Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-336	A. BUILDING: _____ B. WING _____	04/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MCCLAIN HOME	7 BEE WOOD LANE SWANNANOA, NC 28778

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V 000	INITIAL COMMENTS An annual survey was completed on April 17, 2019. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Adults of all Disability Groups-Alternative Family Living.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to have the treatment plan signed by the responsible party for 1 of 1 clients (#1). The findings are: Record review on 4/12/18 for Client #1 revealed: -Admitted on 8/29/16 with diagnoses of Moderate Intellectual Disability, Intermittent Explosive Disorder, Impulsive Disorder and Oppositional Defiance Disorder. -Treatment Plan dated 2/1/19 for Client #1 had not been signed by the agency who served as his guardian. Interview on 4/16/18 with the Qualified Professional revealed: -He was responsible for treatment plan goals and updates. Treatment plans were updated annually. -New goals were reviewed at annual care plan meeting which the guardian was a part of. -Getting treatment plans signed by guardians had been challenging both in submitting to the guardian and in getting a response. -Client #1's treatment plan update was on 2/1/19 but he had failed to obtain the signature. He indicated that this error was an oversight.	V 112	V112 The Provider Plan Signature Page was signed by the guardian representative on 6/12/19. (See attachment.) The QP will be responsible for ensuring that all Provider Plan Signature Pages are signed in a timely manner. In the event that there are barriers to obtaining needed signatures, the QP will document attempts to obtain the signatures.	6/12/18 and ongoing
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden);	V 113		

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V 113	Continued From page 2 (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by:	V 113		

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V 113	Continued From page 3 Based on record review and interviews the facility failed to have a signed statement of permission to seek emergency medical care for 1 of 1 clients (#1). The findings are: Record review on 4/12/18 for Client #1 revealed: -Admitted on 8/29/16 with diagnoses of Moderate Intellectual Disability, Intermittent Explosive Disorder, Impulsive Disorder and Oppositional Defiance Disorder. -No consent for emergency medical treatment had been signed by the guardian. Interview on 4/16/18 with the Qualified Professional revealed: -The QP would be responsible for obtaining the signed consent. -He was unaware that the emergency consent for medical treatment had not been signed.	V 113	V113 The guardian signed the Consent and Authorization to Provide Emergency Medical Dental Treatment form on 6/12/19. (See attachment.) The QP will be responsible for obtaining the needed signature for this form annually. Any barriers and attempts to obtain the signature will be documented by the QP. The guardian signed the Member Emergency Release form on 6/12/19. (See attachment.) The QP will be responsible for obtaining the needed signature annually. Any barriers and attempts to obtain the signature will be documented by the QP.	6/12/19 and ongoing
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following	V 367		

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V 367	Continued From page 4 information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death	V 367		

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V 367	Continued From page 5 immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure Level II incidents were reported to the Local Management Entity (LME) within 72 hours of becoming aware of the incident effecting 1 of 1 clients (#1). The findings are: Review on 4/16/19 of incident reports from 9/2018-4/2019 revealed: -On 12/10/18 " ...QP (Qualified Professional) was contacted by the AFL Provider after consumer (Client #1) had broken a lamp in the home ...became agitated, throwing a chair which broke	V 367	V367 At the time the QP entered the incident in IRIS on 12/12/18, he was unfamiliar with the process. After entering the text for report and receiving the report number, the QP understood that to mean that the report had been submitted. The QP is now aware of the process, and is responsible for ensuring that incidents are entered correctly.	6/12/19 and ongoing

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V 367	Continued From page 6 a lamp in the living room area. Provider got on the phone with police when consumer stood in the doorway refusing to move so that she could exit the room. Police arrived and spoke with consumer ..." -IRIS (Incident Response Improvement System) number was available to indicate that a report had been created. Review on 4/12/19 of incident reports in the IRIS system indicated that no IRIS report had been submitted for the incident on 12/10/18. Interview on 4/16/18 with the Qualified Professional revealed: -He was responsible for IRIS reports. -He had entered the text for the report on 12/12/18 but did not know that the report had not gone through. -He thought that when he received a number for the report that it had been submitted.	V 367		

nc outreach
A SUPPORT SOLUTIONS COMPANY

CONSENT AND AUTHORIZATION TO PROVIDE EMERGENCY MEDICAL AND DENTAL TREATMENT

Pursuant to Federal HIPAA and DDS guidelines concerning my right to confidentiality,

I, [redacted], Parent and/or Guardian

of [redacted], Member,

authorize any employee of NC Outreach, to provide emergency medical and dental treatment when necessary.

I understand that I can revoke this Consent and Authorization to Provide Emergency Medical and Dental Treatment at any time. However, I also understand that any Release which has been made prior to my revocation and which was made in reliance upon this Consent and Authorization shall not constitute a breach of my rights to confidentiality. Unless I revoke this Consent and Authorization prior to such time, this Consent and Authorization to release information shall start and expire (when):

(Start date, event, condition or expiration)

At that time, no express revocation shall be needed to terminate my consent.

[redacted]
Signature of Parent and/or Guardian Date: 6/12/19

Nicholas Bell BAO
Signature of NC Outreach Representative Date: 6/12/2019

ncoutreach
A SERVICE SOLUTIONS COMPANY

MEMBER EMERGENCY RELEASE

Please print clearly

Last Name: [redacted] First Name: [redacted] MI: ____

Address: [redacted]

City: [redacted] State: NC Zip: [redacted]

Date of Birth: [redacted] SS#: ____

Gender (circle one): Female Male

Parent/Legal Guardian:

Name: [redacted] Relationship: Guardian

Home Phone: ____ Cell Phone: [redacted]

Other Emergency Contact:

Name: Nicholas Bell Relationship: Q.P.

Home Phone: ____ Cell Phone: (828) 333-8733

In the event emergency medical treatment is deemed necessary, please list medical conditions medical staff should be aware of: [redacted]

Allergies: No known allergies

Emergency Medical Release:

I, the undersigned parent/legal guardian to the above-stated individual, do hereby authorize emergency personnel to take whatever actions may be necessary to obtain emergency medical care, if warranted. These actions may include, but not be limited to, the following: attempting to contact parent/legal guardian, attempting to contact parent/legal guardian through any of the persons listed above, calling 911 for assistance, and/or having Member transported by ambulance to a hospital, if recommended by emergency personal, etc.

I, the parent/legal guardian of above-named individual, hereby further authorize any emergency medical responders or physician/medical staff of licensed hospital to provide treatment as deemed necessary until I can be notified. I understand this authorization is given in advance of any treatment being required.

X [redacted] 6/12/19

Signature of Parent/Legal Guardian Date