STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mh1095-044	A. BUILDING: _____ B. WING _____	R 06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDSAY HOME	394 CAMP JOY ROAD ZIONVILLE, NC 28698

(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, follow-up and complaint survey was completed on June 6, 2019. The complaint was substantiated (intake #NC 00150846). 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	DHSR - Mental Health JUN 27 2019 Lic. & Cert. Section	
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;	V 113	27G.0206 client records (6) Authorization For Medical Treatment Consent was signed by the guardian for resident #1 and #2. Review of records quarterly to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mh1095-044	A. BUILDING: _____ B. WING _____	R 06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDSAY HOME	394 CAMP JOY ROAD ZIONVILLE, NC 28698

(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 113	Continued From page 1 (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: Based on record review and interview the facility failed to ensure signed consents from legal guardians of 2 of 3 audited clients (Clients #1 and #3) that granted permission to seek emergency medical care for the clients from a hospital or physician The findings are: Review on 6/6/19 of Client #1's record revealed: -Admission date: 9/27/10; -Diagnoses: Mild Intellectual Developmental Disability (IDD), Generalized Anxiety Disorder, Dysthymia, Hypertension, Gastroesophageal Reflux Disease (GERD), and Asthma; -She took a minimum of 12 physician-ordered medications daily which staff administered to her; -She had up to 3 hours of unsupervised time in the community for which she was assessed, found eligible and was approved by signature of her legal guardian on 5/6/19; -The identity of her legal guardian on the 5/6/19 unsupervised time written consent was different from the named legal guardian on her 9/27/10	V 113 27G.0206 client records. (6)	there has been no changes needed. QP will review the records. on 6/23/19, guardian signed new consent form for medical treatment. Records will be reviewed quarterly, by QP. Please see attached.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl095-044	A. BUILDING: _____ B. WING _____	R 06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDSAY HOME	394 CAMP JOY ROAD ZIONVILLE, NC 28698

(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 113	Continued From page 2 written consent to seek emergency medical care. Review on 6/5/19 of a written facility incident report, which was dated 8/4/18 and pertained to Client #1, revealed: -Client #1 told Staff #2 that she had fallen the night before when she went to use the telephone; -She was walking fast when she fell and did not have shoes on her feet; -She was not injured from the fall; -She had reported this incident when it occurred because she was not hurt; -Staff #2 noted Client #1 had no visible injuries. Review on 6/6/19 of Client #3's record revealed: -Admission date: 9/9/13; -Diagnoses: Mild IDD, Mellitus Type II Diabetes Non-Insulin Dependent (NID), Depression, Hypertension, Hypothyroidism, Sleep Apnea, Lichen Sclerosis, and Allergeric Rhinitis; -She took a minimum of 8-9 physician-ordered medications daily which staff administered to her; -9/9/13, Client #3 gave her written permission to the facility to seek emergency medical care for her during a period in which she was her own guardian; -9/22/17, she had a legal guardian appointed to her; -Her written consent was not updated with her legal guardian's written consent for the facility to seek emergency medical care for her from a hospital or physician.	V 113 27 G.0206 (4) client records	Client #3; new guardian signed Authorization For Medical Treatment Agreement on 6/21/19. Her records will be reviewed quarterly by QP. Please see attached.	6/24/19
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl095-044	A. BUILDING: _____ B. WING _____	R 06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDSAY HOME	394 CAMP JOY ROAD ZIONVILLE, NC 28698

(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 114	Continued From page 3 shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure disaster drills were conducted under conditions that simulated disaster emergencies. The findings are: Review on 6/5/19 of the disaster drill log revealed: -Disaster drills were documented as held twice each quarter and on each shift from 1/2018 through 1/2019. Interviews on 6/5/19 with Clients #1, #2 and #3 revealed: -Disaster drills such as tornadoes, bomb threat and power outages were done by talking about what actions they would take if a disaster occurred; -They did not practice what was discussed for a disaster occurrence. Interview on 6/5/19 with Staff # 2 revealed: -Disaster drills were held at minimum every other month; -She conducted disaster drills with the clients living at the facility;	V 114	27G.0207 Emergency plans & Supplies Staff was instruced that a disaster drill had to include a simulation of what to do if a disaster occured. This will be carried out and documented quarterly, and reviewed by QP. on 6/24/19, staff conducted a disaster/tornado drill with all residents of Lindsay Home.	6/24/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl095-044	A. BUILDING: _____ B. WING _____	R 06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDSAY HOME	394 CAMP JOY ROAD ZIONVILLE, NC 28698

(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 114	Continued From page 4 -She used a manual that had disaster information and talked with the clients about what would happen in a disaster; -The discussions about different disasters included a meeting place location and supplies they needed to gather; -She reviewed with clients disasters that included tornados and flooding. Interview on 6/5/19 with the Administrative Assistant (AA) revealed: -She was responsible for developing the fire and disaster drills schedule; -She reviewed the paperwork that documented the drills to ensure they were done on each shift and within each quarter. Interview on 6/6/19 with the Qualified Professional (QP) revealed: -She thought all the fire and disaster drills were simulated; -She would follow up with the staff to ensure the disaster drills were practiced under emergency-like conditions. This deficiency constitues a re-cited deficiency and must be corrected within 30 days.	V 114		

Baptist Children's Homes of NC, Inc.
Developmental Disabilities Ministry

AUTHORIZATION FOR MEDICAL TREATMENT AGREEMENT

I, [redacted], a resident in Lindsay Home, hereby authorize *Dr. Karen Criminger (and whomever he/she may designate as his/her assistant/associate) to administer such treatment as is necessary during my stay in above facility.

