United Residential Services of North Carolina, Inc.

Plan of Correction/Preventive Action/Risk Management	
NC Division of Health Services Regulation	**United Residential Services of NC, Inc.** **6503 Kemper Court** **Fayetteville, NC 28303**

Provider Name:	**United Residential Services**	**Phone:**	**(910)584-6268**
Provider Contact Person for follow-up:	**Jessie James, President/CEO** **Gerald Nickelberry, QP**	**Fax:**	
		Email:	**Unitedresidentialservicesinc@yahoo.com**
Address:	6503 Kemper Court Fayetteville, NC 28303		

Finding	Corrective Action Steps	Responsible Party	Time Line
V105 **Based on record reviews and interviews, the facility failed to develop and implement adoption of standards that assure operational and programmatic performance meeting applicable standards of practice for the use of a Glucometer instrument including the CLIA (Clinical Laboratory Improvement Amendments) waiver. The findings are:**	**As a part of Risk Management and as a preventative action a CLIA waiver for URS of NC, Inc. has been applied for Glucose Monitoring.** **Follow-up: Monitor on an ongoing basis as part of QA/QI and risk management.**	**QP URS of NC** **QA/QI** **Risk Management**	**Implementation Date: 7/20/2019** **Projected Completion Date: 9/1/2019**

Finding	Corrective Action Steps	Responsible Party	Time Line
V114 Based on record review and interviews, the facility did not hold disaster drills at least quarterly, repeated for each shift.	As per rule, the United Residential Services #2 facility shall conduct at least one disaster drill on each shift quarterly. This drill shall be documented on the appropriate disaster drill form and available for review. QA/QI shall also maintain a copy of the drill report. The Facility director shall be responsible for this occurring with oversight from the QP and QA/QI committee. Follow-up: Monitor on an ongoing basis as part of QA/QI and risk management.	QP URS of NC QA/QI Risk Management	Implementation Date: 7/15/2019 Projected Completion Date: 7/15/2019

Finding	Corrective Action Steps	Responsible Party	Time Line
V118 Based on record reviews and interviews, the facility failed to administer medications as ordered by the physician and maintain an accurate MAR for 3 of 3 clients audited who received medications (clients #1, #2, #3).	Action: Staff provided supervision and training. Staff at the United Residential Services #2 facility were trained on proper documentation on the MAR. MAR shall mirror the physician orders and documentation shall clearly demonstrate that physician orders are followed. MARs shall be reviewed regularly for accuracy. Follow-up: Monitor on an ongoing basis as part of QA/QI and risk management.	QP URS of NC QA/QI Risk Management	Implementation Date: 7/10/2019 Projected Completion Date: 7/10/2019

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

July 12, 2019

Jessie James, President/CEO
United Residential Services of N.C. Inc.
P.O. Box 25928
Fayetteville, NC 28314

Re: Annual and Follow Up Survey completed July 5, 2019
United Residential Services of North Carolina #2, 6503 Kemper Court,
Fayetteville, NC 28303
MHL # 026-694
E-mail Address: unitedresidentialservicesinc@yahoo.com

Dear Mr. James:

Thank you for the cooperation and courtesy extended during the annual and follow up survey completed July 5, 2019.

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

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

- All tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is September 3, 2019.

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.***

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 Wendy Boone at 252-568-2744.

Sincerely,

Betty Godwin, RN, MSN
Nurse Consultant
Mental Health Licensure & Certification Section

Cc: _DHSR_Letters@sandhillscenter.org
Leza Wainwright, Director, Trillium Health Resources LME/MCO
Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources LME/MCO
Pam Pridgen, Administrative Assistant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-694	A. BUILDING: _____ B. WING _____	R 07/05/2019

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UNITED RESIDENTIAL SERVICES OF NORTH (	6503 KEMPER COURT FAYETTEVILLE, NC 28303

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V 000	INITIAL COMMENTS An annual and follow up survey was completed on July 5, 2019. Deficiencies were cited. This facility is licensed for the service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including:	V 105		

DHSR - Mental Health
AUG 26 2019
Lic. & Cert. Section

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V 105	Continued From page 1 (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement adoption of standards that assure operational and	V 105		

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V 105	Continued From page 2 programmatic performance meeting applicable standards of practice for the use of a Glucometer instrument including the CLIA (Clinical Laboratory Improvement Amendments) waiver. The findings are: Review on 7/3/19 of client #1's record revealed: -25 year old male admitted 12/20/11. -Diagnoses included Diabetes Mellitus Type 2, Sickle Cell Trait, Anemia Chronic Disease, Gastroesophageal Reflux Disease (GERD), Bipolar, Developmental Delay. -Order dated 12/27/18 to check blood sugar 3 times a week in the morning before breakfast. -Order dated 6/25/19 for Metformin 1000 mg twice daily with food (lowers blood sugar). Interview on 7/3/18 client #1 stated: -He checked his blood sugar every Monday, Wednesday, and Friday. -He pricked his finger, "mashes it," put blood on the strip, and put it in the meter to get the reading. -Staff monitored him when checking his blood sugar. -He was checking his blood sugar when moved into the home. -He could not answer who taught him how to check his blood sugar. Interview on 7/3/19 Staff #3 stated: -When he worked 3rd shift he would perform client #1's finger stick blood sugar testing. -He would have client #1 to come to the office for the procedure. -Client #1 would choose the finger to be pricked. -He (Staff #3) would cleaned the client's finger using an alcohol pad, then pricked and would squeeze the finger up against the meter strip, and documented the results.	V 105		

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V 105	Continued From page 3 Interview on 7/5/19 the Group Home Manager stated: -The facility did not have a CLIA certificate. -She had been told by the Qualified Professional a CLIA certificate was not needed. -Client #1 was able to prick his finger but he was not able to independently perform his finger stick blood sugar testing. Staff monitored and assisted him. -She would follow up to obtain the CLIA certificate.	V 105		
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 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 interviews, the facility did not hold disaster drills at least quarterly, repeated for each shift. The findings are:	V 114		

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V 114	Continued From page 4 Interview on 7/3/19 the Group Home Manager stated: -The facility had 3 shifts as follows: -First shift: 8am - 4pm -Second shift: 4pm - 12 am -Third shift: 12am - 8am -When they held a disaster drill for a flood, they discussed with the clients to go to "higher ground" and what they would do should they have a flood. -They did not practice a disaster evacuation procedure. Review of documentation for disaster drills for 7/1/18 - 6/30/19 revealed: -Disaster drills were not documented separately from fire drills. -The following was documented for disaster drills in the quarter 7/1/18 - 9/01/18: -9/10/18 3:30pm Hurricane, "Staff went over what partipants should do if an hurricane was to occur." -9/6/18 8am: Flood, "Staff discuss with partipant what they should do if an flood occur" -7/18/18 8 pm Winter storm, "Staff put all consumer on computer to look at how/what you should do when it is a storm." -7/12/18 8am: Flood, staff played a video of flood and what you should do if it occurred -7/2/18 11 am: Disaster Drill, staff and consumers watched a movie on "what do do and how to handle it." -The following was documented for disaster drills in the quarter 10/1/18 - 12/31/18: -12/22/18 10 am: "Flood See attachment." Handout included information about what to do in the event of a flood. -12/3/19 8am: Winter Advisory, "Staff also turn to the weather channel and watched the weather advisory."	V 114		

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V 114	Continued From page 5 -11/28/18 10 am: Flood, staff and consumers watched the news and observed what they should do in case of a flood. -11/14/18 9am: Hurricane "See attachment." No documentation the facility did a practice drill. -11/7/18 7am: Flood "see attachment." Handout attached but no drill documented. -10/25/18 12 Hurricane, staff watched the weather channel about a hurricane and what they can do. -10/2/18 6pm: Flood, no documentation of a drill for flood disaster -10/11/18 10 am: Winter advisory, "staff talk to partipant about winter and how we can get a lot of bad weather." -The following was documented for disaster drills in the quarter 1/1/19 - 3/31/19 : -3/14/19 7pm: Flood, watched the weather channel -3/4/19 1pm: Winter Advisor, "See attachment." There was no attachment and not disaster drill documented. -2/26/19 7am: Rainstorm, discussed what to do with participants. -3/12/19 4pm: Hurricane, staff and consumer watched the weather channel -2/6/19 11:15am: Floods, participant and staff watched the weather channel -1/29/19 6pm: Flood/Winter advisory: No drill documented -The following was documented for disaster drills in the quarter 4/1/19 - 6/3/19: -6/20/19 6 am: "Other," no documentation of a specific type of disaster drill. -6/10/19 5 pm: "Other," staff watched the news. -6/1/19: 9am: Flood, staff pulled a fire drill. -5/29/19 4pm Flood, staff observed participants meeting at "meet" point.	V 114		

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V 114	Continued From page 6 -5/5/19 8am "Other," staff watched all participants meet at meeting place. Interview on 7/3/19 client #1 stated they would go out to the middle of the street for a fire drill. When asked about disaster drills he stated they may have practiced a tornado drill. If they had a tornado he would go to the bathroom and put his head down. Interview on 7/3/19 client # 2 stated they would go to their meeting place at a tree for fire drills. When asked if they practiced disaster drills, client #2 stated it was hard for everyone to practice but they knew what to do. Interview on 7/3/19 Staff #4 stated they held fire and disaster drills. They always evacuated the home for fire drills. For Tornado drills they would get in hallway and cover their heads. Interview on 7/3/19 Staff #3 stated fire drills were done every month and rotated to different shifts. Clients would practice going either across the street or in corner of the back yard corner. For disaster drills the would get in hallway, put their head down and cover their head. The clients followed the drill procedures.	V 114		
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	V 118		

