieved	D=Discontinued

CHARACTERISTICS/OBSERVATION/JUSTIFICATION FOR THIS GOAL: Allen will remain safe and stable in his current placement

WHAT (Short Range Goal)	**WHO IS RESPONSIBLE**	**SERVICE & FREQUENCY**
5. [redacted] will participate in disaster/fire drills without disruptive behaviors/refusals with prompting from group home staff, over the plan year.	Residential Staff – Someone Does Care, LLC.	Residential Services/ Personal Care

HOW (Support/Intervention)

Residential Staff will:

Staff will educate/discuss the difference between emergency/non-emergency situations with [redacted] Staff will redirect his and remove his from any potentially harmful situation. Staff will provide physical/verbal prompts to his as needed. Staff will monitor his throughout each drill/emergency situation to ensure his safety. Staff will provide feedback and praise to [redacted] Staff will provide [redacted] opportunities for practice and demonstration of skills and techniques in both individual and group sessions; will utilize worksheets, inventories, videos, movies, field trips, etc. as teaching strategies for both Social Relational and Wellness Management.

QP (Someone Does Care, LLC.), will be responsible for the following:

1. Discharge planning when needed
2. Facilitate and arrange treatment team meetings
3. Serve as a liaison between community agencies
4. Coordination and oversight of assessment and reassessment of level of care, need for service and supports
5. Development of the Person Centered plan
6. Monitoring of service delivery to assure quality of care

Medication Management MD, DO, PA, FNP will:

1. Assess, document, and monitor effectiveness of medication prescribed.
2. Psychiatric evaluation.-Psychiatrist

Target Date (Not to exceed 12 months)	**Date Goal was reviewed**	**Status Code**	**Progress toward goal and justification for continuation or discontinuation of goal.**
12/09/2019			

Name: [redacted]

Status Codes:	R=Revised	O=Ongoing	A=Achieved	D=Discontinued

Name: [redacted]

CRISIS PREVENTION AND INTERVENTION PLAN

(Use this form or attach your crisis plan.)

Significant event(s) that may create increased stress and trigger the onset of a crisis. (Examples include: Anniversaries, holidays, noise, change in routine, inability to express medical problems or to get needs met, etc. Describe what one may observe when the person goes into crisis. Include lessons learned from previous crisis events):
Allen can become frustrated at times and needs monitoring a space.

Crisis prevention and early intervention strategies that were effective. (List everything that can be done to help this person **AVOID** a crisis):
[redacted] prefers time alone away from the crisis. Provide clear and upfront explanations for anything he has to sign.

Strategies for crisis response and stabilization. (Focus first on natural and community supports. Begin with least restrictive steps. Include process for obtaining back-up in case of emergency and planning for use of respite, if an option. List everything you know that has worked to help this person to become stable):
Provide time and space when he becomes upset. [redacted] enjoys speaking with Ms. Doris over the phone. Contact first responder: Doris Sessoms 252 469 8068 Administrator – Someone Does Care available 24 hrs/7 days/365 yr Residential Q.P. Charles Martin, 252-375-6407 Contact 911 for medical crisis

Describe the systems prevention and intervention back-up protocols to support the individual. (i.e. Who should be called and when, how can they be reached? Include contact names, phone numbers, hours of operation, etc. Be as specific as possible.)
Provide time and space when he becomes upset. [redacted] enjoys speaking with Ms. Doris over the phone. Contact first responder: Doris Sessoms 252 469 8068 Administrator – Someone Does Care available 24 hrs/7 days/ 365 yr Contact 911 for medical crisis If the incident requires an incident report, one should be completed within the required time and forwarded to Eastpointe 252 937 8141, the Department of Health and Human Services The Department of DSS and all other pertinent related agencies.

Name: Allen Crawford **DOB: 11/25/1959** **Medicaid ID:949-15-8675A** **Record #:047023**

PLAN SIGNATURES

I. PERSON RECEIVING SERVICES:

☐ I confirm and agree with my involvement in the development of this PCP. My signature means that I agree with the services/supports to be provided.

☐ I understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for this PCP.

☐ For CAP-MR/DD services only, I confirm and understand that I have the choice of seeking care in an intermediate care facility for individuals with mental retardation instead of participating in the Community Alternatives Program for individuals with Mental Retardation/Developmental Disabilities (CAP-MR/DD).

Legally Responsible Person: Self: Yes ☐ **No** ☐

Person Receiving Services: (Required when person is his/his own legally responsible person)

Signature: ____________________ ____________________ Date: _/_/____

(Print Name)

Legally Responsible Person (Required if other than person receiving Services)

Signature: [redacted] Date: 12/10/2018

(Print Name)

Relationship to the Individual: ____________________

II. PERSON RESPONSIBLE FOR THE PCP: The following signature confirms the responsibility of the QP/LP for the development of this PCP. The signature indicates agreement with the services/supports to be provided.

