

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL035-035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/03/2019
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NAME OF PROVIDER OR SUPPLIER FRANKLIN COUNTY GROUP HOME #1	STREET ADDRESS, CITY, STATE, ZIP CODE 663 MOULTON ROAD LOUISBURG, NC 27549
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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 A follow-up survey was completed 5/3/19. A deficiency was cited. This was a second follow-up to an annual survey completed 12/4/18. The facility Executive Director requested this follow-up survey after relaying the facility was in compliance as of 2/22/19. This facility is licensed for the following category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the	V 118	SEE ATTACHED	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 5/23/2019

STATE FORM 6899 Z91N11 If continuation sheet 1 of 7

DHSR - Mental Health

MAY 30 2019

Lic. & Cert. Section

Division of Health Service Regulation

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V 118	Continued From page 1 drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on observation, record review and interviews, the governing body failed to assure medications were administered on the written order of a person authorized to prescribe medications for one of three clients (#1). In addition, based on record review and interviews, 2 of 3 staff administering medication failed to demonstrate competency (Lead Staff, staff #1). The findings are: Review on 4/17/19 of Lead Staff's record revealed: - training on the Home Diabetic Chart was completed 2/15/19 and 2/22/19 - additional Diabetes training completed 3/27/19 Review on 4/17/19 of staff #1's record revealed: - training on the Home Diabetic Chart was completed 2/15/19 and 2/22/19 Review on 4/17/19 of Executive Director/Qualified Professional's record revealed: - training on the Home Diabetic Chart was completed 2/15/19 and 2/22/19 - additional Diabetes training completed 3/27/19 Review on 4/17/19 of Qualified Professional #2's record revealed: - training on the Home Diabetic Chart was	V 118		

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V 118	<p>Continued From page 2</p> <p>completed 2/15/19 and 2/22/19 - additional Diabetes training completed 3/27/19</p> <p>Review on 4/17/19 of client #1's record revealed:</p> <ul style="list-style-type: none"> - admission date 5/6/08 - diagnoses including Moderate Intellectual and Developmental Disabilities and Diabetes - a nurse practitioner's order dated 11/29/18 for Novolog sliding scale insulin with instructions to administer the following: blood sugar less than 80 = 0 units; 81-100 = 2 units; 101-150 = 4 units; 151-200 = 5 units; 201-300 = 7 units; greater than 300 = 8 units; re-check blood sugar in 1 hour, if still greater than 300, call doctor - a "Home Diabetic Chart" had documentation that reflected client blood sugar measurements - on 3/1/19 at 5:00 PM client #1's blood sugar (BS) measured 315 and 8 units of sliding scale insulin were administered; at 6:00 PM the BS measured 226 and 7 additional units of sliding scale insulin were given by Lead Staff - on 3/3/19 at 5:00 PM client #1's BS measured 404 and 8 units of sliding scale insulin were given; at 6:00 PM the BS measured 279 and 7 additional units of sliding scale insulin were given by staff #1 - on 3/20/19 at 5:00 PM client #1's BS measured 330 and 8 units of sliding scale insulin were given; at 6:00 PM the BS measured 152 and 5 additional units of sliding scale insulin were given by staff #1 - on 4/3/19 at 5:00 PM client #1's BS measured 325 and 8 units of sliding scale insulin were given; at 6:00 PM her BS measured 134 and 4 additional units of sliding scale insulin were given by staff #1 - on 4/7/19 at 5:00 PM client #1's BS measured 321 and 8 units of sliding scale insulin were given; at 6:00 PM the BS measured 263 and 7 	V 118		

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V 118	<p>Continued From page 3</p> <p>additional units of sliding scale insulin were given by Lead Staff</p> <ul style="list-style-type: none"> - the Home Diabetic Chart documentation was reviewed and initialed several times monthly by Executive Director/ Qualified Professional #1 (ED/QP#1) and Qualified Professional #2 (QP#2) - the agency Registered Nurse (RN) reviewed and initialed the Home Diabetic Chart documentation on 4/12/19 <p>During an interview on 4/17/19, the ED/QP #1 was asked why staff administered additional sliding scale insulin at 6:00 PM without consulting with the on-call doctor when client #1's blood sugar was coming down. The ED/QP #1 reported the instructions didn't say not to.</p> <p>During an interview on 4/25/19, the Lead Staff reported on two occasions, she spoke with on-call endocrinology doctors when client #1's blood sugar measured 300 or higher after a re-check and she was told to give 4 additional units of sliding scale insulin both times. Lead staff reported that depending on the time of day when client #1's blood sugar was high, the instructions would differ. If the BS was high early in the day, she would be instructed to give additional insulin after the re-check. If the BS was high after the re-check in the evening, she would be instructed not to give the sliding scale insulin because the client received a different type of insulin at hour of sleep.</p> <p>During an interview on 5/2/19, the agency RN reported she never spoke with a staff person regarding what client #1's blood sugar measured during a re-check. The RN reported she thought staff inferred that they should give the second dose of sliding scale insulin based on what they had been told previously by endocrinology clinic</p>	V 118		

