

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL007-033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/31/2019
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NAME OF PROVIDER OR SUPPLIER COUNTRY LIVING GUEST HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 3052 MARKET STREET EXTENSION WASHINGTON, NC 27889
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(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	<p>INITIAL COMMENTS</p> <p>An annual survey was completed on July 31, 2019. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.</p>	V 000		
V 112	<p>27G .0205 (C-D) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(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.</p> <p>(d) The plan shall include:</p> <p>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;</p> <p>(2) strategies;</p> <p>(3) staff responsible;</p> <p>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;</p> <p>(5) basis for evaluation or assessment of outcome achievement; and</p> <p>(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.</p>	V 112	<p><i>See attached.</i></p> <p>DHSR - Mental Health</p> <p>SEP 16 2019</p> <p>Lic. & Cert. Section</p>	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Kenneth M. Dwyer

Administrator

8/15/19

Division of Health Service Regulation

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V 112	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement strategies based on assessment affecting one of three clients (#1). The findings are:</p> <p>Review on 07/30/19 of client #1's record revealed:</p> <ul style="list-style-type: none"> - 49 year old male. - Admission date of 04/05/18. - Diagnoses of Schizoaffective - Bipolar Disorder and Diabetes Mellitus. - Treatment Plan dated 12/21/18. - No strategies to address client #1's Diabetes. <p>Review on 07/30/19 of a signed FL-2 for client #1 dated 04/29/19 revealed check Finger Stick Blood Sugar (FSBS) daily.</p> <p>Review on 07/30/19 of a physician order for client #1 dated 02/11/19 revealed:</p> <ul style="list-style-type: none"> - FSBS of 326 and an average of 250 (Under 100 is normal for not eating for at least 8 hours and less than 140 two hours after eating). - Increase Metformin (treats Diabetes). <p>Review on 07/30/19 of client #1's FSBS values for July 2019, June 2019 and May 2019 revealed:</p> <p>July 2019</p> <ul style="list-style-type: none"> - FSBS ranged from a high of 242 and a low of 162. <p>June 2019</p> <ul style="list-style-type: none"> - FSBS ranged from a high of 227 and a low of 160. <p>May 2019</p> <ul style="list-style-type: none"> - FSBS ranged from a high of 226 and a low of 125. 	V 112		

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V 112	Continued From page 2 Interview on 07/30/19 client #1 stated: - He had resided at the facility for 1 year and 3 months. - He was scheduled to be discharged to his own apartment on 09/01/19. - He was diagnosed with Diabetes 3 months ago. - He checked his FSBS values daily. - 2 different doctors told him as long as his FSBS values were under 300 there was no concern. - He visited his health care professional monthly. Interview on 07/30/19 staff #1 stated: - Client #1 was "somewhat" non-compliant with his Diabetes diagnoses. - She provided client #1 with education regarding Diabetes. - Client #1 checked his FSBS daily and she would record the value. Interview on 07/30/19 the Qualified Professional/Registered Nurse stated: - Client #1 had an outside agency which created his Treatment Plan. - He had difficulty with the other agency to include residential strategies for client #1. - Client #1 was scheduled to be discharged on 09/01/19 to his own apartment.	V 112		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug	V 123	See attached .	

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V 123	<p>Continued From page 3</p> <p>shall be charted.</p> <p>.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the physician or pharmacist of medication errors and document refusals affecting one of three audited clients (#1). The findings are:</p> <p>Review on 07/30/19 of client #1's record revealed: - 49 year old male. - Admission date of 04/05/18. - Diagnoses of Schizoaffective - Bipolar Disorder and Diabetes Mellitus.</p> <p>Review on 07/30/19 of a signed FL-2 for client #1 and dated 04/29/19 revealed the following medication order: - Potassium Chloride (treats low blood levels of Potassium (Hypokalemia) 20 milliequivalent - mix 2 packets in 8 ounces of water daily.</p> <p>Review on 07/30/19 of a medical provider discharge sheet for client #1 dated 06/01/19 revealed the following medication order: - Lithium (treats Bipolar Disorder) 300 milligrams - take one tablet twice daily</p> <p>Review on 07/30/19 of client #1's May 2019, June 2019 and July 2019 MARs revealed the following dates and times a handwritten letter "c" was used to indicate a refusal of medication and no documentation a physician or pharmacist was immediately notified of refusals. May 2019</p>	V 123		