I also consent to the performance of any diagnostic or therapeutic measures to be undertaken at Watauga Medical Center Hospital, Inc., or any other hospital of my choice in the event of an emergency or otherwise upon the order of my attending physician or one in attendance at the hospital.

I hereby certify that I have read and fully understand the above Authorization for Medical Treatment.

I also certify that no guarantee or assurance has been made as to the result that may be obtained.

This consent is valid until cessation of services unless revoked.

I acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

* Practice name is acceptable.

[redacted]
Signature of Resident or Guardian

6-21-2019
Date

Pam Edwards
DDM Staff

6-21-2019
Date

REVOCATION:

I hereby revoke this authorization for medical treatment.

_____
Signature of Resident or Guardian

_____
Date

01/02
Rev. 10/04

Baptist Children's Homes of NC, Inc.
Developmental Disabilities Ministry

AUTHORIZATION FOR MEDICAL TREATMENT AGREEMENT

I, [redacted], a resident in Lindsay Home, hereby authorize *Dr. Karen Crimminger (and whomever he/she may designate as his/her assistant/associate) to administer such treatment as is necessary during my stay in above facility.

I also consent to the performance of any diagnostic or therapeutic measures to be undertaken at Watauga Medical Center Hospital, Inc., or any other hospital of my choice in the event of an emergency or otherwise upon the order of my attending physician or one in attendance at the hospital.

I hereby certify that I have read and fully understand the above Authorization for Medical Treatment.

I also certify that no guarantee or assurance has been made as to the result that may be obtained.

This consent is valid until cessation of services unless revoked.

I acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

* Practice name is acceptable.

[redacted]
Signature of Resident or Guardian

6/23/19
Date

Pam Edwards
DDM Staff

6/24/19
Date

REVOCATION:

I hereby revoke this authorization for medical treatment.

Signature of Resident or Guardian

Date

01/02
Rev. 10/04

Baptist Children's Homes of NC, Inc.
Developmental Disabilities Ministry

Fire/Disaster Drill and Safety Log

Home: _____ **Lindsay** **Year:** _____**2019**_____

*If condition of equipment (hose, alarms, extinguisher, etc.) or system (electrical, HVAC, plumbing, etc.) is operational, initial. If not, record and date action taken to restore to satisfactory condition on back of log sheet. Fire drills are to be conducted twice quarterly, 1 daytime and 1 night time. Disaster drills are to be conducted twice quarterly, 1 daytime and 1 night time with topic recorded, ex: tornado, bomb threat, power outage, flood, severe storm, emergency evacuation, etc. Disaster education should be conducted prior to drills with re-education for correction after drills.

Date/Time of Fire Drill	Time to Evacuate	Fire/Safety Equipment	HVAC & Electrical	Staff Signature	Date/Time of Disaster Drill	Disaster Drill	Staff Signature
1-12-19 8am 1st quarter daytime fire drill	30 sec.	Martha Whisnant	Martha Whisnant	Martha Whisnant	1-19-19 11am 1st quarter daytime disaster	9:30am	Billie Proctor
2-22-19 8:15pm 1st quarter nighttime fire drill	30 sec.	Martha Whisnant	Martha Whisnant	Martha Whisnant	3/15/19 8:00pm 1st quarter nighttime disaster	Blizzard	Billie Proctor
4-8-19 6:25am 2nd quarter daytime fire drill	30 sec.	Martha Whisnant	Martha Whisnant	Martha Whisnant	4-20-19 2nd quarter daytime disaster	Bomb Threat 9am	Martha Whisnant
4pm 5-29-19 2nd quarter nighttime fire drill	30 sec.	Martha Whisnant	Martha Whisnant	Martha Whisnant	7:00 pm 06/08/19 2nd quarter nighttime disaster	Billie Proctor 7:00pm	
3rd quarter daytime fire drill					3rd quarter daytime disaster	7:00 am tornado	Laura Carle
3rd quarter daytime fire drill					3rd quarter nighttime disaster		
4th quarter daytime fire drill					4th quarter daytime disaster		
4th quarter nighttime fire drill					4th quarter nighttime disaster		

Rev. 08/09
Rev. 08/10

BCH Rev. 12/06

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

June 18, 2019

Tara Sessoms, Director, Developmental Disabilities Ministry
Baptist Children's Home of NC, Inc.
PO Box 338
Thomasville, NC 27360

Re: Annual, Follow-up and Complaint Survey completed June 6, 2019
Lindsay Home, 394 Camp Joy Road, Zionville, NC 28698
MHL #: 095-044
E-mail Address: tsessoms@bchfamily.org
pedwards@bchfamily.org
Complaint Intake #NC00150846

Dear Ms. Sessoms:

Thank you for the cooperation and courtesy extended during the annual, follow-up and complaint survey completed June 6, 2019.

As a result of the follow up survey, it was determined that some of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

The complaint was substantiated based on the incident having occurred. However, no deficiencies were related to the complaint. A substantiated finding could result in cited deficiencies or no deficiencies. The reason a substantiated finding could result in no cited deficiencies is because at the time of the investigation, the facility had already taken action to correct the deficient practice.

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.