

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/04/2019
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NAME OF PROVIDER OR SUPPLIER STAMEY HOME 1	STREET ADDRESS, CITY, STATE, ZIP CODE 180 JUSTICE ROAD MARION, NC 28752
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(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 survey was completed on 1/4/19. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Individuals of all Disability Group/ Intellectual Development Disabilities.	V 000	V108 .0202 (Personnel Requirements) Staff #1 received client specific trainings for clients #1, #2, #3. Copies are attached for review. QP will ensure all staff receive client specific training on all future clients. Also attached are staff #1 trainings upon hire.	12/21/18
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious	V 108	DHSR - Mental Health FEB 06 2019 Lic. & Cert. Section	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Daniel Merrill

TITLE
VP Quality Assurance
(X6) DATE
01/31/19

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V 108	<p>Continued From page 1</p> <p>and communicable diseases of personnel and clients.</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure each employee received training to meet the needs of the client for mental health and intellectual development disabilities as specified in the treatment plan for 1 of 3 sampled staff (#1). The findings are:</p> <p>Review on 12/18/18 of the personnel record for Staff #1 revealed: -Hire date of 2/21/18. -No documentation of client specific training based on the treatment plan for Client #1, #2, or #3.</p> <p>Interview on 12/18/18 with Staff #1 revealed: -He received training in 4 or 5 different classes when he was hired. -He also received an overview of clients but could not recall anything specific to the treatment plan.</p> <p>Interview on 12/19/18 with the Qualified Professional revealed: -She did not recall Staff #1 receiving any training on client specifics. -Staff #1 was employed by the Director and not the licensee. -It was the responsibility of the licensee and the qualified professional to ensure client specific training was completed with staff.</p>	V 108	<p>VIII .0205 (Assessment and Treatment / Habilitation or Service Plan)</p> <p>Licensee has created (Community Companion Home Care Screening / Admission Assessment Form.) All incoming referrals will be sent the screening / admission form prior to placement to ensure individual needs can be met. A copy of the Screening / Admission Form is attached for review.</p>	1/28/19

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V 111	Continued From page 2	V 111		
V 111	<p>27G .0205 (A-B) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to:</p> <ol style="list-style-type: none"> (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. <p>(b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.</p> <p>This Rule is not met as evidenced by: Based on interview and record review the facility failed to ensure an assessment was completed</p>	V 111	<p>V118 .0209 (Medication Requirements)</p> <p>All staff involved to include the Director of Facility, Staff #1 and the QP have been retrained in medication Administration.</p> <p>Copies of these trainings are attached for review.</p>	12/21/18

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V 111	<p>Continued From page 3</p> <p>prior to providing services to include presenting problems, provisional or admitting diagnoses, needs and strengths, family and medical history for 2 or 3 clients. (#1, #3). The findings are:</p> <p>Review on 12/7/18, 12/18/18 and 12/19/18 of the record for Client #1 revealed: -Admission date of 7/13/18 with diagnoses of Borderline Personality Disorder, Suicidal Ideation, Major Depressive Disorder, Autism Spectrum Disorder, Impulse Control Disorder vs Obsessive Compulsive Disorder and Chronic Non-Suicidal Self Harming Behaviors. -No facility assessment with diagnosis, presenting problems, strengths, needs, family or medical history.</p> <p>Review on 12/17/18 of the record for Client #3 revealed: -Admission date of 10/13/18 with diagnoses of Mild Intellectual Development Disability, Attention Deficit Hyperactivity Disorder, Unspecified Paraphilic Disorder, Self-Injurious Behavior, Asthma, Acid Reflux and Hiatal Hernia. -No facility assessment with diagnosis, presenting problems, strengths, needs, family or medical history.</p> <p>Interview on 12/19/18 with the Qualified Professional revealed: -The facility did an assessment which included personal preferences at the time of admission. -The assessment did not include diagnoses, problems, strengths, needs and family or medical history. -Some of the information was on the face sheet and client specifics. -The qualified professional was not always involved with the intake of new clients. -Some clients were admitted over the weekend</p>	V 111	<p>V123 .0205(Medication Requirements)</p> <p>Incident reports will be completed for all incidents of drug administration errors/refusals. Medication administration errors/refusals will be immediately reported to a physician or pharmacist.</p>	12/21/18

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V 111	Continued From page 4 on an emergency basis and the assessment was not completed until the following work week. -She would ensure assessments were completed to meet the rule.	V 111		
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. This Rule is not met as evidenced by:	V 112	V291 .5603 (Operations) Facility Operator and the QP have implemented weekly summaries of concerns, issues and updates pertaining to all clients in the home. This will be completed on an AFL Weekly Notes Form to keep the QP informed in order to help keep the best Treatment Plan in place for each client.	12/28/18

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V 112	<p>Continued From page 5</p> <p>Based on record review and interview the facility failed to ensure the treatment/service plan was updated and strategies were implemented for 2 of 3 sampled clients (#1). The findings are:</p> <p>Cross Reference 10A NCAC 27G .0209 Medication Requirements (V118) Based on observation, interview, and record review the facility failed to maintain the MAR current and ensure prescription drugs were administered as ordered by the physician for 2 of 3 sampled clients (#1,#2).</p> <p>Cross Reference 10A NCAC 27G .0209 Medication Requirements (V123) Based on record review and interview the facility failed to report drug administration errors/refusals immediately to a physician or pharmacist for 1 of 3 sampled clients (#1).</p> <p>Cross Reference 10A NCAC 27G .5603 Operations (V291) Based on record review and interview the facility failed to ensure coordination was maintained between the facility operator and the qualified professional who was responsible for the treatment plan for 1 of 3 sampled clients (#1).</p> <p>Review on 12/7/18, 12/18/18 and 12/19/18 of the record for Client #1 revealed: -Admission date of 7/13/18 with diagnoses of Borderline Personality Disorder, Suicidal Ideation, Major Depressive Disorder, Autism Spectrum Disorder, Impulse Control Disorder vs Obsessive Compulsive Disorder and Chronic Non-Suicidal Self Harming Behaviors. -Treatment Plan dated 7/11/18 with no identified goals or strategies for medication management.</p>	V 112	<p>V112 .5603(Operations)(V291)</p> <p>Client #1 is currently admitted to a hospital.</p> <p>Client will not be returning to Stamey Home per Team/Guardian decision.</p>	1/20/19

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V 112	Continued From page 6 Review on 12/19/18 and 1/4/19 of the Plan of Protection completed on 12/19/18 and updated on 1/4/19 by the Qualified Professional and Chief Executive Office revealed: "By December 28, 2018 the following will occur: 1. All staff providing direct care services will receive re-medication training to specifically address client refusal of medications, reading medication labels & compare to original physician orders for correct dosage, route & time of day. Training will be implemented by CCHC [licensee] I RN/QP, [name]. 2. All MARS, physician orders, & medications will be reviewed by the attending QP & RN by 12/21/2018 for accuracy & correct dosage as prescribed. 3. Documentation will be gathered from the Marion RHA [mental health provider] as related to identified member who refuses his medication on a daily basis for appropriate interventions /strategies to promote positive outcome for member to willingly take medications as prescribed. 4. The attending QP will revise the current PCP to reflect goals, & strategies for identified individual to take medications as prescribed. In addition, QP will review all members living in the Stamey home for accurate goals & strategies for all identified problems. Beginning 12/20/2018, QP will physically observe strategies & interventions related to identify goals for each individual living in the home. QP will review all members current PCP's for all identified problems & strategies as related to the clients specific needs for overall health & safety. 5. To insure the above happens, the QP will do weekly observations in the home for a period of 6 weeks & then ongoing on a monthly basis. All visits/trainings will be documented. Updates &	V 112	<i>vii2 Plan of Protection</i> <i>1. All staff providing direct care services have received re-medication Administration training which specifically addressed client refusal of meds, reading medication labels and comparing to original physician orders for correct dosage, route and time of day. This training was implemented by CCHC (Licensee) and completed by Laeesha Swepson BSN, RN. Copies of training certificates attached for review.</i> <i>2. All MARS, physician orders and medications have been reviewed by the attending QP, Susan Thompson and the RN, Laeesha Swepson for accuracy and correct dosage as prescribed. The RN also observed the home during a med administration and provided support and counseling on 12/20/18.</i>	<i>12/21/18</i> <i>12/20/18</i>

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V 112	<p>Continued From page 7</p> <p>changes will be implemented as ongoing needs are assessed.</p> <p>6. Added 1/4/2019-Service Coordination will be maintained between the facility director, [name] & the qualified professional, [name], by implementing daily and or weekly updates for each residing member in the home in regards to but not limited to medication changes, doctor appointments, behavioral concerns, goals and overall well-being of each member. All updates will be documented & implemented as of 1/4/19. This will be an ongoing strategy to promote clear communication & care for each individual residing in the home."</p> <p>Client #1 had an extensive psychiatric background and received treatment for approximately 15 years to address Borderline Personality Disorder, Suicidal Ideations, Major Depressive Disorder, Autism Spectrum Disorder, Impulse Control Disorder vs Obsessive Compulsive Disorder and Chronic Non-Suicidal Self Harming Behaviors. Prior to admission to the facility in July of 2018 he was institutionalized for a period of 2 years. From 10/6/18-10/31/18, the client refused his antipsychotic medication, his anti-depression medication, and his medication to prevent extreme mood swings, as well as refusing other medications for his thyroid and reflux. In November he continued to refuse his thyroid and reflux medications; and a missing page in the medication record meant we were unable to tell what other medications he took or didn't take. In December, he continued to refuse his thyroid and reflux medications, as well as refusing his anti depression and mood swing medication. On 12/4/18, he was placed on anti-psychotic injections after refusal of the anti-psychotic medication (invega), but no other actions were</p>	V 112	<p>3. Marion RHA (mental health provider) provided documentation as related to identified member who refuses medication on a daily basis for appropriate interventions/strategies to promote positive outcome for member to willingly take meds as prescribed. Obtained documentation attached to this report.</p> <p>4. Client #1 admitted to hospital for suicidal ideation on 12/16/18 with discharge date of 12/19/18. Client #1 once again admitted to hospital on 12/23/18 and discharged on 1/3/19. Client #1 readmitted on 1/19/19 for suicidal ideation. Do to change in level of care, this client currently remains in hospital and will not be returning to the Stamey Home per Team / guardian decision. Therefore, no PCP update. The QP reviewed Treatment Plans for Client # 2</p>	<p>12/28/18</p> <p>12/28/18</p>