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V 118	<p>Continued From page 4</p> <p>staff. The RN reported she did training with staff on what to do if client #1's BS measured 300 or higher and sliding scale insulin needed to be administered and to re-check the BS after 1 hour and to call the clinic doctor if the blood sugar was still 300 or higher. The RN reported she did not train staff on what to do if client #1's BS was found to be coming down during the re-check.</p> <p>During an interview on 4/17/19, endocrinology clinic RN reported the client's doctor stated the sliding scale insulin should only be given before meals, twice daily except on weekends. If the blood sugar measured 300 or higher, 8 units of the sliding scale insulin should be given and the staff would recheck the blood sugar an hour later. If the blood sugar was coming down, no additional sliding scale insulin should be given.</p> <p>Review on 5/3/19 of a Plan of Protection dated 5/3/19 and signed by the Executive Director revealed:</p> <p>What will you immediately do to correct the above rule violation in order to protect clients from further risk or additional harm?</p> <p>"Immediately upon notification of additional errors, the Executive Director inserviced all staff of FCGH [Franklin County Group Home] on 4/18/19 regarding not giving additional insulin in the contingent situation where her blood sugar was 300, units administered per physician's order and the blood sugar is coming down. The agency is seeking additional clarification in writing from the Endocrinologist, and if support is not given to the agency, another Endocrinologist is being sought to support the staff, RN, and be responsive to the resident's needs.</p>	V 118		

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V 118	<p>Continued From page 5</p> <p>Describe your plans to make sure the above happens.</p> <p>The Executive Director and RN have reached out to the current Endocrinologist for a meeting/ appointment written clarification for all contingencies of administration will be sought. In addition, the resident has signed a release of records for a second opinion and possible transfer to Dr. [name], an Endocrinologist at [local hospital]. This agency is seeking support for all questions regarding the resident, in a timely manner. The Residential Manager will continue to check the Diabetic Charts multiple times weekly, the QP's will check it monthly and the RN will check it no less than quarterly. The RN will be available to provide training and answer questions as needed and remains on call for constant staff availability."</p> <p>This deficiency was cited as a Type B Violation during the survey completed December 4, 2018. This deficiency was then cited as an Imposed Type B Violation during the survey completed February 21, 2019, but evidence in this survey has increased the severity of this deficiency.</p> <p>This deficiency was cited 6 times on 12/8/15, 11/1/16, 9/21/17, 12/4/18, 2/21/19 and 5/3/19.</p> <p>Client #1, diagnosed with diabetes, was administered additional sliding scale insulin by the Lead Staff and staff #1 a total of 4 times between 3/1/19 and 4/17/19 without a physician's order to do so or without consulting with an on call doctor. During each incident, blood sugar measurements revealed the client's blood sugar was coming down after a dose of sliding scale insulin had been administered the hour before. Three levels of supervision, beyond the staff members that</p>	V 118		

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V 118	Continued From page 6 incorrectly administered additional doses of insulin, were unaware of the errors until this survey. The administration of additional doses of insulin without consulting a doctor was serious neglect of client #1's health. 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 beyond the 23rd day.	V 118		

Plan of Correction

Date of Correction: May 26, 2019

Deficiency Cited: V118: 10A NCAC 27G.0209 Medication Requirements. This rule was not met as evidenced by; Based on observation, record review and interview, the governing body failed to assure medications were administered on the written order of a person authorized to prescribe medications for one of three clients.

Review on 5/3/2019 of client #1's diabetic chart indicated that staff administered the appropriate dose of sliding scale insulin when the client's blood sugar was over 300, then upon recheck in one hour, administered additional sliding scale insulin, although the blood sugar was going down. The written doctor's order does not address this contingent situation, and the staff member acted based on previous verbal orders of the endocrinologist, rather than calling and seeking current instructions from the on call endocrinologist on how to proceed. This error resulted in incorrect insulin administration on 4 occasions between 3/1/2019 and 4/17/2019.

