PRINTED: 01/11/2019
FORM APPROVED

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
	MHL098-155	A. BUILDING: _____ B. WING _____	R 01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENTLE HANDS I	1615 WASHINGTON STREET EAST WILSON, NC 27893

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V 000	INITIAL COMMENTS An annual and follow up survey was completed on January 10, 2019. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C, Supervised Living for Adults with Developmental Disabilities.	V 000		
V 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 JAN 25 2019 Lic. & Cert. Section	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Cynthia Powell — 1-22-19

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement goals and strategies based on assessment affecting 3 of 3 audited clients (#3, #4, and #6). The findings are: Review on 1/10/19 of client #3's record revealed: - 41 year old female admitted to the facility 1/13/14. - Diagnoses included Mild Intellectual/Developmental Disability, Schizophrenia, and sleep apnea. - Person Centered Plan dated 4/25/18 did not include residential specific goals or strategies or a goal and strategies regarding client #3's sleep apnea and the use and care of her continuous positive airway pressure (CPAP) machine. During interview on 1/10/19 client #3 stated: - She used her CPAP nightly. - She cleaned her machine with staff assistance. Review on 1/10/19 of client #4's record revealed: - 24 year old female admitted to the facility 10/23/18. - Diagnoses included Mild Intellectual/Developmental Disability, Seizures, Pre-Diabetes, Post-Traumatic Stress Disorder, Mood Disorder, Anxiety, hypothyroidism, morbid obesity. - Person Centered Plan dated 11/5/18 included the goal "[client #4] will choose to eat healthy foods throughout the plan year to assist in weight reduction and better overall health" but no strategies to address making healthy food choices. During interview on 1/10/19 client #4 stated: - Her personal goals were to get her general	V 112	**V112** **Treatment Plans – Clients #3, 4 & 6** Residential Treatment Plans will be revised to compliment the current Treatment Plan in place from the PSR, but more specific to the client's residential needs. The QP, director, client and/or legal guardian will meet and develop for each noted resident a Person Centered Treatment Plan inclusive of the residential goals identified on the progress goal grids and based on needs indicated in the Daily Notes. The Plans will also include how they will be implemented and a Crisis Plan. **Monitoring and frequency will be as Follows:** All staff will continue to record progress on a daily basis. **Treatment Team** will meet per the plan and review overall progress of goals. The Plan will be updated at least annually or as revisions are needed. This will ensure that there is always a current Residential Treatment Plan (PCP) in place that addresses the specific Residential needs of the clients which Should prevent this type of deficiency from being cited again.	**2/7/2019**

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V 112	Continued From page 2 education diploma and, eventually, her own apartment. - Since the fire in the facility in November, the clients had been eating frozen, microwavable foods with some meals being prepared at a sister facility and delivered. Review on 1/10/19 of client #6's record revealed: - 80 year old female admitted to the facility 7/25/11. - Diagnoses included Mild Intellectual/Developmental Disability and Dementia. - "Monthly Progress Noted dated 10/3/18 and signed by the Qualified Professional (QP) included " . . . Goal Progress: 1. [Client #6] continues to experience behaviors symptomatic of her diagnosis of dementia. Her bouts of anger have increase. . . . 2. . . . continues to receive full assistance from staff with her hygiene. She has started to have bladder incidents, requiring cleanup by staff. . . " - "Monthly Progress Note" dated 11/5/18 and signed by the QP included ". . . Goal Progress . . . 2. [Client #6] continues to receive full assistance from staff with her hygiene except the washing of her face, but needs to be prompted and/or reminded to brush her teeth. . . " - Person Centered Plan dated 4/25/18 did not include any goals or strategies regarding client's dementia diagnosis or "bladder incidents" and included only one strategy related to personal hygiene, ". . . Ensure [client #6's} hair is shampooed every other day . .. " Client #6 was in the hospital and not available for interview. During interview on 1/10/19 the Director/Chief Executive Officer (CEO) stated:	V 112	**V112** **<u>Treatment Plans – Clients #3, 4 & 6</u>** Residential Treatment Plans will be revised to compliment the current Treatment Plan in place from the PSR, but more specific to the client's residential needs. The QP, director, client and/or legal guardian will meet and develop for each noted resident a Person Centered Treatment Plan inclusive of the residential goals identified on the progress goal grids and based on needs indicated in the Daily Notes. The Plans will also include how they will be implemented and a Crisis Plan. **Monitoring and frequency will be as Follows:** <u>All staff</u> will continue to record progress on a daily basis. **<u>Treatment Team</u>** will meet per the plan and review overall progress of goals. The Plan will be updated at least annually or as revisions are needed. This will ensure that there is always a current Residential Treatment Plan (PCP) in place that addresses the specific Residential needs of the clients which Should prevent this type of deficiency from being cited again.	**2/7/2019**