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V 112	<p>Continued From page 8</p> <p>taken to address his refusals. The director and the registered nurse were aware of the continuous refusals but failed to communicate this to the qualified professional who did not address, develop or implement strategies for medication management. On 12/16/18, at supper time, the client informed staff that this was his last meal because he planned to go to the railroad tracks and kill himself. The client was admitted to the hospital on 12/17/18 through 1/3/19 to address his suicidal thoughts and plan.</p> <p>This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of \$2000.00 is imposed.</p> <p>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.</p> <p>This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of \$2000.00 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.</p>	V 112	<p>- continued from page 8 -</p> <p>and client #3 and they currently meet the individual needs. client #2 does have annual review on 11/16/19 and client #3 has annual review on 11/15/19.</p> <p>5. CCHC (licensee) ensuring that the AP will do weekly observations in the home for a period of at least 6 weeks and then ongoing on a monthly basis. All visits/trainings will be documented. AP will ensure updates/changes will be implemented as ongoing needs are assessed.</p>	12/28/18
V 118	<p>27G .0209 (C) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(c) Medication administration:</p> <p>(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.</p> <p>(2) Medications shall be self-administered by</p>	V 118	<p>6. Service Coordination is being maintained between the facility Director, Jamey Stamey and the AP, Susan Thompson of the implementation of weekly updates for each residing member in the home regarding but not limited to medication changes, doctor appointments, behavioral concerns, goals & overall well being of each member.</p>	12/28/18

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V 118	<p>Continued From page 9</p> <p>clients only when authorized in writing by the client's physician.</p> <p>(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.</p> <p>(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:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p> <p>(D) date and time the drug is administered; and</p> <p>(E) name or initials of person administering the drug.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review the facility failed to maintain the MAR current and ensure prescription drugs were administered as ordered by the physician for 2 of 3 sampled clients (#1,#2). The findings are:</p> <p>Review on 12/7/18, 12/18/18 and 12/19/18 of the record for Client #1 revealed: -Admission date of 7/13/18 with diagnoses of Borderline Personality Disorder, Suicidal Ideation, Major Depressive Disorder, Autism Spectrum</p>	V 118	<p><i>-Continued from page 9 -</i></p> <p><i>This will be ongoing strategy to promote clear communication and care for each individual residing in the home.</i></p> <p><i>V118 .0209 (C)(Medication Requirements)</i></p> <p><i>1. All involved direct staff have had updated medication administration training. 12/21/18</i></p> <p><i>2. Medications will be self administered by clients only when authorized in writing by the client's physician. 12/21/18</i></p> <p><i>3. All involved direct staff have had updated medication administration training. 12/21/18</i></p> <p><i>4. Staff will ensure the MARs of all drugs administered to each client are kept current and accurate by the review of the Facility Director, the AP, the c/c RN as well as an independent hired personnel by the Facility Director to review MARs - All medication prescriptions have been transferred to 12/28/18</i></p>	

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V 118	<p>Continued From page 10</p> <p>Disorder, Impulse Control Disorder vs Obsessive Compulsive Disorder and Chronic Non-Suicidal Self Harming Behaviors.</p> <p>Observation at approximately 11am on 12/7/18 of the medications for Client #1 revealed: -Naltrexone HCL 50mg (opiate antagonist) 1 tablet daily. -Levothyroxine 25mcg (thyroid condition) 1 tablet daily. -Omeprazole 40mg (stomach acid) 1 capsule daily. -Seroquel 25mg (for agitation and mood symptoms) 1 tablet 3 times daily as needed. -Cetirizine 10mg (allergies) 1 tablet daily. -Lithium Carbonate Extended Release 300mg (mood symptoms) 4 tablets in the morning and 4 tablets at bedtime. -Lamotrigine 100mg ½ tablet (mood symptoms) 2 times daily. -Benzotropine 1 mg, 1 tablet as needed for stiffness.</p> <p>Review on 12/7/18 and 12/18/18 of the record for Client #2 revealed: -Admission date of 7/21/18 with diagnoses of Autistic Disorder, Moderate Intellectual Development Disability and Oppositional Defiant Disorder. -Physician order dated 8/6/18 for Vistaril Pamoate (Hydroxyzine) 25 mg 3 times daily as needed. -Physician order dated 11/15/18 for Hydroxyzine 50mg 1 tablet at night.</p> <p>Observation at approximately 10:25am on 12/7/18 of the medications for Client #2 included: -Hydroxyzine Pamoate 25mg (anxiety) 1 tablet 3 times daily as needed.</p> <p>Review on 12/18/18 of the physician orders for</p>	V 118	<p><i>- Continued from page 10 -</i></p> <p><i>PSA Pharmacy. PSA Pharmacy delivers all meds and pre-written MARs directly to the Facility.</i></p> <p><i>5. Facility Director and DR will ensure requests for medication change or checks are recorded and kept with the MAR file followed up by an appointment or consultation with a physician.</i></p>	12/28/18

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NAME OF PROVIDER OR SUPPLIER STAMEY HOME 1	STREET ADDRESS, CITY, STATE, ZIP CODE 180 JUSTICE ROAD MARION, NC 28752
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(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
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V 118	<p>Continued From page 11</p> <p>Client #1 revealed: -Physician order dated 9/14/18 for Naltrexone HCL 1 tablet each day, Lithium Carbonate Extended Release, 300mg 4 tablets in the morning and 4 tablets at bedtime, Invega 6mg 1 tablet each morning, Lamotrigine 100mg ½ tablet 2 times each day and Seroquel 25mg 1 tablet 3 times daily as needed. -Levothyroxine 25mcg 1 tablet daily, order dated 7/20/18. -Famotidine 20mg 1 tablet 2 times daily. -Cetirizine 10mg 1 tablet daily, order dated 11/14/18. -Benzotropine 1 mg 2 times daily as needed for stiffness, dated 12/4/18. -Invega Sustenna 234mg (mood) Intramuscular 12/4/18 then Q21-28day. -Physician order dated 12/4/18 to discontinue Invega 6mg , Naltrexone, Lamotrigine, and Lithium.</p> <p>Review on 12/7/18 and 12/18/18 of the October, November and December 2018 MAR for Client #1 revealed: -October 2018 - Invega, Lithium, Lamotrigine, Naltrexone, Levothyroxine, Omeprazole and Famotidine was refused 10/6/18-10/31/18. -November 2018 - Naltrexone HCL, Levothyroxine, Omeprazole were refused 11/1/18-11/30/18. -November 2018 was missing page 2 of the MAR. -December 2018 -Invega 6mg documented as refused from 12/1/18-12/16/18, order was discontinued on 12/4/18 and placed on injection. -Cetirizine, Famotidine, Lithium, Lamotrigine, Naltrexone, Levothyroxine, Omeprazole refused from 12/1/18-12/16/18. -Note on the back of the October-November MAR indicated the guardian was notified. The</p>	V 118	<p>-</p> <p>V118 Client #1 was missing page 2 of the November 2018 MAR. A copy of this page is attached to this report.</p>	12/28/18
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V 118	<p>Continued From page 12</p> <p>December MAR indicated the pharmacy was notified for all missed medications. -The October MAR was signed off by the facility registered nurse as being reviewed.</p> <p>Review on 12/7/18 and 12/18/18 of the October, November and December 2018 MAR for Client #2 revealed: -Hydroxyzine was not listed on the MAR for October. -Hydroxyzine 25mg take one 3 times daily as needed, administered at 6am and 10pm daily 11/1/18-11/30/18. -Documentation on the "PRN Results ..." of November MAR indicated 50mg of Hydroxyzine was administered 2 times each day 11/1/18-11/30/18. -December MAR listed Hydroxyzine 50mg 1 tablet at night as needed for anxiety and administered 1 tablet at night. Administered correctly but listed as needed.</p> <p>Interview on 12/7/18 with Client #1 revealed: -He reported no problems with medication and said he had not missed any medication.</p> <p>Interview on 12/7/18 with Client #2 revealed: -He took his medication every morning and night. -He had never missed any of his medication.</p> <p>Interview on 12/19/18 with the Guardian for Client #1 revealed: -He was aware Client #1 was refusing medications. -He visited the client once each month. -The director maintained good communication with him. -Client #1 did not exhibit any change in mood or behaviors from refusal of medications.</p>	V 118	<p><i>V118 - Client #2 documentation regarding prescribed hydroxyzine attached to this report.</i></p>	<p><i>12/20/18</i></p>