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V 123	Continued From page 4 - Potassium Chloride - 05/01/19, 05/08/19 and 05/29/19. June 2019 - Potassium Chloride - 06/02/19 thru 06/07/19 and 06/09/19 thru 06/30/19. - Lithium - 06/02/19 thru 06/30/19 at 8am. - Lithium - 06/01/19, 06/06/19, 06/09/19 and 06/09/19 thru 06/30/19 at 8pm. July 2019 - Potassium Chloride - 07/03/19, 07/05/19 thru 07/14/19, 07/16/19 thru 07/20/19 and 07/22/19 thru 07/30/19. Interview on 07/30/19 client #1 stated: - He had resided at the facility for 1 year and 3 months. - He was scheduled to be discharged to an apartment on September 1, 2019. - He refused his Lithium because it caused complications with his blood sugar values. - His physician changed his Lithium to another medication and he was doing well. - He had refused his Potassium because the powder made him feel like he had a "lump" in his stomach. - He usually visited his doctor monthly. Interview on 07/30/19 the Qualified Professional/Registered Nurse stated: - He was aware a physician or pharmacist should be notified of medication errors. - Client #1's physician was aware of the refusal of Lithium and recently changed the medication. - Client #1 was very independent.	V 123		
V 366	27G .0603 Incident Response Requirments	V 366	See attached.	

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V 366	<p>Continued From page 5</p> <p>10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by:</p> <p>(1) attending to the health and safety needs of individuals involved in the incident;</p> <p>(2) determining the cause of the incident;</p> <p>(3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;</p> <p>(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;</p> <p>(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;</p> <p>(6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and</p> <p>(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.</p> <p>(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.</p> <p>(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:</p> <p>(1) immediately securing the client record</p>	V 366		
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V 366	<p>Continued From page 6</p> <p>by:</p> <p>(A) obtaining the client record;</p> <p>(B) making a photocopy;</p> <p>(C) certifying the copy's completeness; and</p> <p>(D) transferring the copy to an internal review team;</p> <p>(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:</p> <p>(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;</p> <p>(B) gather other information needed;</p> <p>(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and</p> <p>(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to</p>	V 366		
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V 366	<p>Continued From page 7</p> <p>three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to document their response to level I incidents. The findings are:</p> <p>See Tag V123 for specifics.</p> <p>Review on 07/30/19 of facility records revealed no incident reports documented for client #1's medication refusals in May 2019, June 2019 or July 2019.</p> <p>Interview on 07/30/19 the Qualified Professional/Registered Nurse stated: - He was aware a level I incident report should be generated for medication errors or refusals. - Client #1's physician was aware of the refusal of Lithium and recently changed the medication.</p>	V 366		
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V 366	Continued From page 8 - Client #1 was very independent.	V 366		

Country Living Guest Home, Inc. #2

3052 Market Street, Extension
Washington, NC 27889

Plan Of Correction:

V112 – Country Living QP will add the diagnosis of Diabetes to Client #1's Person Centered Plan within 30days of citation. The addition to the plan will detail a goal of reducing the average fingerstick Blood Sugar readings. The Plan will also detail protocol concerning who to contact should an excessive reading (high or low) be measured. The facility will continue to work with outside agencies that have clinical home responsibility to ensure that Residential Support goals are included into the Person Centered Plan.

V123 – QP will ensure that all future medication refusals are documented on the MAR and that a Level 1 Incident Report is made within 72 hours of each refused dose. The responsible physician and pharmacist will be notified of the refusal within 72 hours. Continuous refusals will be communicated to the physician and a decision will be reached by the physician as to whether or not a Discontinuation of the medication should be issued.

V366 – QP will document all future medication refusals on a Level 1 Incident reporting form within 72 hours of refusal.

Kevin McDaniel *MSW CSW QP, Admin.*



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

ROY COOPER • Governor

MANDY COHEN, MD, MPH • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

August 13, 2019

Ms. Kellie Hardison
Country Living Guest Home #5
204 Stewart Drive
Washington, NC 27889

Re: Annual Survey completed July 31, 2019
Country Living Guest Home #5, 204 Stewart Drive, Washington, NC 27889
MHL # 007-058
E-mail Address: countrylivinginc@yahoo.com

Dear Ms. Hardison:

Thank you for the cooperation and courtesy extended during the annual survey completed 7/31/19.

Enclosed you will find the deficiency 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

- Standard level deficiencies.

Time Frames for Compliance

- Standard level deficiency must be **corrected** within 60 days from the exit of the survey, which is September 29, 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 DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718
www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

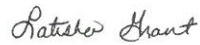
AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

August 13, 2019
Kellie Hardison
Country Living Guest Home #5

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, Team Leader at (252) 568-2744.

Sincerely,



Latisha Grant
Facility Compliance Consultant I
Mental Health Licensure & Certification Section



Keith Hughes
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

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