STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-190	A. BUILDING: _____ B. WING _____	03/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE ON ONE CARE HOME A	607 WEST DIXON BLVD SHELBY, NC 28150

(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 March 13, 2020. 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		
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 shall be charted. . This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure medication errors were reported immediately to a physician or pharmacist affecting 2 of 3 sampled clients (Clients #1 and #3). The findings are: Record review on 3/13/20 for Client #1 revealed: -Admission date of 8/1/17 with diagnoses including Mild Intellectual Developmental Disability, Organic Personality Disorder, Osteoporosis, Intermittent Explosive Disorder, Nicotine Dependence, Epilepsy, Chronic Obstructive Pulmonary Disease (COPD), and Methicillin-Resistant Staphylococcus Aureus.	V 123		

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V 123	Continued From page 1 Review on 3/13/20 of an Accident/Med/Incident Report for Client #1 dated 8/6/19 revealed: -"This med was out Due to it was Finished When Finished It was to Be D/C'd It was only for Few Days." -there was no medication listed on the form and the "Med Error" box was not completed. -"Required - Prescribing Physician Contacted...Dispensing Pharmacist Contacted..." were not completed. Review on 3/13/20 of Client #3's record revealed: -an admission date of 12/21/18. -diagnoses of Profound Intellectual Developmental Disability, Legally Blind, COPD, and Diabetes. -physician orders dated 12/13/18 included Fiber-Lax 625 milligrams (mg) one 3 times a day with meals; and Hydralazine HCL 100 mg one 3 times a day. Review on 3/12/20 of Client #3's Medication Administration Record for March 2020 revealed: -on the back for 3/7/20 - forgot to give Fiber-Lax and Hydralazine HCL. -there was no medication error note or incident report to review to indicate the pharmacist or physician had been notified. Interview on 3/12/20 with Staff #1 revealed: -she forgot to give two of Client #3's medications at noon. -she was used to his day treatment center giving these medications; however it was the weekend and she some how skipped over it. -she did not complete an incident report and the pharmacist or physician was not notified.	V 123		

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V 366	Continued From page 2	V 366		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (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: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (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 (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (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. (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	V 366		

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V 366	Continued From page 3 by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (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: (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; (B) gather other information needed; (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 (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	V 366		

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V 366	Continued From page 4 available within three months of the incident, the LME may give the provider an extension of up to 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. This Rule is not met as evidenced by: Based on record review and interview the facility failed to implement written policies governing their response to level I and level II incidents. The findings are: Record review on 3/13/20 for Client #1 revealed: -Admission date of 8/1/17 with diagnoses including Mild Intellectual Developmental Disability, Organic Personality Disorder, Osteoporosis, Intermittent Explosive Disorder, Nicotine Dependence, Epilepsy, Chronic Obstructive Pulmonary Disease (COPD), and Methicillin-Resistant Staphylococcus Aureus. Review on 3/13/20 of an Accident/Med/Incident	V 366		

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V 366	Continued From page 5 Report for Client #1 dated 8/6/19 revealed: -"This med was out Due to it was Finished When Finished It was to Be D/C'd It was only for Few Days." -there was no medication listed on the form and the "Med Error" box was not completed. -"Required - Prescribing Physician Contacted...Dispensing Pharmacist Contacted..." were not completed. -other blank areas included where the incident took place, how staff intervened, who was contacted, preventative suggestions, and results of follow-up process. Review on 3/13/20 of Client #3's record revealed: -an admission date of 12/21/18. -diagnoses of Profound Intellectual Developmental Disability, Legally Blind, COPD, and Diabetes. -physician orders dated 12/13/18 included Fiber-Lax 625 milligrams (mg) one 3 times a day with meals; and Hydralazine HCL 100 mg one 3 times a day. Review on 3/12/20 of Client #3's Medication Administration Record for March 2020 revealed: -on the back for 3/7/20 - forgot to give Fiber-Lax and Hydralazine HCL. -there incident report to review to indicate the pharmacist or physician had been notified, where the incident took place, how staff intervened, who was contacted, preventative suggestions, and results of follow-up process. Interview on 3/12/20 with Staff #1 revealed: -she forgot to give two of Client #3's medications at noon. -she was used to his day treatment center giving these medications; however it was the weekend and she some how skipped over it.	V 366		

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V 366	Continued From page 6 -she did not complete an incident report.	V 366		