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V 118	<p>Continued From page 13</p> <p>Interview on 12/18/18 with Staff #1 revealed:</p> <ul style="list-style-type: none"> -When a client refused a medication he put an "R" on the MAR. -He understood this was all he needed to do with a refusal of medication. -He did not notify the physician or pharmacist when a client refused a medication. -Client #1 had refused his medications for 1-2 months. -He administered the Hydroxyzine for Client #2 according to the MAR, he was not sure why he documented 50mg each time it was administered. -He thought this was a documentation error for Client #2. -Staff #1 also reported Client #1 was hospitalized on 12/16/18 due to suicidal ideations. -Client #1 came to him on 12/16/18 and asked what they were having for supper that evening, then further stated it would be his last meal because he planned to go down to the railroad tracks to kill himself. -Staff notified the director who took Client #1 to hospital for evaluation and he was admitted due to the suicidal ideations. <p>Interview on 12/18/18 and 1/4/19 with the Director revealed:</p> <ul style="list-style-type: none"> -He was aware Client #1 was refusing his medications. -He directed the staff to document the refusal of medications on the MAR. -The director notified the guardian of the refusals and the guardian informed him to continue to document the refusals. -The nurse practitioner and the therapist were aware Client #1 was refusing his medication. -No changes in the client behavior had been observed with his refusal of medications. -He was placed on an invega injection 12/4/18 and the physician had discontinued most of his 	V 118	<p>V118-0205 (Assessment and Treatment/Habilitation or Service Plan (V112))</p> <p>Deficiency corrected with implementation of the CCHC Screening/ Admission Assessment Form, all staff retrained in Medication Administration, Facility Switched to PSA Pharmacy which is efficient in keeping updated prescriptions as well as delivering medications with MARS, improved communication lines between the Facility Director and the AP with implementation of the AFC weekly Notes Form as well as closer monitoring of the Facility by the AP.</p>	12/28/18
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V 118	<p>Continued From page 14</p> <p>oral medications due to the continued refusals. -Client #1 was hospitalized on 12/16/18 - 1/3/19 due to suicidal ideations. -He was not aware the physician or pharmacist should be notified with any refusal of medication. -He was not aware of the inaccuracy on the MAR for Client #2 with the Hydroxyzine, he should have made sure the MAR was correct.</p> <p>Interview on 12/20/18 with the facility Registered Nurse (RN) revealed: -She did not go to the facility for oversight of medications. -She reviewed the facility MAR every month. -If she noted any errors or questions regarding the MAR she would follow up with the staff. -The staff should document "R" on the MAR for any refusal and explain what the R indicated. -For any continued refusal she would discuss with staff what could be done differently with the client. -She did not recall anything specific about Client #1's continued refusal of medication, therefore she had no discussion with staff on what could be done differently. -She could not recall anything specific about the hydroxyzine for Client #2. If she noted the discrepancy with the MAR, she would have gone to the facility to verify the order.</p> <p>Interview on 12/19/18 with the Qualified Professional revealed: -It was the responsibility of the RN to review the MAR for clients. -She visited the clients and staff at the day program and office 2-3 times each month. -She was not aware of the ongoing medication refusals by Client #1. -Since she did not review the MAR, she was not aware of the error with the hydroxyzine for Client #2.</p>	V 118		

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V 118	<p>Continued From page 15</p> <p>Interview on 1/3/19 and 1/4/19 with the Therapist for Client #1 revealed:</p> <ul style="list-style-type: none"> -She was aware Client #1 was refusing medication. -She did not observe any changes in mood or behavior related to the medication refusal. -He had a history of medication refusals. -He recently re-started the invega injection. -Prior to re-starting the invega injection he was on oral medications, which gave him more control over the day to day refusal. -Client #1 was institutionalized for 2 years prior to his admission to the current facility. -She met with the client 1 time each week and he was also involved with community support 2 times each week. -In the event of a crisis visits would be increased. <p>Interview on 12/19/18 with the assistant for the Nurse Practitioner revealed:</p> <ul style="list-style-type: none"> -The nurse practitioner recently discontinued the medications for Client #1 because he was refusing to take the medication. -He agreed to take the invega injection on 12/4/18. -All of the oral medications were discontinued on 12/4/18. -Client #1 was seen by the nurse practitioner on 8/1/18, 8/8/18, 8/16/18, 8/31/18, 9/14/18, 10/4/18, 12/4/18 and 12/11/18. -Not taking his medication had no effect on his mood or behavior. <p>This deficiency is cross referenced into 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) for a Type A1 rule violation and must be corrected with 23 days.</p>	V 118		

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V 123	Continued From page 16	V 123		
V 123	<p>27G .0209 (H) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted.</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to report drug administration errors/refusals immediately to a physician or pharmacist for 1 of 3 sampled clients (#1). The findings are:</p> <p>-Admission date of 7/13/18 with diagnoses of Borderline Personality Disorder, Suicidal Ideation, Major Depressive Disorder, Autism Spectrum Disorder, Impulse Control Disorder vs Obsessive Compulsive Disorder and Chronic Non-Suicidal Self Harming Behaviors.</p> <p>Review on 12/7/18 and 12/18/18 of the October, November and December 2018 MAR for Client #1 revealed: -Refusal of all routine medications, naltrexone, levothyroxine, omeprazole, lamotrigine, cetirizine, lithium, from 10/6/18-12/16/18, notation on the back of the MAR's "refused medication, notified guardian." -Invega 6mg was refused from 10/6/18-12/4/18, with the same documentation, "refused</p>	V 123	<p>V123 (.0209 Medication Requirements)</p> <p>Medication errors/refusals will be charted and documented on an incident report by the Facility Director which is then submitted to the QP. The Facility will immediately report such incident to a physician or pharmacist. QP will ensure this notification was made.</p>	12/21/19

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V 123	<p>Continued From page 17</p> <p>medication, notified guardian."</p> <p>Interview on 12/18/18 with Staff #1 revealed: -When a client refused a medication he put an "R" on the MAR. -He understood this was all he needed to do with a refusal of medication. -He did not notify the physician or pharmacist when a client refused a medication. -Client #1 had refused his medications for 1-2 months.</p> <p>Interview on 12/18/18 and 1/4/19 with the Director revealed: -He was aware Client #1 was refusing his medications. -He directed the staff to document the refusal of medications on the MAR. -The director notified the guardian of the refusals and the guardian informed him to continue to document the refusals. -The nurse practitioner and the therapist were aware Client #1 was refusing his medication. -He was not aware the physician or pharmacist should be notified with any refusal of medication.</p> <p>Interview on 12/19/18 with the Qualified Professional revealed: -She was not aware of the medication refusals by Client #1.</p> <p>This deficiency is cross referenced into 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) for a Type A1 rule violation and must be corrected with 23 days.</p>	V 123		

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V 291	Continued From page 18	V 291		
V 291	<p>27G .5603 Supervised Living - Operations</p> <p>10A NCAC 27G .5603 OPERATIONS</p> <p>(a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity.</p> <p>(b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management.</p> <p>(c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals.</p> <p>(d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure coordination was maintained between the facility operator and the qualified professional who was responsible for the</p>	V 291	<p>V291 .5603 (Operations)</p> <p>Deficiency corrected with the implementation of the Facility Director completing AFL weekly notes or summaries concerning all clients in the home. These notes are submitted to the DP on a weekly basis as well as the DP will be conducting weekly monitoring in the home for a period of at least 6 weeks and then ongoing on a monthly basis. Copies of AFL weekly notes are attached to this report.</p>	12/28/18

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V 291	<p>Continued From page 19</p> <p>treatment plan for 1 of 3 sampled clients (#1). The findings are:</p> <p>Review on 12/7/18, 12/18/18 and 12/19/18 of the record for Client #1 revealed: -Admission date of 7/13/18 with diagnoses of Borderline Personality Disorder, Suicidal Ideation, Major Depressive Disorder, Autism Spectrum Disorder, Impulse Control Disorder vs Obsessive Compulsive Disorder and Chronic Non-Suicidal Self Harming Behaviors. -MAR from October to December 2018 indicated Client #1 had refused all routine medications from 10/6/18-12/4/18.</p> <p>Interview on 12/18/18 with Staff #1 revealed: -When a client refused a medication he put an "R" on the MAR. -He understood this was all he needed to do with a refusal of medication. -Client #1 had refused his medications for 1-2 months. -The director was aware of the medication refusals.</p> <p>Interview on 12/18/18 and 1/4/19 with the Director revealed: -He was aware Client #1 was refusing his medications. -He directed the staff to document the refusal of medications on the MAR. -The director notified the guardian of the refusals and the guardian informed him to continue to document the refusals. -The nurse practitioner and the therapist were aware Client #1 was refusing his medication. -He handled the refusals and at the time believed this was sufficient. -He did not make the Qualified Professional aware of the ongoing refusals by Client #1.</p>	V 291		

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STAMEY HOME 1 **180 JUSTICE ROAD**
MARION, NC 28752

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V 291	Continued From page 20 -He should have communicated this issue to the QP. Interview on 12/20/18 with the facility Registered Nurse (RN) revealed: -She did not go to the facility for oversight of medications. -She reviewed the facility MAR every month. -If she noted any errors or questions regarding the MAR she would follow up with the staff. -The staff should document "R" on the MAR for any refusal and explain what the R indicated. -For any continued refusal she would discuss with staff what could be done differently with the client. -She did not recall anything specific about Client #1's continued refusal of medication. Interview on 12/19/18 with the Qualified Professional revealed: -The MARS were reviewed by the nurse. -She did not recall being informed by the nurse or the director Client #1 was refusing his medications. -She was not aware of the medication refusals by Client #1, but she should have known this information. -The treatment plan should have been updated to include medication management. This deficiency is cross referenced into 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) for a Type A1 rule violation and must be corrected with 23 days.	V 291	<i>V3166 (.0603 Incident Response Requirements for Category A and B Providers) A copy of Incident level I, II and III definitions provided to all staff and the Facility Director. That copy is also attached to this report. All level II and III incidents will initiate a team meeting for implementation of corrective and preventative measures.</i>	<i>12/21/19</i>
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR	V 366		

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V 366	<p>Continued From page 21</p> <p>CATEGORY A AND B PROVIDERS</p> <p>(a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by:</p> <ol style="list-style-type: none"> (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. <p>(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.</p> <p>(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:</p> <ol style="list-style-type: none"> (1) immediately securing the client record <p>by:</p> <ol style="list-style-type: none"> (A) obtaining the client record; 	V 366		