Signature: ____________________ ____________________ Date: _/_/____

(Person responsible for the PCP) (Name of Case Management Agency)

Child Mental Health Services Only:

For individuals who are less than 21 years of age (less than 18 for State funded services) and who are receiving or in need of enhanced services and who are actively involved with the Department of Juvenile Justice and Delinquency Prevention or the adult criminal court system, the person responsible for the PCP must attest that he or he has completed the following requirements as specified below:

☐ Met with the Child and Family Team - Date: _/_/____

☐ OR Child and Family Team meeting scheduled for - Date: _/_/____

☐ OR Assigned a TASC Care Manager - Date: _/_/____

☐ AND conferred with the clinical staff of the applicable LME to conduct care coordination.

If the statements above do not apply, please check the box below and then sign as the Person Responsible for the PCP:

☐ This child is not actively involved with the Department of Juvenile Justice and Prevention or the adult criminal court system.

Signature: ____________________ ____________________ Date: _/_/____

(Person responsible for the PCP) (Print Name)

III. SERVICE ORDERS: *REQUIRED for all Medicaid funded services; RECOMMENDED for State funded services.*

(SECTION A): For services ordered by one of the Medicaid approved licensed signatories (see Instruction Manual).

My signature below confirms the following: (Check all appropriate boxes.)

- Medical necessity for services requested is present, and constitutes the Service Order(s).
- The licensed professional who signs this service order has had direct contact with the individual. ☐ Yes ☐ No
- The licensed professional who signs this service order has reviewed the individual's assessment. ☐ Yes ☐ No

Signature: ____________________ ____________________ License #: ________ Date: _/_/____

(Name/Title Required) (Print Name)

(SECTION B): For Qualified Professionals (QP) / Licensed Professionals (LP) ordering:

- CAP-MR/DD or
- Medicaid Targeted Case Management (TCM) services (if not ordered in Section A)
- **OR recommended** for any state-funded services not ordered in Section A.

My signature below confirms the following: (Check all appropriate boxes.) Signatory in this section must be a Qualified or Licensed Professional.

☐ Medical necessity for the CAP-MR/DD services requested is present, and constitutes the Service Order.

☐ Medical necessity for the Medicaid TCM service requested is present, and constitutes the Service Order.

☐ Medical necessity for the State-funded service(s) requested is present, and constitutes the Service Order

Signature: ____________________ Charles Martin , BSQP License #: NA Date: _/_/____

(Name/Title Required) (Print Name) (If Applicable)

IV. SIGNATURES OF OTHER TEAM SARAHS PARTICIPATING IN DEVELOPMENT OF THE PLAN:

Other Team Member (Name/Relationship): ____________________ Date: _/_/____

Other Team Member (Name/Relationship): ____________________ Date: _/_/____

Name: [redacted]

PLAN SIGNATURES

I. PERSON RECEIVING SERVICES:

☐ I confirm and agree with my involvement in the development of this PCP. My signature means that I agree with the services/supports to be provided.

☐ I understand that I have the choice of service providers and may change service providers at any time, by contacting the person responsible for this PCP.

☐ For CAP-MR/DD services only, I confirm and understand that I have the choice of seeking care in an intermediate care facility for individuals with mental retardation instead of participating in the Community Alternatives Program for individuals with Mental Retardation/Developmental Disabilities (CAP-MR/DD).

Legally Responsible Person: Self: Yes ☑ **No** ☐

Person Receiving Services: (Required when person is his/his own legally responsible person)

Signature: ______________________ ______________________ Date: __/__/____

(Print Name)

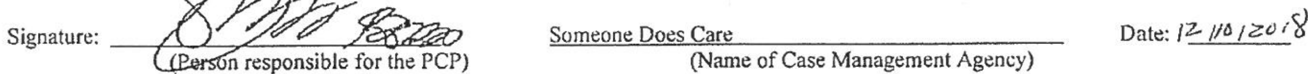
Legally Responsible Person (Required if other than person receiving Services)

Signature: ______________________ ______________________ Date: __/__/____

(Print Name)

Relationship to the Individual: ______________________

II. PERSON RESPONSIBLE FOR THE PCP: The following signature confirms the responsibility of the QP/LP for the development of this PCP. The signature indicates agreement with the services/supports to be provided.