Provider's Plan of Correction: D. D. Residential Services Inc. will assure that all medications are administered based on the physician's orders. A Plan of Protection was implemented 5/3/2019 which included the following interventions and remains current and effective:

- Immediate In-service training of all staff working in the home 4/18/2019 to cease administration of sliding scale insulin in the contingent situation when the resident's blood sugar was over 300, sliding scale insulin is administered, and the blood sugar is coming down.
- Immediately sought written doctor's orders on how to react in that situation. Those were received on May 8, 2019 and immediately In-serviced to all staff of the home.
- Continued review of the Diabetic Home Chart multiple times weekly by the Residential Manager, Monthly by the Qualified Professionals, and no less than quarterly by the RN. The RN will be available to provide training and answer questions as needed and remains on call for constant staff availability and support.

Additional Plan of Correction:

The agency is seeking additional clarification IN WRITING from the Endocrinologist, for ALL contingent situations of Blood Sugar and the written instruction of how to proceed with administration of insulin. It has been determined that the current Endocrinologist Clinic gives mixed verbal instructions causing liability to the client as well as the agency. A second opinion for the client's Diabetes care has been sought (appt completed 5/21/2019) from Franklin

County Health Department. A third opinion has also been scheduled on June 20, 2019 for review by Maria Parham Endocrinology. The client has signed a release of records authorizing both practices to evaluate her medication regimen. The agency will work with all physicians to assure an understanding that written orders must be clear, cover all contingent situations and the physician clinic must be responsive to phone calls from the agency, consistent with directives, and prompt in returning calls at all times regarding the client's care.

Responsible Parties: Direct Support Professionals, Qualified Professionals, RN, Executive Director, Residential Manager, and Quality Improvement Team auditing the home.

Provider Signature: _____

A handwritten signature in black ink, appearing to be 'J. P. Smith', is written over a horizontal line.



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

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

May 21, 2019

Jacinta Johnson, Executive Director
D.D. Residential Services, Inc.
PO Box 88
Henderson, NC 27536

Re: Follow-up Survey completed May 3, 2019
Franklin County Group Home #1, 663 Moulton Road, Louisburg, NC 27549
MHL # 035-035
E-mail Address: jjohnson_ddrs@embarqmail.com

Dear Ms. Johnson:

Thank you for the cooperation and courtesy extended during the follow-up survey completed May 3, 2019.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Type A1 rule violation is cited for 10A NCAC 27G .0209 Medication Requirements (V118).

Time Frames for Compliance

- Type A1 violations must be **corrected** within 23 days from the exit date of the survey, which is May 26, 2019. Pursuant to North Carolina General Statute § 122C-24.1, failure to correct the enclosed Type A1 violation by the 23rd day from the date of the survey may result in the assessment of an administrative penalty of \$500.00 (Five Hundred) against D.D. Residential Services, Inc. for each day the deficiency remains out of compliance.

What to include in the Plan of Correction

- Indicate what measures will be put in place to **correct** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to **prevent** the problem from occurring again.
- Indicate **who will monitor** the situation to ensure it will not occur again.
- Indicate **how often** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

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

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718
www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

May 21, 2019
D.D. Residential Services, Inc.
Jacinta Johnson

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Renee R. Kowalski at (919) 552-6847.

Sincerely,



Toni Rankin-Green
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: qmemail@cardinalinnovations.org
Pam Pridgen, Administrative Assistant

D. D. Residential Services, Inc.
Administrative Office
Post Office Box 88
Henderson, North Carolina 27536
(252) 438-6700 Fax (252)438-6720

DHSR - Mental Health

MAY 30 2019

Lic. & Cert. Section

May 23, 2019

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Dear Sir/Madam,

Please find enclosed the plan of correction for the Type A1 rule violation cited at the Franklin County Group Home, Located at 663 Moulton Road, Louisburg, NC 27549. This is in conjunction with MHL #: 035-035.

The Plan of Protection was completed 5/3/2019 and an additional Plan of Correction is enclosed.

You shall find upon return that the citation has been addressed globally and the correction has been made May 26, 2019. Should you have any questions or concerns, please do not hesitate to contact me at the number provided. We thank you for your feedback, and welcome your return.

Sincerely,



Jacinta Johnson
Executive Director

Franklin County Group Home
Vance Adult Group Home
Warren County Group Home

Graham Ave Group Home
Louisburg Group Home
Oxford Group Home
Roanoke Avenue Group Home

