Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-228	A. BUILDING: _____ B. WING _____	R 09/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVEREUX RESIDENTIAL SERVICES KINCAID	5 KINCAID COURT DURHAM, NC 27703

(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 and follow up survey was completed on 9/5/2019. 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	Sanitation and Fire Documentation (V112): A. Management will In-service staff on Consumer's Behavior Support Plan(s) B. DRS, LLC will ensure that a member of management monitor BSP's on a monthly basis. Management will make recommendations as needed. Facility Grounds and Maintenance (V119): A. Management will ensure that all medication in the home is current/in date. B. Management will ensure that any out of date medications are disposed of and reordered. C. DRS, LLC will ensure that a member of management check medication supplies in all homes on a weekly basis.	10.14.19
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		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	9.14.19

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interviews facility staff failed to implement a client's treatment plan affecting one of one client (#1). The findings are: Review on 9/4/19 of client # 1's record revealed: -Admission date of 3/27/11. -Diagnoses of Autism, Moderate Mental Retardation, Attention Deficit Hyperactivity Disorder and Pica. -Behavioral Intervention Plan dated 7/8/19 had the following: "If [Client #1] is observed exhibiting early warning signs of agitation and/or frustration remain with him and monitor him until warning signs are no longer observed. Do not leave him unattended until the warning signs are no longer observed. Do not attempt physical restraint. If [Client #1] exhibits early signs of agitation and/or express frustration e.g. I'm mad, show the choices chart for When I'm mad I can...and encourage him to show what he needs. If [Client #1] continues with the signs of agitation, direct him back to his room for timed calming time/break. Once [Client #1] has calmed, direct his back to his schedule or a choice chart, if appropriate. Monitor [Client #1] for safety during calming time." Review of facility records on 9/4/19 revealed: -An incident report for client #1 dated 8/30/19 had the following: "While shaving [Client #1] he said upset and started attacking staff scratching and trying to bite staff eventually [Client #1] did bite staff on hand. Gave PRN (Pro re nata) and [Client #1] finally calmed down." Interview with staff #1 on 9/4/19 revealed: -Client #1 had an incident about a week ago. -Client #1 got upset with him because he was	V 112	See Pg 1	

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V 112	Continued From page 2 trying to shave his face. -Client #1 was really agitated and scratched and bit him on the arm. -Client #1 kept trying to attack him. -He left client #1 alone and locked himself in the the bathroom until client #1 calmed down. -Whenever client #1 displays those behaviors he would normally lock himself in another room. -He locked himself in another room in order to give client #1 time to calm down. Interview with the Administrator on 9/4/19 revealed: -She was aware client #1 had an incident with staff #1 about a week ago. -Staff #1 informed her client #1 got upset when he tried to shave him. -Staff #1 informed her that client #1 bit him during the incident. -Staff #1 never indicated he left client #1 unattended during that incident. -Staff #1 never told her that he locked himself in the bathroom. -She confirmed staff #1 failed to implement Behavioral Intervention Plan for client #1.	V 112	See Pg 1	
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program.	V 119		

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V 119	Continued From page 3 Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge. This Rule is not met as evidenced by: Based on observation, record review and interview the facility staff failed to dispose of prescription medications in a manner that guards against diversion or accidental ingestion affecting one of one client (#1). The findings are: Review on 9/4/19 of client # 1's record revealed: -Admission date of 3/27/11. -Diagnoses of Autism, Moderate Mental Retardation, Attention Deficit Hyperactivity Disorder and Pica. -Physician's order dated 3/7/19 for Diazepam 5 mg, one tablet as needed for agitation. -The Controlled Medication Count sheet indicated a Diazepam 5 mg tablet was given to client #1 on 8/30/19. Observation on 9/4/19 at approximately 10:55 AM	V 119	See pg 1	

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V 119	Continued From page 4 of the medication area revealed: -The packet of Diazepam 5 mg tablets for client #1 had expired on 12/20/18. Interview on 9/4/19 with the Administrator revealed: -Client #1 would normally get a Diazepam 5 mg tablet if he was agitated. -Client #1 just recently had an incident with staff #1 about a week ago. -Staff #1 gave client #1 the Diazepam 5 mg tablet due to his agitation. -Staff possibly did not realize the Diazepam 5 mg tablets had expired for client #1. -She confirmed the facility staff failed to ensure medications were disposed of in a manner that guards against diversion or accidental ingestion.	V 119	See pg 1	

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

September 11, 2019

Jennifer Williams, Administrator
Devereux Residential Services, LLC
115 Market Street, Ste. 204 G
Durham, NC 27701

Re: Annual and Follow up Survey completed September 5, 2019
Devereux Residential Services-Kincaid Court, 5 Kincaid Court, Durham, NC 27703
MHL # 032-228
E-mail Address: jwilliamsdevereux612@gmail.com

Dear Ms. Jennifer Williams:

Thank you for the cooperation and courtesy extended during the Annual and Follow up survey completed September 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 11/4/19.

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 Bryson Brown at 919-855-3822.

Sincerely,

Kimberly R Sauls
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc:
DHSR@Alliancebhc.org
Pam Pridgen, Administrative Assistant

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL032-228 Y1	A. Building B. Wing Y2	9/5/2019 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVEREUX RESIDENTIAL SERVICES KINCAID COURT	5 KINCAID COURT DURHAM, NC 27703

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0736 Reg. # 27G .0303(c) LSC	Correction Completed 09/05/2019	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
			Kimberly R Sauls	9/11/19
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
2/19/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO