Appendix 1-B: Plan of Correction Form

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By DHSR - Mental Health Lic. & Cert. Section at 3:20 pm, Jul 12, 2019

Plan of Correction

Please complete all requested information and email completed Plan of Correction form to:

Plans.Of.Correction@dhhs.nc.gov

Provider Name:	**A Caring Alternative, LLC**	**Phone:**	**(828)475-0590**
Provider Contact Person for follow-up:	**Helen Austin, Chief Compliance Officer**	**Fax:**	
		Email:	**haustin@caringalternative.com**
Address:	PO Box 1536, Morganton NC, 28680	**Provider #** 059-075	

Finding	Corrective Action Steps	Responsible Party	Time Line
INITIAL COMMENTS An annual survey was completed on May 22, 2019. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5100 Community Respite Services for Individuals of all Disability Groups. 27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (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: (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. (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	Respite staff will implement an abbreviated treatment plan for all new clients at intake – this step will be included in the intake documentation so that it is completed before admission. The plan will include strategies to address the client's presenting problem. All respite services staff will have access to the plan as a part of the client specific competencies that they are trained in. Respite Services are audited quarterly by the QA department and this item is included in the auditing tool. This is a part of A Caring Alternative's policy III-41 Respite Services.	Caitlyn Throneburg, Care Haven Manager Chris Lovett, Child Services Director Helen Austin, Chief Compliance Officer	Implementation Date: 07/17/19 Projected Completion Date: 07/21/19

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client's presenting problem shall be documented. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure when services were provided prior to the establishment and implementation of the treatment/habilitation plan, strategies were developed to address the client's presenting problem for two of three clients (Clients #2 and #3) audited. The findings are: Review on 5/21/19 of Client #2's record revealed: -an admission date of 5/5/19. -15 years old. -diagnoses of Anxiety Disorder, Gastroesophageal Reflux Disease, Post-Traumatic Stress Disorder, Conduct Disorder, and Major Depression Disorder. -a Psychosocial Assessment addendum dated 3/5/19 and Initial Referral form dated 5/7/19. -he had a history of smoking, and no unsupervised access to electronics or Internet use. Review on 5/21/19 of Client #2's "Client Specific Competencies" dated 5/8/19 revealed: -a list of the client's diagnoses. -trauma history due to neglect and sexual abuse. -behavior concerns of persistent irritability and attachment issues. -a history of dishonesty and theft. -there were no strategies developed to address the presenting problems thus far. Review on 5/21/19 of Client #3's record revealed: -an admission date of 5/16/19. -16 years old. -diagnoses of Anxiety Disorder, Sleep difficulties, Social Anxiety Disorder, Allergies, Oppositional Defiant Disorder, and Persistent Depressive Disorder. -a Clinical Intake Evaluation dated 2/18/19 with a history of suicidal threats with no follow-up, parental abandonment, history of being "messed with", irritable, moody, binges, and exploring sexuality. Review on 5/21/19 of Client #3's "Client Specific Competencies" dated 5/16/19 revealed: -a list of the client's diagnoses. -no behavior concerns. -trauma history due to neglect and abandonment. -there were no strategies developed to address the presenting problems thus far. Interview on 5/21/19 with the Qualified Professional (QP) revealed: -she was assigned as the QP for this facility on 4/22/19. -she developed the "Client Specific Competencies" based on the former Comprehensive Clinical			

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Assessments, and/or the former Person-Centered Plans. -each staff member signed the client specific form and they also discussed each client in their every two week team meetings. -there were no other documents available that addressed strategies for the identified presenting problems.			
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: Based on interview and record review, the facility failed to develop and implement strategies within 30 days of admission to address the needs of the clients for one of three clients (Client #1) audited. The findings are: Review on 5/21/19 of Client #1's record revealed: -an admission date of 4/8/19. -16 years old. -diagnoses of Major Depressive Disorder, and Post-Traumatic Stress Disorder. -"Client Specific Competencies" dated 4/8/19 included history of physical abuse, self-harm, poor impulse control, verbal aggression, persistent irritability, dishonesty, theft, physical aggression, running away, auditory hallucinations, and obsession with his girlfriend. -an addendum to the Comprehensive Clinical Evaluation dated 4/24/19 addressed the client's level of impulsivity as a current major concern. -a former Person-Centered Plan (PCP) updated 3/25/19 addressed goals of decreasing depressive	All clients who are enrolled in respite services at Care Haven for at least 30 or more will have a person-centered plan (PCP) completed on or before their 30th day of enrollment. The plan will include person-specific strategies to address the needs of the client. The client's electronic record is completed so that there is an alert when the client has been enrolled in the service for 20 days as a reminder. Respite Services are audited quarterly by the QA department and this item is included in the auditing tool. This is a part of A Caring Alternative's policy III-41 Respite Services.	**Caitlyn Throneburg, Care Haven Manager** **Chris Lovett, Child Services Director** **Helen Austin, Chief Compliance Officer**	Implementation Date: 05/31/19 Projected Completion Date: **07/15/19**

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symptoms, and resolving childhood trauma. -the facility was not list as part of who was responsible for the two goals. -presenting problems identified thus far in the "Client Specific Competencies" and the Comprehensive Clinical Assessment were not addressed in the PCP. -the PCP was not updated within 30 days to develop pertinent strategies to the problems identified. Interview on 5/22/19 with the Facility Director revealed: -when they initially opened the plan was for clients maximum stay to be 24 days. -they were finding out some clients had circumstances that required them to stay longer. -now the number of days a client stayed was going to be determined on a case-by-case basis. -she would re-address updating the PCP with the Qualified Professional.			
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 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 interview and record review, the facility failed to ensure disaster drills were held on each shift at least quarterly. The findings are: Review on 5/21/19 of fire and disaster drills from October 2018 through March 2019 revealed: -no documentation of disaster drills during the fourth quarter of 2018 (October - December). Interview on 5/21/19 with the Qualified Professional revealed: -they staffed the facility Monday through Sunday with two twelve hour shifts; -6:00 a.m. - 6:00 p.m. and 6:00 p.m. to 6:00 a.m. Interview on 5/21/19 with the Child Services Director revealed: -they were not "fully" opened until December 2018. -their first two clients	Disaster drills will be held on each shift at least quarterly and will be documented in the Disaster Drills Record. This record will be monitored by the Safety Committee at least quarterly. This is a part of A Caring Alternative's policy V-3 Emergency Action Plan for Residential and Respite Services Providers.	**Caitlyn Throneburg, Care Haven Manager** **Taskina McCauslin, QA Specialist & Chair of Safety Committee**	Implementation Date: 05/31/19 Projected Completion Date: 07/15/19

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were admitted on 10/31/18. Interview on 5/21/19 with Client #1 (client with l longest stay at facility) revealed: -he had lived at the facility for "43 days." -the facility practiced fire drills "all the time." -for disaster drills the facility "ran through the procedures." -they did not physically do a disaster drill where they practiced taking shelter, they just talked about where they would go. Interview on 5/21/19 with Residential Coach #1 revealed: -disaster drills were to be conducted "quarterly" and they discussed with the clients where and what to do. -for example, if there was a tornado, the clients were to go to the hallway.			
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 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, interview and record review the facility failed to administer medications on the written order of a physician affecting three of three clients (Clients #1, #2	All clients prescribed medications, who are admitted to the respite services at Care Haven, will be required to have a written order of a physician for all prescribed scripts before admission. This has been included as a part of the intake process. When giving medications, Care Haven staff will verify the physician's order before the medications are administered. This is a part of A Caring Alternative's policy III-8 Medication Management.	Caitlyn Throneburg, Care Haven Manager Chris Lovett, Child Services Director	Implementation Date: 05/31/19 Projected Completion Date: 07/15/19

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and #3). The findings are: Review on 5/21/19 of Client #1's record revealed: -admission date of 4/8/19. -diagnoses of Major Depressive Disorder, and Post-Traumatic Stress Disorder. -no physician orders for the client's medications were located in the facility file. Observation on 5/21/19 at approximately 12:00 p.m. of Client #1's medications revealed: -Flovent HFA 110 mcg - 2 sprays in each nare - 2 times a day. -Proair HFA 90 mcg - 6 puffs every 4 hours as needed for wheezing. -Singular - 10 mg - one tablet every day. -Zoloft - 100 mg - 1 tablet every day. -Cetirizine HCL - 10 mg - 1 tablet every day. -Trazadone - 50 mg - 1 tablet at bedtime as needed. Interview on 5/21/19 with Residential Coach #1 revealed: -she called the doctor's office and had the client's orders faxed to the facility (fax dated 5/21/19). -all the medications observed had a signed physician's order dated 4/8/19 except Flovent HFA 110 mcg. -she called another physician's office where the client had been seen and received another fax (dated 5/21/19) of the client's medications. -the client's Flovent HFA 110 mcg, inhale 2 puffs, twice a day was listed, however the medication list was not signed by the physician. Review on 5/21/19 of Client #2's record revealed: -an admission date of 5/5/19. -diagnoses of Anxiety Disorder, Gastroesophageal Reflux Disease, Post-Traumatic Stress Disorder, Conduct Disorder, and Major Depression Disorder. Observation on 5/21/19 at approximately 12:15 p.m. of Client #2's medications revealed: -two - Epinephrine (EpiPen) 0.3 mg - auto-I - inject for reaction to bee sting. -Afrin Allergy Sinus - allergy spray - 2 or 3 sprays in each nostril - not more often than 10 to 12 hours. -Lexapro - 10 mg - 1 tablet every day. -Prazosin HCL - 5 mg - 1 tablet at bedtime -GS Melatonin ODT - 10 mg - dissolve 1 tablet on tongue one time a day at bedtime. Review on 5/21/19 of Client #2's physician orders dated 4/10/19 revealed: -signed orders for all the above medications, except Afrin Allergy Sinus spray. -no signed standing physician orders for over-the-counter Afrin was found. Interview on 5/21/19 with Residential Coach #1 revealed: -they did not have an order for Client #2's Afrin. Review on 5/21/19 of Client #3's			

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record revealed: -an admission date of 5/16/19. - diagnoses of Anxiety Disorder, Sleep difficulties, Social Anxiety Disorder, Allergies, Oppositional Defiant Disorder, and Persistent Depressive Disorder. -no physician orders for the client's medications were located in the facility file. Observation on 5/21/19 at approximately 12:45 p.m. of Client #3's medications revealed: -Zoloft - 25 mg - one tablet every day. -Prozac - 10 mg - one tablet every day. -Doxycycline - 100 mg - one tablet - 2 times a day with food. Interview on 5/21/19 with Residential Coach #1 revealed: -she called the doctor's office and had the client's orders faxed to the facility (fax dated 5/21/19). Review on 5/21/19 of Client #3's signed physician orders dated 4/2/19 revealed: -Doxycycline - 100 mg - one tablet - 2 times a day with food - was not listed. -Albuterol - 90 mcg - inhale 2 puffs every 4 hours (not observed). -Benzoyl peroxide - clindamycin topical - (Benzaclin) 5% - 1% gel - apply 2 times a day for 30 days - 2 refills (not observed). -Benzoyl peroxide- clindamycin topical - (Benzoyl) 5% - 1% gel - apply 2 times a day for 30 days - 5 refills (not observed). - Tretinoin topical (Retin A Micro Gel) - 0.1% apply topically every night at bedtime for 30 days – 5 refills (not observed). Interview on 5/21/19 with Residential Coach #1 revealed: - she called the client's guardian and the topical medications were for the client's acne and she would bring this and the Albuterol to the facility as soon as possible. Interview on 5/21/19 with the Qualified Professional revealed: -it was the responsibility of the staff on duty at the time of intake (admission) to ensure the client had all their medications and signed physician orders. - the staff were to use a "Respite Services Intake Checklist" upon placement to remind them of this. -she was going to start holding team meetings two times a month and would address this issue. Review on 5/22/19 of the facility "Respite Services Intake Checklist" revealed: - "Upon Placement (Client WILL NOT be admitted without these documents)" -the list included "...Medication orders and Medication...Over-the-Counter medication form signed by guardian & physician..."			

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27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure all internal medications were stored separately from external medications affecting two of three clients (Clients #1 and #2). The findings are: Review on 5/21/19 of Client #1's record revealed: - admission date of 4/8/19. -diagnoses of Major Depressive Disorder, and Post-Traumatic Stress Disorder. Observation on 5/21/19 at approximately 12:00 p.m. of Client #1's medications revealed: -Flovent HFA 110 mcg - 2 sprays in each nare - 2 times a day - dispensed 5/5/19. -Proair HFA 90 mcg - 6 puffs every 4 hours as needed for wheezing - dispensed 4/8/19. -both medications were stored in the same locked box as the internal medications.	All medications stored at the respite services facility will be stored in accordance with 10A NCAC 27G .0209; all internal medications will be stored separately from external medications. This is a part of A Caring Alternative's policy III-8 Medication Management.	Caitlyn Throneburg, Care Haven Manager Chris Lovett, Child Services Director	Implementation Date: 05/31/19

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Review on 5/21/19 of Client #2's record revealed: -an admission date of 5/5/19. - diagnoses of Anxiety Disorder, Gastroesophageal Reflux Disease, Post-Traumatic Stress Disorder, Conduct Disorder, and Major Depression Disorder. Observation on 5/21/19 at approximately 12:15 p.m. of Client #2's medications revealed: -two Epinephrine 0.3 mg - auto-I - inject for reaction to bee sting - dispensed 4/10/19 and 5/9/19. -Afrin Allergy Sinus - over-the-counter - expiration date of June 2020 - 2 or 3 sprays in each nostril. -both medications were stored in the same locked box as the internal medications. Interview on 5/21/19 with Residential Coach #1 revealed: -she was not aware the internal and external medications needed to be stored separately.			Projected Completion Date: 07/15/19