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V 118	Continued From page 7 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 record reviews and interviews, the facility failed to administer medications as ordered by the physician and maintain an accurate MAR for 3 of 3 clients audited who received medications (clients #1, #2, #3). The findings are: Finding #1: Review on 7/3/19 of client #1's record revealed: -25 year old male admitted 12/20/11. -Diagnoses included Developmental Delay; Sickle Cell Trait; Anemia, Chronic; Gastroesophageal	V 118		

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V 118	Continued From page 8 Reflux; Bipolar; Diabetes Mellitus Type 2. -Order dated 2/5/19 for Risperidone 4 mg (milligrams) at bedtime. (mental/mood disorders including bipolar disorder) Review of client #1's MARs for April, May, June and July 2019 transcribed and documented Risperidone 4 mg had been administered at 4 pm daily. Finding #2: Review on 7/3/19 of client #2's record revealed: -30 year old male admitted 2/21/19. -Diagnoses included Mental Retardation, Autism, and Schizophrenia. -Documentation client was seen by a primary care medical group to establish care on 6/18/19. Review on 7/3/19 of client #2's orders and MARs for April, May, June and July 2019 revealed: -Naproxen DR (delayed release) 500 mg (Nonsteroidal anti-inflammatory medication given to relieve pain.): -Order dated 2/20/19 for Naproxen DR 500 mg twice daily as needed (PRN). -FL-2 order dated 6/18/19 for Naproxen DR 500 mg twice daily. -Ordered frequency transcribed on the June and July MARs as "twice daily PRN." No documentation Naproxen DR had been administered after 6/18/19. -Oxcarbazepine 300 mg (treats epilepsy and bipolar disorder): -Order dated 4/30/19 for Oxcarbazepine 300 mg twice daily. -FL-2 order dated 6/18/19 for Oxcarbazepine 300 mg daily. -Ordered frequency transcribed and administration documented twice daily on the June and July 2019 MARs.	V 118		

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V 118	Continued From page 9 -Olanzapine 7.5 mg (treats mental/mood conditions such as schizophrenia, bipolar disorder): -FL-2 order dated 6/18/19 for Olanzapine 7.5 mg every morning. -July 2019 MAR dosage transcribed and documented as given was 2 tablets (=15 mg) at 7am daily. -Olanzapine 15 mg: -Order dated 2/20/19 for Olanzapine 15 mg, 2 tablets at bedtime. -FL-2 order dated 6/18/19 for Olanzapine 15 mg every evening. -Ordered dosage transcribed and documented as given was 2 tablets (=30 mg) at 7pm daily on the June and July 2019 MAR. -Famoditine 20 mg (Used to treat/prevent ulcers in the stomach/intestines; also treats conditions in which the stomach produces too much acid.): -Order dated 2/20/19 for Famoditine 20 mg twice daily as needed (PRN). -FL-2 order dated 6/18/19 for Famoditine 20 mg twice daily. -Ordered frequency transcribed on the June and July MARs as "twice daily PRN." No documentation Famoditine 20 mg had been administered after 6/18/19. -Order dated 4/30/19 for Risperidone 2 mg twice daily, and 1 daily PRN agitation. May and June MARs documented the medication had been discontinued and none was documented as administered after 4/30/19. Finding #3: Review on 7/3/19 of client #2's record revealed: -29 year old male admitted 12/9/11. -Diagnoses included Autism Spectrum Disorder, Turret's Disorder, Anxiety Unspecified, and Obsessive Compulsive Disorder. -Order dated 4/28/19 for Fluticasone Propoinate	V 118		

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V 118	Continued From page 10 50 Mcg (micrograms) Nasal Spray, 1 spray in each nostril daily (relieve seasonal and year-round allergic and non-allergic nasal symptoms, such as stuffy/runny nose, itching, and sneezing). -MAR dosing times transcribed 12am, 7am, 8am, 4pm, 8pm. The number "1" or "2" was documented at each dosing time daily on the MARs for April, May, June, and July 2019. Interview on 7/3/19 the Group Home Manager stated: -Client #1's Risperidone was documented at 4pm daily because the MAR did not have a dosing time at 8pm. Staff signed that they administered the Risperidone at 4pm, but they actually administered the medication at 8pm. -She had not recognized the differences in the FL-2 orders for client #2. She would contact the provider and clarify the orders. -The numbers documented for the administration of nasal sprays represented the number of boxes of medication on hand. With the documentation system in use there was no way to document if a client received the nasal spray. She would revise the MARs in a way for staff to document if the client received a nasal spray. -Client #2's Olanzapine 7.5 mg every morning was transcribed incorrectly on the July MAR. The counts documented he only received 1 tablet each morning in July 2019. -Client #2's physician had discontinued his Risperidone in May 2019. She called the pharmacy and they did not have a discontinue order. She would contact the physician for the discontinue order. Due to the failure to accurately document medication administration it could not be determined if clients received their medications	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-694	A. BUILDING: _____ B. WING _____	R 07/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED RESIDENTIAL SERVICES OF NORTH (	6503 KEMPER COURT FAYETTEVILLE, NC 28303

(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 118	Continued From page 11 as ordered by the physician.	V 118		