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V 112	Continued From page 3 - The person centered plans were written by the QP at the clients' Psychosocial Rehabilitation (PSR) programs. - None of the plans had residential specific goals and strategies. - Client #6 was hospitalized 12/15/18 for treatment of a urinary tract infection; while in the hospital, she developed influenza and a staphylococcus infection. - She was to be discharged from the hospital to a local nursing home for rehabilitative care on 1/10/19; upon discharge from the rehabilitation program, client #6 would return to the facility. - She understood the requirement for goals and strategies based on client assessment. - She would have her QP develop and implement appropriate residential goals and strategies. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 112	**V112** **Treatment Plans – Clients #3, 4 & 6** Residential Treatment Plans will be revised to compliment the current Treatment Plan in place from the PSR, but more specific to the client's residential needs. The QP, director, client and/or legal guardian will meet and develop for each noted resident a Person Centered Treatment Plan inclusive of the residential goals identified on the progress goal grids and based on needs indicated in the Daily Notes. The Plans will also include how they will be implemented and a Crisis Plan. **Monitoring and frequency will be as Follows:** All staff will continue to record progress on a daily basis. **Treatment Team** will meet per the plan and review overall progress of goals. The Plan will be updated at least annually or as revisions are needed. This will ensure that there is always a current Residential Treatment Plan (PCP) in place that addresses the specific Residential needs of the clients which Should prevent this type of deficiency from being cited again.	**2/7/2019**
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic	V 367		

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V 367	Continued From page 4 means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion	V 367	**V367** **Incident Reporting Requirements** Going forward, should there be any incident in question as to whether it should be entered into IRIS as a Level 2 based on the guidelines on the Incident Report, GHI will err on the side of caution, make individual entries into the system for each resident involved and anticipate the LME's notification/or validation of the level status. Failed attempts to make entries into IRIS shall be followed up with calls to LME and DHSR until a full understanding can be obtained and the incident properly documented. **Monitoring and frequency will be as Follows:** QP and Director will continue to monitor and assess all Incident Reports on an "as needed" basis.	**1/10/19**

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V 367	Continued From page 5 or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review, observation and interview the facility failed to complete a Level II incident report on the form provided by the Secretary as required. The findings are: Review on 1/10/19 of "Incident Report . . . " dated 11/29/18 revealed: - "Incident Report - fire in Kitchen on November 27, 2018 - Time: 5:05 pm." - "Staff was preparing supper. Blaze broke out from a grease spill under burner. Fire	V 367		

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V 367	Continued From page 6 extinguished by staff with extinguisher located in kitchen. Staff proceeded to evacuate residents and call 911 and Director per protocol. Fire department arrived at 5:10 pm. Fire department removed smoke from house and provided ventilation. Fire Department removed stove and range hood from kitchen and shut off electrical power to the area. Levels were assessed throughout the house and fire department determined house Oxygen to be "All Clear" and safe for staff and residents to reenter at 5:45 pm. Director contacted QP [Qualified Professional]." - " . .. . QP meets with Director to prepare and enter Level 2 Incident Report into IRIS once all information and documentation has been gathered." - A report from local fire department, dated 11/27/18 included "Dates & Times Alarm 11/27/18 17:04:18 [5:04:18 pm] Arrival . . . 17:09:44 [5:09:44 pm] . . . Last Unit Cleared . . . 17:48:03 [5:48:01]. . . . Estimated Dollar Losses & Values Property $2500, Contents $500 . . . " Review on 1/10/19 of the North Carolina Incident Response Improvement System (IRIS) revealed no Level II incident reports from the facility. Observation on 1/10/19 at approximately 12:30 pm of the facility kitchen revealed heavy black scorching and damage to the kitchen cabinets, wall and ceiling above and around the recess where the stove was located. During interview on 1/10/19 the Director/Chief Executive Officer stated: - Staff followed protocol by evacuating the clients, extinguishing the fire and contacting the fire department and facility management. - She contacted DHSR in November for guidance following the kitchen fire.	V 367		

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V 367	Continued From page 7 - She notified the Construction Section about the fire and damage as instructed. - The QP was going to enter a level II incident report in IRIS, but she was told by the Local Management Entity a level II report was not necessary since no clients were injured. - A level II report was not completed. - She understood the requirement to complete level II incident reports.	V 367		