PRINTED: 01/15/2020
FORM APPROVED

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
	MHL058-003	A. BUILDING: ______ B. WING ______	R 12/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCLAWHORNE HOME	**1044 MCLAWHORNE ROAD ROBERSONVILLE, NC 27871**

(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 12/19/19. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
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	DHSR - Mental Health MAR 3 2020 Lic. & Cert. Section	

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview the facility failed to implement strategies for 1 of 3 audited clients. The findings are: Review on 12/18/19 of client #1's record revealed: - admitted 4/24/06 - diagnoses of Hypertension, Intellectual Development Disorder (severe) & Incontinence - FL2 dated 4/1/19: Miralax twice a day (can treat occasional constipation) Review on 12/18/19 of client #1's treatment plan dated 4/1/19 revealed: - "...I had a blockage in my colon; right now this is being monitored. I am to have bowel movements, however, I will try to hold my bowel and staff are monitoring and I am on toileting schedule every 2 hours. I take medication for constipation. My bowel movements are tracked to ensure that I don't become constipated or try to hold my bowel movement." Review on 12/18/19 of the bowel movement - monthly monitoring record for client #1 revealed: - last completed monitoring log was November 2019 - two days were logged in (November 11 & 12) During interview on 12/18/19 staff #1 reported: - staff are independent of ensuring bowel movement sheets were completed - staff are supposed to check after each other to ensure the sheets are completed - she checked the monthly monitoring sheets every other week - the monthly monitoring sheets have not been checked	V 112		

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V 112	Continued From page 2 - client #1 will hold his bowels therefore, staff has to ensure he has bowel movements - client #1 had bowel movements because she has observed them - the medication prescribed helps him with the bowel movements - staff failed to document the bowel movements During interview on 12/19/19 the day support staff reported: - he was the 1:1 for client #1 at the day program - has worked with client #1 for 2 years - client #1 has regular bowel movements - day program staff do not have to document client #1's bowel movements During interview on 12/19/19 the Qualified Professional reported: - she visits the facility 3 times a week - she has not visited the facility this month (December 2019) - the last time she checked the bowel movement log was 1st week of November 2019 - she implemented the bowel movement log to monitor his bowel movements - client #1 wears diapers and the bowel movements could be monitored - day program staff are supposed to monitor his bowel movements - she would follow up with day program staff - bowel monitoring sheets will be monitored weekly - she (QP) & staff will sign off on the bowel monitoring sheets	V 112	Bowel log is presently being documented daily by support staff. Supervisor will review bowel log weekly as log is turned in as well as review log during pop up visits to the home. Log will also note any additional comments, such as constipation issues etc. A copy of this log will be filed in Supervisor's office as well as Group Home. ~~Enclosed a copy (sample) of monitoring record.~~	

[signature] Residential Service Mgr

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL058-003 (Y1)	A. Building B. Wing (Y2)	12/19/2019 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MCLAWHORNE HOME	1044 MCLAWHORNE ROAD ROBERSONVILLE, NC 27871

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 V0291 Reg. # 27G .5603 LSC	Correction Completed 12/19/2019	ID Prefix V0752 Reg. # 27G .0304(b)(4) LSC	Correction Completed 12/19/2019	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
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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 Rhonda Smith	DATE 1/15/20
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 11/28/2018	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: EKFF12

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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

January 16, 2020

DHSR - Mental Health

MAR 3 2020

Lic. & Cert. Section

Becky Bullock, Executive Director
Martin Co. Res. Services., Inc. d/b/a Martin Enterprises
PO Box 1042
Williamston, NC 27892

Re: Annual & Follow up Survey completed December 19, 2019
McLawhorne Home, 1044 McLawhorne Road, Roberson, NC 27871
MHL # 058-003
E-mail Address: rebeccabullock@martinenterprises.org

Dear Ms. Bullock:

Thank you for the cooperation and courtesy extended during the Annual & Follow up survey completed December 19, 2019.

As a result of the follow up survey, it was determined that all of the deficiencies are in compliance. An additional deficiency was 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 other tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is February 17, 2020.

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.

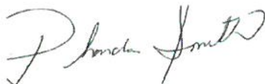
Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

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 Renee Ames at (919) 552-6847.

Sincerely,



Rhonda Smith
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

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