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V 366	<p>Continued From page 22</p> <p>(B) making a photocopy;</p> <p>(C) certifying the copy's completeness; and</p> <p>(D) transferring the copy to an internal review team;</p> <p>(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:</p> <p>(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;</p> <p>(B) gather other information needed;</p> <p>(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and</p> <p>(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and</p> <p>(3) immediately notifying the following:</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/04/2019
NAME OF PROVIDER OR SUPPLIER STAMEY HOME 1		STREET ADDRESS, CITY, STATE, ZIP CODE 180 JUSTICE ROAD MARION, NC 28752		
(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 366	<p>Continued From page 23</p> <p>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;</p> <p>(B) the LME where the client resides, if different;</p> <p>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;</p> <p>(D) the Department;</p> <p>(E) the client's legal guardian, as applicable; and</p> <p>(F) any other authorities required by law.</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to implement written policies governing their response to level I incidents. The findings are:</p> <p>Review on 12/7/18, 12/18/18 and 12/19/18 of the record for Client #1 revealed: -Admission date of 7/13/18 with diagnoses of Borderline Personality Disorder, Suicidal Ideation, Major Depressive Disorder, Autism Spectrum Disorder, Impulse Control Disorder vs Obsessive Compulsive Disorder and Chronic Non-Suicidal Self Harming Behaviors.</p> <p>Review on 12/7/18 and 12/18/18 of the October, November and December 2018 MAR for Client #1 revealed: -October 2018 - Invega, Lithium, Lamotrigine, Naltrexone, Levothyroxine, Omeprazole and</p>	V 366		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-077	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/04/2019
NAME OF PROVIDER OR SUPPLIER STAMEY HOME 1		STREET ADDRESS, CITY, STATE, ZIP CODE 180 JUSTICE ROAD MARION, NC 28752		
(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 366	<p>Continued From page 24</p> <p>Famotidine was refused 10/6/18-10/31/18. -November 2018 - Naltrexone HCL, Levothyroxine, Omeprazole were refused 11/1/18-11/30/18. -November 2018 was missing page 2 of the MAR. -December 2018 -Invega 6mg documented as refused from 12/1/18-12/16/18, order was discontinued on 12/4/18 and placed on injection. -Cetirizine, Famotidine, Lithium, Lamotrigine, Naltrexone, Levothyroxine, Omeprazole refused from 12/1/18-12/16/18.</p> <p>Review on 12/18/18 of the facility incident reports revealed: -No level 1 incident reports were completed for any of the medication refusals for Client #1.</p> <p>Interview on 12/19/18 with the Director revealed: -He did not notify the qualified professional of the refusals and was not aware of the requirement for incident reports.</p> <p>Interview on 12/19/18 with the Qualified Professional revealed: -She was not made aware of the refusals and level 1 incident reports were not completed.</p>	V 366		

Page 2 – V108 (Cross Referenced 10A NCAC 27G .0202 Personnel Requirements) Staff #1 received client specific trainings for Client #1, #2 and #3. Copies are attached for review. Qualified Professional will ensure all staff receive client specific training on all future clients. Also attached are Staff #1 trainings upon hire. Complete Date: 12/21/18

Page 4 – V111 (Cross Referenced 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan) Licensee has created (Community Companion Home Care Screening/Admission Assessment Form). All incoming referrals will be sent the screening/admission form prior to placement to ensure individual needs can be met. A copy of the Screening /Admission Form is attached for review. Complete Date: 01/28/19

Page 6 – V112 (Cross Referenced 10A NCAC 27G .0209 Medication Requirements (V118)) All staff to include the Director of the facility, Staff #1 and the Qualified Professional have been retrained in Medication Administration. Copies of these trainings are attached for review. Complete Date: 12/21/18

Page 6 – V112 (Cross Referenced 10A NCAC 27G .0209 Medication Requirements (V123)) Incident reports will be completed for all incidents of drug administration errors/refusals. Medication administration errors/refusals will be immediately reported to a physician or pharmacist. Complete Date: 12/21/18

Page 6 – V112 (Cross Referenced 10A NCAC 27G .5603 Operations (V291)) Facility Operator and the Qualified Professional have implemented weekly summaries of concerns, issues and updates pertaining to all clients in the home. This will be completed on an AFL Weekly Notes form to keep the Qualified Professional informed in order to help keep the best Treatment Plan in place for each Client. Complete Date: 12/28/18

Page 6 – V112 (Cross Referenced 10A NCAC 27G .5603 Operations(V291)) Client #1 is currently admitted to St. Joseph's Hospital. Client will not be returning to the Stamey Home per Team/Guardian decision. Complete Date: 01/20/19

Page 7 – V112 “By December 28, 2018 the following will occur.

- 1- All staff providing direct care services have received re-medication administration training which specifically addressed client refusal of medications, reading medication labels and comparing to original physician orders for correct dosage, route and time of day. This training was implemented by CCHC (licensee) and completed by Laesha Swepson, BSN, RN. Copies of training certificates attached for review. Complete Date: 12/21/18
- 2- All MARS, physician orders and medications have been reviewed by the attending QP, Susan Thompson and the RN, Laesha Swepson for accuracy and correct dosage as prescribed. The RN also observed the home during a medication administration and provided support and counseling on 12/20/2018. RN also met with Facility Director on 01/30/19 and reviewed documentation regarding medication administration of the Home. See attached Supervision Notes. Date Complete: 12/20/18
- 3- Marion RHA (mental health provider) provided documentation as related to identified member who refuses medication on a daily basis for appropriate interventions/strategies to promote positive outcome for member to willingly take medications as prescribed. Obtained documentation attached to this report. Date Complete: 12/28/18
- 4- Client #1 admitted to hospital for suicidal ideation on 12/16/18 with a discharge date of 12/19/18. Client #1 readmitted to hospital for suicidal ideation on 12/23/18 and discharged on 01/03/19. Client #1 was once again admitted to the hospital on 01/19/19 for suicidal ideation. Do to change in level of care, this client currently remains in hospital and will not be returning to the Stamey Home per team/guardian decision. Therefore, no PCP update. The Qualified Professional has treatment plans for Client #2 and Client #3 and they currently meet the individuals needs. Client #2 does have an annual review as well for 01/16/2019 and Client #3 has an annual review on 01/15/2019. Date Complete 12/28/18
- 5- CCHC (licensee) ensuring that the QP will do weekly observations in the home for a period of at least 6 weeks and then ongoing on a monthly basis. All visits/trainings will be documented. QP will ensure updates/ changes will be implemented as ongoing needs are assessed. Date Complete: 12/28/18
- 6- Service Coordination is being maintained between the facility director, Jamey Stamey and the Qualified Professional, Susan Thompson by the implementation of weekly updates for each residing member in the home regarding but not limited to medication changes, doctor appointments, behavioral concerns, goals and overall well-being of each member. This will be ongoing strategy to promote clear communication and care for each individual residing in the home. Date Complete 12/28/18

Page 9 & 10 – V118 (27G .0209 (c) Medication Requirements)

1. All involved direct staff have had updated medication administration training.
Date Complete: 12/21/18
2. Medications will be self-administered by clients only when authorized in writing by the client's physician. Date Complete: 12/21/18
3. All involved direct staff have had updated medication administration training.
Date Complete: 12/21/18
4. Staff will ensure the Medication Administration Records of all drugs administered to each client are kept current and accurate by the review of the Facility Director, the Qualified Professional, the CCHC (licensee) Registered Nurse as well as an independently hired personnel by the Facility Director to review MARS. All medication prescriptions have been transferred to PSA Pharmacy. PSA Pharmacy delivers all medications and pre-written MARS directly to the facility.
Date Complete: 12/28/18
5. Facility Director and QP will ensure requests for medication changes or checks are recorded and kept with the MAR file followed up by an appointment or consultation with a physician.
Date Complete: 12/28/18

Page 12 – V118

Client #1 was missing page 2 of the November 2018 MAR. A copy of this page is attached to this report.
Date Complete: 12/28/18

Page 13 – V118

Client #2 documentation regarding prescribed hydroxyzine attached to this report.
Date Complete: 12/20/18

Pages 14, 15 & 16 – V118 (Cross Referenced into 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112))

Deficiency corrected with the implementation of the CCHC Screening/Admission Assessment Form, all staff retrained in Medication Administration, Facility switched to PSA Pharmacy which is efficient in keeping updated prescriptions as well as delivering medications with MARS, Improved communication lines between the Facility Director and the Qualified Professional with the implementation of the AFL Weekly Notes Form as well as closer monitoring of the facility by the QP. Date Complete: 12/28/18

Page 17 & 18 – V123 (Cross Referenced 10A NCAC 27G .0209 Medication Requirements)

Medication errors/refusals will be charted and documented on an incident report by the Facility Director which is then submitted to the Qualified Professional. The Facility will immediately report such incident to a physician or pharmacist. QP will ensure this notification was made. Date Complete: 12/21/18

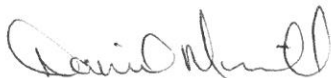
Page 19, 20 & 21 – V291 (Cross referenced 10A NCAC 27G .5603 Operations)

Deficiency corrected with the implementation of the Facility Director completing AFL Weekly Notes or summaries concerning all clients in the home. These Notes are submitted to the Qualified Professional on a weekly basis as well as the QP will be conducting weekly monitoring in the home for a period of at least six weeks and then ongoing on a monthly basis. Copies of AFL Weekly Notes are attached to this report for review. Date Complete: 12/28/18

Page 21, 22, 23, 24 & 25 – V366 (Cross Referenced 27G .0603 Incident Response Requirements for Category A and B Providers)

A copy of Incident Level I, II and III definitions provided to all staff and the Facility Director. That copy is also attached to this report. All level II and III incidents will initiate a team meeting for implementation of corrective and preventative measures. Date Complete: 12/21/18

Daniel Merrill



VP Quality Assurance

Community Companion Home Care, LLC

Community Companion Home Care, LLC

Client Specific Competencies

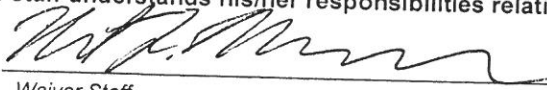
Indicate competencies to be trained as determined by the individual's treatment planning team and date trainings occurred:

Category	Notes:	Initials
<input checked="" type="checkbox"/> Diagnosis/Needs	Autism Spectrum D/O, Impulse Control, Depression, Anxiety, Chronic & recurrent self-harming behaviors, Obesity	
<input type="checkbox"/> Approved Physical Interventions	NA	
<input checked="" type="checkbox"/> Goals/Outcomes	See provider action plan	
<input checked="" type="checkbox"/> Behavior Concerns	SIB, (cutting), Overdosing with psychotropics	
<input checked="" type="checkbox"/> Communication Techniques		
<input checked="" type="checkbox"/> Medical Concerns	Heart Healthy diet recommended, can have severe headaches	
<input type="checkbox"/> Seizures		
<input checked="" type="checkbox"/> Allergies	Penicillin	
<input type="checkbox"/> Medications	Lithium, Benadryl	
<input type="checkbox"/> Medication Administration		
<input type="checkbox"/> Assistance with Self Administration		
<input type="checkbox"/> Routines		
<input type="checkbox"/> Daily Care		
<input type="checkbox"/> Use of Adaptive Equipment		
<input type="checkbox"/> Transfers/Carries		

Within 90 days or as specified:

Category	Notes:	Date
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		

The signatures below verify that training in elements indicated above has been completed and the direct care staff understands his/her responsibilities relating to the elements.


