MT

PRINTED: 03/17/2020
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
	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	DHSR-Mental Health MAR 25 2020 Lic. & Cert. Section	

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Eddie Scipp TITLE Director (X6) DATE 3-22-2020

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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		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL023-190 (Y1)	A. Building B. Wing (Y2)	3/13/2020 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 V0118 Reg. # 27G .0209 (C) LSC	Correction Completed 03/13/2020	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
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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 Sally Thayer, MSW	DATE 3/13/20
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 2/11/2019		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?		☐ YES ☐ NO

One On One Care Home A

Shelby, NC

MHL #023-190

V123: Medication Requirements

Measures in place to correct and prevent the deficient area of practice:

When medication error occurs, staff has been instructed to contact Home Manager immediately to receive guidance on what to do. If doctor's office is open, contact will be made. If after hours, Medical Arts Pharmacy and/or CVS Pharmacy will be contacted. The incident report will be filled out in its entirety.

Who will monitor the situation to ensure it will not occur again?: Staff, Home Manager, and QP will monitor the situation.

How often will the monitoring take place?: Each time a medication error occurs.

V366: Incident response requirement

Measures in place to correct and prevent the deficient area of practice:

After medication error, staff will complete an incident report and contact Home Manager. Report will be reviewed by Home Manager and completed in its entirety before it is turned in. This information will include preventative suggestions and follow up process.

Who will monitor the situation to ensure it will not occur again?: Staff, Home Manager, and QP will monitor the situation.

How often will the monitoring take place?: Each time an incident report is done.

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

March 18, 2020

Eddie Scruggs, Director
One on One Care, Inc.
PMB 109 1137 East Marion Street
Shelby, NC 28150

Re: Annual and Follow-up Survey completed March 13, 2020
One on One Care Home A, 607 West Dixon Blvd., Shelby NC 28150
MHL # 023-190
E-mail Address: escruggs@oneononecare.net

Dear Mr. Scruggs:

Thank you for the cooperation and courtesy extended during the annual and follow-up survey completed March 13, 2020.

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 May 12, 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.

March 18, 2020
One on One Care, Inc.
Eddie Scruggs, Director

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 Ms. Sonia Eldridge, Mountains Team Leader, at 828-200-6605.

Sincerely,

Sally Thayer, MSW

Sally Thayer, MSW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: qmemail@cardinalinnovations.org
QM@partnersbhm.org
dhhs@vayahealth.com
Pam Pridgen, Administrative Assistant