Signature: ______________________ Someone Does Care Date: 12/10/2018

(Person responsible for the PCP) (Name of Case Management Agency)

Child Mental Health Services Only:

For individuals who are less than 21 years of age (less than 18 for State funded services) and who are receiving or in need of enhanced services and who are actively involved with the Department of Juvenile Justice and Delinquency Prevention or the adult criminal court system, the person responsible for the PCP must attest that he or he has completed the following requirements as specified below:

☐ Met with the Child and Family Team - Date: __/__/____

☐ **OR** Child and Family Team meeting scheduled for - Date: __/__/____

☐ **OR** Assigned a TASC Care Manager - Date: __/__/____

☐ **AND** conferred with the clinical staff of the applicable LME to conduct care coordination.

If the statements above do not apply, please check the box below and then sign as the Person Responsible for the PCP:

☐ This child is not actively involved with the Department of Juvenile Justice and Prevention or the adult criminal court system.

Signature: ______________________ ______________________ Date: __/__/____

(Person responsible for the PCP) (Print Name)

III. SERVICE ORDERS: *REQUIRED for all Medicaid funded services; RECOMMENDED for State funded services.*

(SECTION A): For services ordered by one of the Medicaid approved licensed signatories (see Instruction Manual).

My signature below confirms the following: (Check all appropriate boxes.)

- Medical necessity for services requested is present, and constitutes the Service Order(s).
- The licensed professional who signs this service order has had direct contact with the individual. ☐ Yes ☐ No
- The licensed professional who signs this service order has reviewed the individual's assessment. ☐ Yes ☐ No

Signature: ______________________ ______________________ License #: ________ Date: __/__/____

(Name/Title Required) (Print Name)

(SECTION B): For Qualified Professionals (QP) / Licensed Professionals (LP) ordering:

- CAP-MR/DD or
- Medicaid Targeted Case Management (TCM) services (if not ordered in Section A)
- **OR recommended** for any state-funded services not ordered in Section A.

My signature below confirms the following: (Check all appropriate boxes.) Signatory in this section must be a Qualified or Licensed Professional.

☐ Medical necessity for the CAP-MR/DD services requested is present, and constitutes the Service Order.

☐ Medical necessity for the Medicaid TCM service requested is present, and constitutes the Service Order.

☐ Medical necessity for the State-funded service(s) requested is present, and constitutes the Service Order

Signature: ______________________ Charles Martin . BSQP License #: NA Date: __/__/____

(Name/Title Required) (Print Name) (If Applicable)

IV. SIGNATURES OF OTHER TEAM SARAHS PARTICIPATING IN DEVELOPMENT OF THE PLAN:

Other Team Member (Name/Relationship): ______________________ Date: 12/10/2018

Other Team Member (Name/Relationship): ______________________ Date: __/__/____

MAR and Medication Administration In-service
12/24/18
for
Some One Does Care Group Home

A. Correction of Transcription error leaving out the time on a medication when transcribing the order to the MAR.

1. Review of Core Instructions on Medication Administration
    a) Using the 6 "R"s of Medication Administration reviewed and policy **will be enforced.**
    b) Special emphasis on the **required 3 Checks** of comparing the label on the medication to the instructions on the Medication Administration Record (MAR).
    c) Emphasis on giving medications **ONLY by the MAR** and not from the medication packages or memory.

2. Medication Labeling:
    a) Emphasis on assuring that the **label on the medication is the same as on the MAR** and **as most recently ordered by the physician.** If the Label on any medication **does NOT** match the MAR then the staff must get the order clarified **BEFORE administering** the medication to the client. **CALL Mrs. Sessoms ASAP.** This may mean the order has changed or the order has been transcribed incorrectly.
    b) When Transcribing orders to the MAR the staff will change the instructions on the actual medication package if still using the (OLD) same package. E.g.... dose change on medication. This is not required if the pharmacy sent a new package with the new instructions!
    c) If new medication is received from the pharmacy with new instructions, the staff is responsible for assuring the medication label matches the MAR as specified by **the latest physicians order**. (Check all for accuracy BEFORE giving the medication).
    d) If questions arise, contact Ms. Doris Sessoms immediately for guidance.

3. Transcribing Medication Orders:
    a) Review the handout on General Guidelines on transcribing medications.
    b) Review the documentation skills practice by staff to take orders off and **transcribe them properly to the MAR.** Use blank MAR and the FL-2 for Clayton Garrett
    c) Practice Exercise to answer questions regarding Transcribed orders.

B. Correction of error related to missed "order" noted on client consult sheet after medical appointment to discontinue use of a treatment and/or medication.