 Waiver Staff _____ Date: 12-21-18


 Susan Thompson, BSAP _____ Date: 12-21-18
 Community Companion Home Care, LLC Trainer

Community Companion Home Care, LLC

Client Specific Competencies

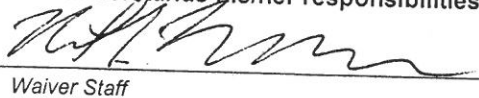
Indicate competencies to be trained as determined by the individual's treatment planning team and date trainings occurred:

Category	Notes:	Initials
<input checked="" type="checkbox"/> Diagnosis/Needs	Autistic D/O, Moderate IDD, Oppositional Defiant D/o	
<input type="checkbox"/> Approved Physical Interventions	NA	
<input checked="" type="checkbox"/> Goals/Outcomes	See provider action plan	
<input checked="" type="checkbox"/> Behavior Concerns	History of cursing & hitting others, Property destruction, use of racial slurs, kicking, pulling hair, throwing objects, punching walls, breaking windows.	
<input checked="" type="checkbox"/> Communication Techniques	Verbal	
<input type="checkbox"/> Medical Concerns	History of Pre-diabetic, monitor for overeating & healthy food intake. History of in-grown toe nails & will pick the area causing further irritation.	
<input type="checkbox"/> Seizures		
<input checked="" type="checkbox"/> Allergies	Seasonal, may cause nose bleeds	
<input type="checkbox"/> Medications	Aripiprazole, S/D Vit.D SFT Gel, Divalproex, Vyvanse, Retin Cream	
<input type="checkbox"/> Medication Administration		
<input type="checkbox"/> Assistance with Self Administration		
<input checked="" type="checkbox"/> Routines	Community Networking	
<input checked="" type="checkbox"/> Daily Care	Takes pride in dressing & looking good. Bathing, hygiene & grooming require monitoring	
<input type="checkbox"/> Use of Adaptive Equipment		
<input type="checkbox"/> Transfers/Carries		

Within 90 days or as specified:

Category	Notes:	Date
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		
<input type="checkbox"/>		

The signatures below verify that training in elements indicated above has been completed and the direct care staff understands his/her responsibilities relating to the elements.



 Waiver Staff

Date: 12-21-18



 Community Companion Home Care, LLC Trainer

Date: 12.21.18

Community Companion Home Care, LLC

Client Specific Competencies

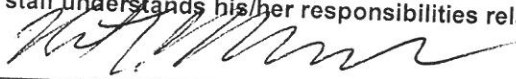
Indicate competencies to be trained as determined by the individual's treatment planning team and date trainings occurred:

Category	Notes:	Date
<input checked="" type="checkbox"/> Diagnosis/Needs	ADHD, Oppositional Defiant Disorder, Unspecified Paraphilic Disorder, Personal sexual abuse history, SIB, Mild I/DD, Seizure Disorder, Asthma, Acid reflux, Hiatal Hernia,	_____
<input type="checkbox"/> Approved Physical Interventions	See Provider Plan (copy given to DCW)	_____
<input checked="" type="checkbox"/> Goals/Outcomes	Residential Supports, Day-supports Individual	_____
<input checked="" type="checkbox"/> Behavior Concerns	Occasionally has outburst for attention, prefer consistent and structured environment, will trust strangers	_____
<input checked="" type="checkbox"/> Communication Techniques	Verbal	_____
<input checked="" type="checkbox"/> Medical Concerns	History of a tissue pocket on part of his brain that was a sign of either a stroke during gestation or closed head injury, Gall bladder removed in 2010	_____
<input checked="" type="checkbox"/> Seizures	History of seizures	_____
<input checked="" type="checkbox"/> Allergies	Amoxicillin, Seasonal Allergies, Mold, Dust, Pet Fur and dander, pollen, leaves	_____
<input checked="" type="checkbox"/> Medications	See Mar	_____
<input checked="" type="checkbox"/> Medication Administration	As Needed	_____
<input type="checkbox"/> Assistance with Self Administration	N/A	_____
<input checked="" type="checkbox"/> Routines	Following goals for services and standard PC	_____
<input checked="" type="checkbox"/> Daily Care	Standard Residential PC	_____
<input type="checkbox"/> Use of Adaptive Equipment	N/A	_____
<input type="checkbox"/> Transfers/Carries	N/A	_____

Within 90 days or as specified:

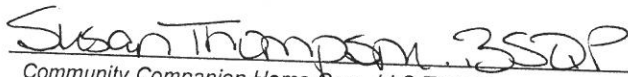
Category	Notes:	Date
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____
<input type="checkbox"/>	_____	_____

The signatures below verify that training in elements indicated above has been completed and the direct care staff understands his/her responsibilities relating to the elements.



Waiver Staff

Date: 12-21-18



Community Companion Home Care, LLC Trainer

Date: 12/21/18

Certificate of Completion

is hereby granted to:

Nathan Hanson

*To certify their satisfactory completion of the
Medication Administration for Unlicensed Personnel
In Community Facilities*

Location: CCHC Office

Contact Hours:

Agency: Community Companion Home Care

Address: 49-A State Street

Marion, NC 28752

Laeesha Swepson BSN, RN
Laeesha Swepson BSN, RN

Date: 12-21-18

Certificate of Completion

is hereby granted to:

Nathan Hansen

To certify their satisfactory completion of the
Medication Administration for Unlicensed Personnel
in Community Facilities

Location: CCHC Office

Contact Hours: /

Agency: Community Companion Home Care

Address: 3288 Harmony Grove Road

Nebo, North Carolina 28761

Sharon T. Warren

Sharon T. Warren, RN, BSN

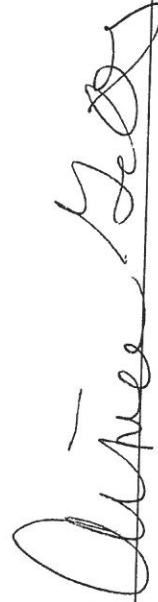
Date: 3/12/18

Community Companion Home Care, LLC
Certificate of Completion

is hereby granted to

Nathan Hanson
to certify that he/she has completed to satisfaction
Cultural Competency

Granted: 3/12/2018



Office Staff

Community Companion Home Care, LLC
Certificate of Completion

is hereby granted to

Nathan Hanson

to certify that he/she has completed to satisfaction

First Aid and CPR

Granted: 3/14/2018 Expires: 3/14/2020



[David Cable, AHA Instructor]

Community Companion Home Care, LLC
Certificate of Completion

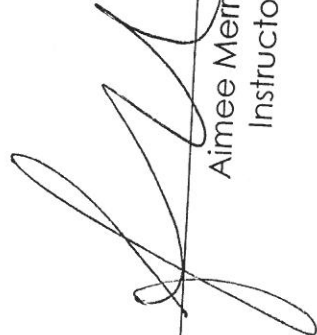
is hereby granted to

Nathan Hanson

to certify that he/she has completed to satisfaction a Nonviolent Crisis
Intervention: NCI-Units- 1-10 training class

CPI

Granted: 3/12/2018 Expires: 3/12/2019



Aimee Merritt, Certified CPI
Instructor # 1062169

Community Companion Home Care, LLC
Supervision Agreement

Type of Supervision

- Clinical (Associate Professionals and Paraprofessionals)
- Administrative Supervision (Qualified Professionals)

Employee Name: Nathan Hanson

Supervisor: Susan Thompson BS QP

Supervision Agreement will remain in effect for one year beginning 12/20/2018 and ending 12/20/2019

Supervision will take place: Monthly (frequency)
For at least: 1/2 hour (duration)

The goals of supervision are to develop/foster technical skills, communication skills, clinical skills, analytical skills, interpersonal skills, decision-making skills and cultural awareness. The QP will assist supervisee to accomplish states goals through training, direct observation, case discussion, documentation review and evaluation:

Individualized Plan for Employee Development:

Nathan will maintain client confidentiality.

He will keep all of his certifications up to date and keep supervisor up to date with any and all changes pertaining to clients' level of care.

He will maintain quality documentation by initialing & signing all billing documentation before submitting.

Signatures:



Supervisee

Date:

12-2018

Susan Thompson, BSQP
Community Companion Home Care QP

Date:

12.20.18

**Community Companion Home Care, LLC
Screening/Admission Assessment**

Name: _____ DOB: _____
 Current Residential Placement: _____
 Address: _____
 Mailing Address (if different): _____
 Home Phone: _____ Other Phone # _____
 Directions: _____

Gender: Male Female
 Marital Status: Single Married Separated Divorced Widowed
 Social Security # _____ Medicaid # 948-61-7006-L
 Other Funding Source (s): _____

Legal Guardian: _____ Relationship: _____
 Guardian Address: _____
 Guardian Phone Number: _____

Emergency Contact: _____ Phone: _____

Presenting Need for Services - summarize below:

Current Services

Service	Amount Authorized	Place of Services (Home, Community, etc.)	Funding Source Medicaid, IPRS, Private Pay, Private Insurance

Name: _____ DOB: _____ Medicaid # _____ Record # _____
CONFIDENTIAL INFORMATION

**Community Companion Home Care, LLC
Screening/Admission Assessment**

DIAGNOSIS

Type: (P) Principal, (R) Primary, (B) Both Principal and Primary, (A) Additional

AXIS	CODE	DESCRIPTION	TYPE
I			
III			
IV		Problems with Primary Support Group, Other Interpersonal Problems, Educational Problems, Housing Problems, Occupational Problems, Economic Problems, Problems with Health Care, Legal Problems, Psychosocial and Environmental Problems, Other (describe above)	
V	GAF	SNAP – Index Score	<input type="checkbox"/> NC TOPPS
	<input type="checkbox"/> Other – please describe		

Documentation of Screening Contacts

(Document date of initial contact and all ongoing contacts prior to admission)

Date	Contact	Signature/Title
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

To be Completed if Client not Admitted to Services

- Services/resources not available - to be kept on file for future consideration
- Client or Guardian declined services.
- Other: _____

Name:

DOB: _____ Medicaid # _____
CONFIDENTIAL INFORMATION

Record # _____

Community Companion Home Care, LLC Screening/Admission Assessment

Date of Admission: _____

Primary Physician: _____

Phone: _____

Address: _____

Allergies: _____

Special Dietary Needs: _____

Current Medications

Name	Dosage	Frequency

Education and Employment History

Current or last school attended:

High School Diploma GED Other: _____

Current or Previous Employment:

Vocational Rehabilitation Does not qualify for VR Other: _____

Adaptive Living Skills

Personal Hygiene: _____

Eating: _____

Dressing: _____

Communication: _____

Ambulation: _____

Other: _____

Supports and Strengths

Supports:

Family

In School

Community

Other:

Friends

Employed

Transportation

Good Health

Spiritual

Leisure

Basic Needs Met

Stable Living Environment

Financial Resources

Name: _____

DOB: _____

Medicaid # _____

Record # _____

CONFIDENTIAL INFORMATION

**Community Companion Home Care, LLC
Screening/Admission Assessment**

Strengths (list):

Behavioral Risks or Concerns

Current Behavior Plan?
If yes, attach a copy.

Yes No
Developed by:

Qualified Professional's Signature:

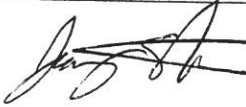
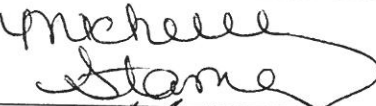
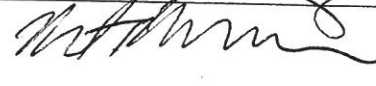

Date:

Name: t

DOB: Medicaid #
CONFIDENTIAL INFORMATION

Record #

Plan of Protection for
 180 Justice Rd. Marion, NC
 Medication Administration Re-Training
 Instructor: Laesha Swepson, BSN, RN/QP for CCHC

Attendees	Print Name	Date	Signature
Jamey Stamey, AFL	Jamey Stamey	12/21/18	
Michelle Stamey, Care Provider	Michelle Stamey	12/21/18	
Nathan Hanson, Care Provider	Nathan Hanson	12/21/18	
Susan Thompson, BSQP	Susan Thompson, BSQP	12/21/18	

Medication Requirements Covered:

- Medication dispensing
- Medication packaging & labeling
- Medication administration
- Medication disposal
- Medication Storage
- Medication Errors & Incident reporting

Date: 12/21/18

Instructors Signature: Laesha Swepson BSN, RN

Certificate of Completion

is hereby granted to:

Susan Thompson

*To certify their satisfactory completion of the
Medication Administration for Unlicensed Personnel
In Community Facilities*

Location: CCHC Office

Contact Hours: _____

Agency: Community Companion Home Care

Address: 49-A State Street

Marion, NC 28752

Laeshia Swepson BSN, RN
Laeshia Swepson BSN, RN

Date: 12-21-18

Certificate of Completion

is hereby granted to:

Michelle Stamey

*To certify their satisfactory completion of the
Medication Administration for Unlicensed Personnel
In Community Facilities*

Location: CCHC Office

Contact Hours: _____

Agency: Community Companion Home Care

Address: 49-A State Street

Marion, NC 28752

Laeesha Swepson BSN RN
Laeesha Swepson BSN, RN

Date: 12-21-18

Certificate of Completion

is hereby granted to:

James Stamey

*To certify their satisfactory completion of the
Medication Administration for Unlicensed Personnel
In Community Facilities*

Location: CCHC Office

Contact Hours: _____

Agency: Community Companion Home Care

Address: 49-A State Street

Marion, NC 28752

Laesha Swepson BSN RN
Laesha Swepson BSN, RN

Date: 12-21-18

Community Companion Home Care, LLC

Supervision Notes

Employee Name: Jamey Stamey

Date/Time 12/20/2018	Location Justice Home
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Topics Discussed	
<input type="checkbox"/> Communication	<input type="checkbox"/> Therapeutic Relationships
<input type="checkbox"/> Crisis Prevention and Intervention	<input type="checkbox"/> Client Rights
<input type="checkbox"/> Confidentiality	<input type="checkbox"/> Abuse and Neglect
<input type="checkbox"/> Person-Centered Thinking	<input type="checkbox"/> Philosophy of Services
<input type="checkbox"/> Service Definitions	<input checked="" type="checkbox"/> Documentation
<input type="checkbox"/> Incident Reporting	<input checked="" type="checkbox"/> Client Specific Medical Issues
<input checked="" type="checkbox"/> X	<input type="checkbox"/> Diagnoses
<input type="checkbox"/> Client Specific Behavioral Issues	<input type="checkbox"/> Planning Needs/Progress on Goals
<input type="checkbox"/> Client Support Needs	<input type="checkbox"/> Natural Supports
<input type="checkbox"/> Positive Behavior Supports	<input type="checkbox"/> Employee Support Needs
<input type="checkbox"/> Home/Environmental Modifications	<input checked="" type="checkbox"/> Training Updates
<input type="checkbox"/> Employee Counseling	<input type="checkbox"/> Other
<input type="checkbox"/> Employee Evaluation	

Comments:

Met at Justice home for home monitoring and evaluation of client specific needs. Discussed with Justice home the appropriate manner to report any medication incidents. Provided education regarding appropriate documentation needed regarding prescriptions such as medication discontinuation orders, new medication orders, etc. Provided education and support on appropriate medication labels. Also spoke with Home about tips and habit to support maintaining appropriate documentation. Observed home in medication administration and provided support and counseling. Education on the appropriate documentation needed regarding PRN administration. Staff was receptive to education and asked appropriate questions.

Supervisor Signature: Shaesha Suepro BSN, RN,

Community Companion Home Care, LLC Supervision Notes

Employee Name: Jamey Stamey / Justice Home

Date/Time 1/30/19 9a	Location Justice Home
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Topics Discussed			
<input type="checkbox"/>	Communication	<input type="checkbox"/>	Therapeutic Relationships
<input type="checkbox"/>	Crisis Prevention and Intervention	<input type="checkbox"/>	Client Rights
<input type="checkbox"/>	Confidentiality	<input type="checkbox"/>	Abuse and Neglect
<input type="checkbox"/>	Person-Centered Thinking	<input type="checkbox"/>	Philosophy of Services
<input type="checkbox"/>	Service Definitions	<input checked="" type="checkbox"/>	Documentation
<input checked="" type="checkbox"/>	Incident Reporting	<input checked="" type="checkbox"/>	Client Specific Medical Issues
<input type="checkbox"/>	Client Specific Behavioral Issues	<input type="checkbox"/>	Diagnoses
<input type="checkbox"/>	Client Support Needs	<input type="checkbox"/>	Planning Needs/Progress on Goals
<input type="checkbox"/>	Positive Behavior Supports	<input type="checkbox"/>	Natural Supports
<input type="checkbox"/>	Home/Environmental Modifications	<input type="checkbox"/>	Employee Support Needs
<input type="checkbox"/>	Employee Counseling	<input type="checkbox"/>	Training Updates
<input type="checkbox"/>	Employee Evaluation	<input type="checkbox"/>	Other

Comments:

Met with Jamey face to face regarding continued supervision of medication management for the Justice home. Jamey and I reviewed each individual chart regard medications, prescriptions, and other medical needs. Reviewed documentation policy regarding medication administration and incident reporting of any medication errors/refusals related to client care. Continued education and reviewed information related to the need for supportive documentation such as prescriptions or MD visits notes to correspond with medication administration. Jamey was receptive to all suggestions and education provided throughout the session.

Supervisor Signature: _____

Aaisha Swenson BSN, RN



RHA
HEALTH SERVICES, INC.

RHA Health Services, Inc.
2415 Morganton Blvd., SW
Lenoir, NC 28645
828-394-5563
Fax 828-754-1560

FAX TRANSMISSION

CONFIDENTIAL HEALTH INFORMATION ENCLOSED

828-559-7546

To:	Community Care	FAX:	828-559-8031	
From:	RHA	Date:	1/28/19	
Re:	D. Cierson	Pages:	7 (Including Cover)	
CC:				
Urgent	For Review	As Requested	Please Reply	Please Recycle

Additional Comments: _____

Confidentiality Note: The enclosed facsimile transmission contains confidential medical record information. This information has been disclosed to the recipient identified above and is protected by State and Federal law. Those laws limit your ability to further disclose this confidential medical information without the prior written consent of the patient/client and his/her legal guardian or unless otherwise permitted by State and Federal law. If you are not the intended recipient, you are hereby notified that any USE, disclosure, copying, distribution, or OTHER action taken WITHOUT RESPECT TO the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.



AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Person Receiving Services: _____

DOB: _____

- Use this form to obtain client or legally responsible person/personal representative authorization for the release of information
- Form must indicate whether this is to release information, obtain information, or both.
- Form must be completely filled out before client or legally responsible person/persons representative signs
- File original form in client record. **MUST GIVE COPY TO CLIENT**

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION 45 C.F.R. Parts of 160; 42 C.F.R. Part 2; G.S. 122C

~~This form implements the requirements for client authorization to use and disclose health information protected by the federal health privacy law (45 C.F.R. parts 160-164), the federal drug and alcohol confidentiality law (42 C.F.R. part 2), and state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122C).~~

I, _____, authorize Community Companion (Client or legally responsible person or personal representative) (Agency or person authorized use or disclose the information) to obtain from: _____ to release/disclose to: RHA Health Services

(Agency or person to whom the requested use or disclosure will be made)

The following protected information:

- Assessments/Evaluations
- Service Notes
- Treatment History Summary
- Other (Specify): _____
- Psychotherapy Notes
- Treatment Plan/Plan of Care
- Medication Records
- Lab Reports
- Emergency Contact Only
- Discharge Summary
- Screening
- NC-TOPPS

The Purpose of the disclosure is: To coordinate care

(Describe each purpose of the requested use or disclosure)

REDISCLASURE

Once information is disclosed pursuant to this authorization, I understand that the federal health privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure. When this agency discloses mental health and developmental disabilities information protected by state law (G.S. 122C), substance abuse treatment protected by federal law (42 C.F.R. Part 2), and HIV Infection Information which is protected by state law (G.S. 130A-143) we must inform the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws. Our Privacy Notice describes the circumstances where disclosure is permitted or required by these laws. I understand that the information to be released may include information regarding drug abuse Alcohol abuse, HIV Infection, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments.

NOTICE OF VOLUNTARINESS

I certify that this authorization is made freely, voluntarily and without coercion. I understand that RHA cannot deny or refuse to provide treatment, payment, enrollment in a health plan or eligibility for benefits if I refuse to sign this authorization, except in limited circumstances, i.e. Research related treatment, services provided solely for reason of creating PHI for disclosure to 3rd party.

REVOGATION AND EXPIRATION

I understand that, with certain exceptions, I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on it. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke are explained in RHA Health Services Privacy Notice, a copy of which has been provided to me.

If not revoked earlier, this authorization automatically expires 1 year after the date of signature below unless otherwise indicated:

(event that relates to the client or the purpose of the use or disclosure)
Signature: _____ Date: 9/7/18 (verbal at start of services)

Please explain authority of person signing above to act on behalf of individual: Guardian Rep. Hope for the Future

Signature: _____ Date: _____
(Minors Signature-only required if minor has a substance abuse diagnosis)

Fax 828-559-8031

NAME: [REDACTED] DOB: [REDACTED] MEDICAID ID: N/A MEDICAL ID: [REDACTED]



Progress Note

Billable: No

Service Date: 10/01/2018	Location: Marion	Program: Behavioral Health
Place of Service: Office	Contact Type: Not face to face	Non Billable Reason: Attempt to Contact Via Phone
Service: NB - Non-Billable Service		
Service Duration: 15		

COMMENTS:

Therapist receives message from Michelle Stamey that [REDACTED] has been obsession about cutting and has cut, and that he wants to talk to therapist, requests that therapist call back. Therapist calls [REDACTED] who confirms report, states he has used "all" of his coping skills to no effect, and cannot stop obsessing about cutting. Therapist coaches [REDACTED] and Michelle on how to use "Ice" coping technique, requests David call back after using. Therapist calls after 45 min to assure safety. [REDACTED] reports he used "Ice" and that it worked, he is no longer obsessing over cutting. He thanks therapist, agrees to attend appointment this Friday.

Approved By: Lisa Ripperton, MSW, LCSW, LCAS	Date Approved: 10/4/2018 1:51:52 PM
Created By: Lisa Ripperton, MSW, LCSW, LCAS	Date Created: 10/4/2018 1:51:40 PM
Provided By: Lisa Ripperton, MSW, LCSW, LCAS	



Progress Note

Billable: Yes

Service Date:	11/29/2018	Location:	Lenoir	Program:	Behavioral Health
Place of Service:	Office	Contact Type:	Not face to face	Authorization:	Yes
Service:	H2015 HT - Community Support Team				
Service Duration:	15				

PURPOSE OF CONTACT (GOALS/OBJECTIVES FROM PCP): List short term goal(s) addressed directly from PCP (Example: Diane will decrease symptoms of depression...Diane will improve budgeting skills...)

decrease or alleviate depressive symptoms

THERAPEUTIC INTERVENTIONS PROVIDED: Interventions should reflect the interventions listed on the PCP under the specific goal that is addressed in the Purpose of Contact. Interventions may include assessment, treatment planning, linking to services, and evaluating effectiveness of the Person Centered Plan as well as direct skill building activities.

LPC called AFL provider to arrange session for later in the week. LPC learned that client had engaged in self injurious behaviors earlier in the week. LPC gathered more information through active listening and questioning. LPC confirmed that legal guardian had been notified of behaviors as client required medical attention. LPC reiterated use of crisis line and asked that family utilize the line for these type situations. LPC made arrangements to see client on Friday. LPC reached out to [REDACTED] legal guardian to discuss and ensure he had been notified as needed. LPC discussed need for treatment team meeting to review progress and ensure team is all on same page with treatment of client. LPC notified QP who is scheduled to see client F:F today. LPC left message with clinical director to staff further.

RESPONSE TO INTERVENTION PROVIDED/PROGRESS TOWARD GOAL: Discuss the progress or lack of progress toward the PCP goal(s) being addressed. (Assessment of progress.)

[REDACTED] is making minimal progress decrease depressive symptoms as AFL provider reports that he took a pencil sharpener from PSR and removed the blade in the middle of the night to cut himself and then required medical treatment. He was transported to ER and received staples in his arm to close the wound. AFL provider reports that he self harms 1-2 times per week however on most occasions wounds are superficial and require no follow up treatment. He also reports they have taken precautions to lock up any sharp items including cans to assist in preventing these type of behaviors from client. Legal guardian was notified by AFL provider to approve needed medical treatment and agreed to need for treatment team meeting to ensure consistency.

PLAN: (What is planned for next contact with consumer?)

Continue to monitor and address self injury. Follow up treatment team meeting to process further.

Approved By:	Tracey Irvine, MA, LPC	Date Approved:	12/1/2018 9:18:37 AM
Created By:	Tracey Irvine, MA, LPC	Date Created:	12/1/2018 9:18:23 AM
Provided By:	Tracey Irvine, MA, LPC		



Progress Note

Billable: Yes

Service Date:	12/16/2018	Location:	Lenoir	Program:	Behavioral Health
Place of Service:	Other Place of Service	Contact Type:	Not face to face	Authorization:	Yes
Service:	H2015 HT - Community Support Team				
Service Duration:	90	Service Start Time:	6:30 PM	Service End Time:	8:00 PM

PURPOSE OF CONTACT (GOALS/OBJECTIVES FROM PCP): List short term goal(s) addressed directly from PCP (Example: Diane will decrease symptoms of depression...Diane will improve budgeting skills...)

decrease or alleviate depressive symptoms
show an increase in self esteem

THERAPEUTIC INTERVENTIONS PROVIDED: Interventions should reflect the interventions listed on the PCP under the specific goal that is addressed in the Purpose of Contact. Interventions may include assessment, treatment planning, linking to services, and evaluating effectiveness of the Person Centered Plan as well as direct skill building activities.

QP received call on crisis phone from Michelle Stamey from AFL where client resides. QP actively listened as AFL director voiced concern over client's statements of wanting to be hospitalized. Once director met with client, she conferenced client with QP. QP engaged client in conversation relating to his preference to be hospitalized. QP note significant symptoms by client. QP provided symptom management techniques, such as grounding and CBT by challenging client to implement interventions developed during sessions to achieve goal of stabilization. QP addressed the issue of medication refractory with client QP praised client for symptom management to avoid degradation of mental health. Client stated he knew his limitations, AFL director and QP agreed with his decision with hospitalization to avoid self-injurious behavior.

RESPONSE TO INTERVENTION PROVIDED/PROGRESS TOWARD GOAL: Discuss the progress or lack of progress toward the PCP goal(s) being addressed. (Assessment of progress.)

Client's mood was expansive. His affect was incongruent; blunted. No improvement in client's symptoms have been made in the last week according to AFL director and as evidenced by client increased intrusive thoughts of self injurious behavior and SI. AFL director voiced concern over client's statements of wanting to be hospitalized. Client engaged in conversation relating to his preference to be hospitalized. Client was provided symptom management techniques, such as grounding and CBT by challenging him to implement interventions developed during sessions to achieve goal of stabilization. Medication refractory with discussed with client and client was challenged to discuss with doctor. Client was praised for symptom management to avoid degradation of mental health. Client stated he knew his limitations and stated he was at the point that he would self-injure if he was not at hospital. AFL director and QP agreed with his decision with hospitalization to monitor client and for him to avoid self-harm.

PLAN: (What is planned for next contact with consumer?)

Client was hospitalized. Guardian (on call staff) with Hope for the Future was contacted by QP and AFL director for consent. CST will follow up after hospitalization. Client has other supportive services to follow up.

