STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-158	A. BUILDING: _____ B. WING _____	R 06/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING WAY 104	104 CARING WAY SHELBY, NC 28150

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

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a client (Client #2)'s treatment plan was updated in coordination with his legally responsible person. The findings are: Review on 6/12/19 of Client #2's record revealed: Date of admission: 12/7/09 Diagnoses: Autism, Schizophrenia, Severe Intellectual Developmental Disability, Seizure Disorder, Seasonal Allergies -His 1/1/19 treatment plan revealed: -No signature from Client #2's legal guardian that indicated the guardian's acknowledgement and/or approval of his updated treatment plan; -The following written statements were on Client #2's plan, "Unable to reach Guardian by fax or phone," and "Explained to the person served the goal revision and prompt level change." Interview and observation on 6/11/19 at 3:52 pm with Client #2 revealed: -He was non-verbal; -He communicated by nodding his head and blinking his eyes in response to questions. Interview on 6/17/19 with the Director/Qualified Professional (QP) revealed: -Client #2's treatment plan had been revised on 1/1/19 because he met a goal; -He did not have communication with Client #2's legal guardian when the plan was updated; -Client #2 had a meeting scheduled for 6/18/19 for his annual treatment plan to be updated; -Client #2's legal guardian was expected to attend this meeting and participate in updating Client #2's annual plan for which he would secure all the required signatures for the plan.	V 112		

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V 113	Continued From page 2	V 113		
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); (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	V 113		

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V 113	Continued From page 3 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: Based on record review and interview, the facility failed to maintain a client record with current emergency information for a client and failed to obtain a signed statement from the client's legally responsible person that granted permission to the facility to seek emergency care for the client from a hospital or a physician. The findings are: Review on 6/12/19 of Client #2's record revealed: Date of admission: 12/7/09 Diagnoses: Autism, Schizophrenia, Severe Intellectual Developmental Disability, Seizure Disorder, Seasonal Allergies -Client #2's record maintained at the facility contained emergency contact information for two legal guardians from two separate entities; -9/25/13, date of the guardianship appointment of Client #2's previous legal guardian; -11/29/18, date of the guardianship appointment of Client #2's current legal guardian; -A written consent from Client #2's previous legal guardian was dated in 2013 which authorized the facility to seek emergency care for Client #2 from a hospital or a physician; -There was not a current written consent from Client #2's current guardian for the facility to seek emergency care for him. Interview and observation on 6/11/19 at 3:52 pm with Client #2 revealed: -He was non-verbal and communicated with hand	V 113		

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V 113	Continued From page 4 and facial gestures in response to questions; Interview on 6/12/19 with the Home Manager (HM) revealed: -She identified Client #2's previous guardian when asked about contact information for Client #2's current guardian. Interview on 6/17/19 with the Director/Qualified Professional (QP) revealed: -He confirmed the identity of Client #2's current legal guardian; -Client #2 had a meeting scheduled for 6/18/19 for his annual treatment plan; -He would have Client #2's consent for emergency care updated at this meeting.	V 113		
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 information: (1) reporting provider contact and identification information;	V 367		

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V 367	Continued From page 5 (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 immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a	V 367		

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V 367	Continued From page 6 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 notify the Local Management Entity (LME) of all Level II incident reports within 72 hours. The findings are: Review on 6/12/19 of Client #4's record revealed: Date of admission: 1/23/19; Diagnoses: Moderate Intellectual Developmental Disability, Schizophrenia, Personality Disorder, Type B Wolf Parkinson White Syndrome, Temporal Lobe Epilepsy, Hypothyroidism, Hypertension, Gastroesophageal Reflux Disease (GERD), Hyperlipidemia -Behaviors that were erratic due to Schizophrenia diagnosis and included a history of aggression	V 367		

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V 367	Continued From page 7 toward others (throwing objects, threats, slapping, property destruction); -Her 1/23/19 treatment plan contained behavioral goals and treatment strategies. Review on 6/12/19 of a written 6/2/19 entry in a staff communication log revealed: -6/2/19 at an un identified time, Client #4 hit a staff (Staff #1) who told her to quit hitting her; -Client #4 threw a chair and almost hit Client #2 with the chair; -She threw a chair to break a window; -Client #4 stated she wanted to return to a psychiatric hospital from which she had been discharged; -Staff #1 called local emergency services (911) and local law enforcement came to the facility and told Client #4 to stop throwing chairs and informed her that she was not returning to the hospital; -Client #4 agreed to stop throwing chairs; -There was no documentation that Client #4 had further aggression after local law enforcement involvement; -Staff written entries from 6/3/19 to 6/11/19 had Client #4 with no further incident of aggression. Review on 6/12/19 of written facility incident reports from 4/1/19 to 6/12/19 revealed: -No written Level I or Level II incident report about Client #4's aggressive behaviors on 6/2/19 that involved a report to local law enforcement. Review on 6/12/19 of the NC Incident Response Improvement System (IRIS) revealed: -No Level II IRIS report about Client #4's behaviors on 6/2/19 with local law enforcement involvement, additional interventions taken by Staff #1 and measures were identified to prevent a reoccurrence of her aggression.	V 367		

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V 367	Continued From page 8 Interview on 6/12/19 with Staff #1 revealed: -Client #4 had behaviors that included threatening to harm others; -Client #4 hit her and threw a chair which missed hitting Client #2 with the chair; -Client #4 picked up a chair and threatened threatened to throw the chair through the window; -Client #4 hit her last weekend because she wanted to stay up later than usual; -She called the Home Manager (HM) who came to the facility; -Client #4 called her mother which helped her to calm down; -She just wrote down what happened with Client #4 in the staff communication log; -The staff communication log was used by staff to share client changes and facility issues from one shift to another; -She made no mention about recent law enforcement involvement with Client #4. Interview on 6/12/19 with the HM revealed: -The 6/2/19 written entry in the staff communication log was made by Staff #1; -Staff documented client changes and facility issues in the staff communication log; -She was uncertain whether Staff #1 had completed a written incident report on 6/2/19 about Client #4's aggressive behaviors which resulted in a visit from local law enforcement; Interview on 6/17/19 with the Director/Qualified Professional revealed: -No written incident report was found regarding Client #4's behaviors on 6/2/19 with involvement by local law enforcement.	V 367		