1. To assure that all orders are taken off completely, correctly, and in a timely fashion the following policy will become effective Jan 01, 2019.
   a. Whenever a client attends a medical appointment, clinic, psychiatrist appointment, etc... **ALL paperwork**, (consultation sheets, prescriptions, office notes, etc....) are to be immediately reviewed carefully by the staff to assure that no orders or doctors instructions have been included in the notes. The staff will continue to fax orders/prescriptions to the pharmacy as usual, and will transcribe any new orders (&/or changes) on the MAR as trained.
   b. Whenever a client attends a medical appointment, clinic, psychiatrist appointment, etc... **ALL paperwork**, (consultation sheets, prescriptions, office notes, etc....) the staff will also assure all documents are faxed immediately upon return to the facility to the Nurse for review. Please be sure and use a cover sheet indicating the fax is from the SOME ONE DOES CARE HOME.

Nursing Fax Number# 252- 643-0828, ATTN: KAREN

   c. The facility nurse upon review of the faxed documents will review all clinic notes, et... to determine if any orders or other medical instructions are included in the document. They will then (at their convenience) communicate with the staff in the home to assure that all orders/instructions have been noted and are being carried out.

Staff Name: (print) Dorio Sessoms Date: 12/24/2018

By signing this document I attest that have received instruction on the above listed topics presented. That I have had the opportunity to ask questions and have had my questions answered to my satisfaction. I agree that I understand and will follow these polices as instructed.

Staff Signature: [signature]

[signature], RN-C

Presenters Signature: ______

General Guidelines for Transcribing Orders onto the MAR

- **Transcribe** - means to write down or to copy from one place to another.
  - With medication administration, transcribing orders is when the information from the order is transferred or copied to the MAR.
  - When an order is received from the prescribing practitioner, the information from the order is transcribed to the current MAR.
  - With medication transcription, it is important to follow certain guidelines to ensure accuracy and compliance.

- If you are responsible to transcribe an order to the MAR, the following are basic guidelines to follow:
  - Transcribe the information from the order onto the MAR only if you are able to read all the information on the order.
  - Transcribe the information on the MAR only if the order is complete for administering the medication.
  - Transcribe all the information onto the MAR as it is written on the order.

<u>Other guidelines for transcription onto MARs:</u>

- Do not use abbreviations

- Record each medication ordered from the order form to include:
  - Name and strength of the medication
  - Dose, Route and Time(s) the medication is to be given
  - Date the medication is to be started
  - Date the medication is to be stopped (if provided)
  - The date and name of person who transcribed the order should be documented

- Mark out days the medication is not to be given **IF** the medication is not prescribed every day.

(continued)

- For new orders, include the date and indicate the time to start.
- Count number of dosages to be administered instead of number of days when calculating stop dates for medication orders that have been prescribed for a specific time period, such as antibiotics
- Do not schedule PRN orders for administration at specific times; are administered when resident "needs" the medication for a certain circumstance
- If a medication order is discontinued (stopped or changed) by the prescriber, Discontinue or D/C (abbreviation for discontinued) should be noted for the medication. The date discontinued and your initials should be included.
- If the medication is not discontinued BUT the dose is reduced or changed, this should be transcribed as a NEW medication order. The old order would be discontinued on the MAR. The new order with the revised dosage would be transcribed onto the MAR exactly as a new order would be.

NOTE: It is important to follow the facility policy regarding how a discontinued medication is indicated on the MAR as procedures may vary. When a new medication is ordered, changed or discontinued, be sure to notify the resident of changes.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL033-052 Y1	A. Building B. Wing Y2	12/7/2018 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMEONE DOES CARE	601 WEST WALNUT STREET TARBORO, NC 27886

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 V0109 Reg. # 27G .0203 LSC	Correction Completed 12/07/2018	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
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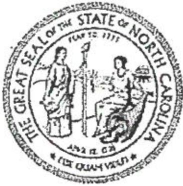
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR Rhonda Smith	DATE 12-11-18
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 11/27/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: UT4213

STATE FORM: REVISIT REPORT (11/06)



NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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

DHSR-Mental Health
DEC 27 2018
Lic. & Cert. Section

December 13, 2018

Doris Sessoms, Administrator/Owner
Someone Does Care, LLC
PO Box 1232
Tarboro, NC 27886

Re: Annual & Follow up Survey completed December 7, 2018
Someone Does Care, 601 West Walnut Street, Tarboro, NC 27886
MHL #033-052
E-mail Address: doris.sessoms@yahoo.com

Dear Ms. Sessoms:

Thank you for the cooperation and courtesy extended during the Annual & Follow up survey completed December 7, 2018.

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

- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is February 5, 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.

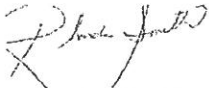
Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

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 Renee Ames at (919) 552-6847.

Sincerely,



Rhonda Smith
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: Leza Wainwright, Director, Trillium Health Resources LME/MCO
Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources LME/MCO
Sarah Stroud, Director, Eastpointe LME/MCO
Jeanette Jordan-Huffam, Quality Management Director, Eastpointe LME/MCO
File