Approved By:	Jewell Gist, MSW, QP	Date Approved:	12/17/2018 10:08:13 AM
Created By:	Jewell Gist, MSW, QP	Date Created:	12/17/2018 10:07:51 AM
Provided By:	Jewell Gist, MSW, QP		



Progress Note

Billable: No

Service Date: 01/08/2019	Location: Lenoir	Program: Behavioral Health
Place of Service: Other Place of Service	Contact Type: Not face to face	Non Billable Reason: Basic Benefit Coordination
Service: NB - Non-Billable Service		
Service Duration: 45		

COMMENTS:

late entry- LPC received call from client in crisis. LPC assessed symptoms via phone and reviewed crisis plan with client in an attempt to divert from hospitalization. LPC processed triggers leading to current symptoms. LPC processed recent hospital stay and changes in medications. [REDACTED] continued to verbalize thoughts of self harm and felt he needed to be hospitalized to ensure his safety stating "once I get to this place I can't stop myself" LPC discussed crisis stabilization options to include BHUC and FRTC. [REDACTED] insisted that he felt his needs would be better met at hospital. LPC spoke with AFL provider to ensure client was being observed closely during transport to hospital. LPC reached out to HFTF guardian to obtain consent and advise of plan to present at hospital for assessment.

Approved By: Tracey Irvine, MA, LPC	Date Approved: 1/28/2019 11:31:18 AM
Created By: Tracey Irvine, MA, LPC	Date Created: 1/28/2019 11:22:00 AM
Provided By: Tracey Irvine, MA, LPC	



Progress Note

Billable: Yes

Service Date: 01/18/2019	Location: Lenoir	Program: Behavioral Health
Place of Service: Other Place of Service	Contact Type: Not face to face	Authorization: Yes
Service: H2015 HT - Community Support Team		
Service Duration: 30	Service Start Time: 6:30 PM	Service End Time: 7:00 PM

PURPOSE OF CONTACT (GOALS/OBJECTIVES FROM PCP): List short term goal(s) addressed directly from PCP (Example: Diane will decrease symptoms of depression...Diane will improve budgeting skills...)

decrease or alleviate depressive symptoms

THERAPEUTIC INTERVENTIONS PROVIDED: Interventions should reflect the Interventions listed on the PCP under the specific goal that is addressed in the Purpose of Contact. Interventions may include assessment, treatment planning, linking to services, and evaluating effectiveness of the Person Centered Plan as well as direct skill building activities.

QP entertained phone call from client. QP actively listened as client explained that his depressive symptoms were overwhelming and that he felt the need to go back to hospital. QP processed with client to get a better understanding of triggers. QP processed coping skills discussed with client and what had he done to minimize negative thoughts. QP actively listened as client explained several coping skills attempted with no success. QP processed with AFL provider that was with client. QP listened as she shared that client most likely would be hospitalized again for his safety especially since they were in Asheville at time of crisis. QP noted that AFL stated that hospital has made recommendation for long term psychiatric treatment due to frequent hospitalizations. QP noted AFL provider's statement and explained to client and AFL provider that his safety is priority. QP thanked client for reaching out and informed AFL provider to keep him informed of decisions made in terms of hospitalization.

RESPONSE TO INTERVENTION PROVIDED/PROGRESS TOWARD GOAL: Discuss the progress or lack of progress toward the PCP goal(s) being addressed. (Assessment of progress.)

Minimal progress was made with calming client and working towards a resolution to his depressive episode. Client shared that he felt unsafe and that he would most likely attempt to self-harm if he remained in the home. Client shared that he had attempted many coping skills discussed but none of them calmed his negative thoughts. Client was able to express his needs and concerns clearly. Client shared that he would be placed in long term treatment according to hospital recommendations from last stay. Client and AFL provider agreed that his safety was priority. AFL provider shared that she would discuss plan with client before taking him to hospital for further evaluation. AFL provider will contact QP with decision with update.

PLAN: (What is planned for next contact with consumer?)

QP will follow up with client/AFL provider for update on hospitalization

Approved By: Richard Carson, BA, QP	Date Approved: 1/19/2019 3:59:10 PM
Created By: Richard Carson, BA, QP	Date Created: 1/19/2019 3:58:00 PM
Provided By: Richard Carson, BA, QP	

Community Companion Home Care, LLC. Medication Administration Record

Month/Year: 11/2018

Name: [REDACTED] DOB: [REDACTED] Sex: M Record #: [REDACTED]

Allergies: Penicillin

Name	Initials	<p>A. Put initials in appropriate box when medication is given. B. State reason for refusal / omission on back of form. C. PRN Medications: Reason given and results must be noted on back of form. D. Legend: S = School; H = Home visit; W = Work</p>
Jamey Stamey	JS	
Michelle Stamey	MS	

[Signature]
Name

Medication	Hour	Day																																	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31			
CETIRIZINE 10 MG. TAKE ONE TAB BY MOUTH DAILY 8 P.M.	8AM																																		
FAMOTIDINE 20 MG. TAKE ONE TAB. BY MOUTH TWICE PER DAY	8PM	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R		
	8AM	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R		
INVEGA 6 MG TAB. TAKE ONE TAB BY MOUTH DAILY	8PM	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R		
	8AM	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R		
LITHIUM 300 MG. TAKE 4 TABS (1200 MG.) BY MOUTH TWICE PER DAY	8PM	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R		
	8AM	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R		
LAMOTRIGINE 25 MG. TAKE ONE TAB BY MOUTH DAILY	8PM	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R		
	8AM	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R		
	8PM																																		
	8AM																																		

Community Companion Home Care, LLC. Medication Administration Record

Month/Year: 11/2018

Name: [REDACTED]

DOB: [REDACTED]

Sex: M

Record #: [REDACTED]

Allergies: Penicillin

Name	Initials	A. Put initials in appropriate box when medication is given. B. State reason for refusal / omission on back of form. C. PRN Medications: Reason given and results must be noted on back of form. D. Legend: S = School; H = Home visit; W = Work																															Name	Initials
Jamie Stamey	JS																																	JS
Michelle Stamey	MS																																	
Medication	Hour/Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		
NALTREXONE HCL 50 MG. TAKE ONE TAB BY MOUTH DAILY	8AM		R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R		
LEVOTHYROXINE 25 MCG. TAKE ONE TAB BY MOUTH DAILY	8PM		R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R			
OMEPRAZOLE 40 MG. TAKE ONE CAP. BY MOUTH DAILY	8AM		R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R			
OMEPRAZOLE 40 MG. TAKE ONE CAP. BY MOUTH DAILY	8PM																																	
SEROquel 25 MG. TAB. TAKE ONE TAB. BY MOUTH 3 TIMES DAILY AS NEEDED FOR AGITATION. -PRN-	8AM																																	
	8PM																																	
	8AM																																	
	8PM																																	

Month/Year: 11/2018

Name		Initials		PRN Result Instructions		Name		Initials			
				1) Condition Improved 2) Condition not Improved (Please contact QP) 3) Condition worsened (Contact QP) 4) If condition becomes critical, please contact 911 and QP							
Date	Time Given	Medication & Dosage	Reason	Results	Time Noted	Initials					
11-15-18	6:31 PM	Seroquel 25 mg	Anxiety	Calmed down	8:30	SS					
11-19-18	8:30 PM	Seroquel 25mg	Anxiety	Calmed down	4:02	MS					
11-20-18	8:14 PM	Seroquel 25 mg	Anxiety	Went to sleep	9:33	MS					
11-21-18	3:12 PM	Seroquel 25 mg	Anxiety	Went to sleep	4:25	MS					
11-23-18	10:05 AM	Seroquel 25mg	Anxiety	Calmed down	12:00	MS					
11-26-18	1:10 PM	Seroquel 25mg	Anxiety	Fell asleep	2:35	MS					
11-27-18	7:07 PM	Seroquel 25mg	Anxiety	Fell asleep	8:25	MS					

[Signature]
 [Signature]

Month/Year: 11/2018

Name		Initials	PRN Result Instructions		Name	Initials
			1) Condition Improved 2) Condition not Improved (Please contact QP) 3) Condition worsened (Contact QP) 4) If condition becomes critical, please contact 911 and QP		<u>Nathan Hansen</u>	<u>NH</u>
Date	Time Given	Medication & Dosage	Reason	Results	Time Noted	Initials
11-1	8 AM		Refused meds			NH
11-1	8 PM		Refused meds			NH
11-2	8 AM		Refused meds			NH
11-2	8 PM		Refused meds			NH
11-3	8 AM		Refused meds			NH
11-3	8 PM		Refused meds			NH
11-4	8 AM		Refused meds			NH
11-4	8 PM		Refused meds			NH
11-5	8 AM		Refused meds			NH
11-5	8 PM		Refused meds			NH
11-6	8 AM		Refused meds			NH
11-6	8 PM		Refused meds			NH
11-7	8 AM		Refused meds			NH
11-7	8 PM		Refused meds			NH
11-8	8 AM		Refused meds			NH
11-8	8 PM		Refused meds			NH
11-9	8 AM		Refused meds			NH
11-9	8 PM		Refused meds			NH
11-10	8 AM		Refused meds			NH

Month/Year: 11/2018

Name		Initials	PRN Result Instructions		Name		Initials
			1) Condition not Improved (Please contact QP) 2) Condition worsened (Contact QP) 3) Condition becomes critical, please contact 911 and QP 4)		Bethan Hanson		BJH
Date	Time Given	Medication & Dosage	Reason	Results	Time Noted	Initials	
11-10	8 PM		Refused meds			BJH	
11-11	8 AM		Refused meds			BJH	
11-11	8 PM		Refused meds			BJH	
11-12	8 AM		Refused meds			BJH	
11-12	8 PM		Refused meds			BJH	
11-13	8 AM		Refused meds			BJH	
11-13	8 PM		Refused meds			BJH	
11-14	8 AM		Refused meds			BJH	
11-14	8 PM		Refused meds			BJH	
11-15	8 AM		Refused meds			BJH	
11-15	8 PM		Refused meds			BJH	
11-16	8 AM		Refused meds			BJH	
11-16	8 PM		Refused meds			BJH	
11-17	8 AM		Refused meds			BJH	
11-17	8 PM		Refused meds			BJH	
11-18	8 AM		Refused meds			BJH	
11-18	8 PM		Refused meds			BJH	
11-19	8 AM		Refused meds			BJH	
11-19	8 PM		Refused meds			BJH	