STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL097-046	A. BUILDING: _____ B. WING _____	R 03/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SWAIN STREET GROUP HOME	1224 SWAIN STREET N WILKESBORO, NC 28659

(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 10, 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 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111	RECEIVED MAR 27 2020 DHSR-MH Licensure Sect	

Brushy Mountain Group Homes, Inc.

P.O. Box 1045

North Wilkesboro, NC 28659

Plan of Correction

VIII 27G .0205 (A-B) ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN

Brushy Mountain Group Homes will create a preadmission assessment form to be completed by and/or for all potential Residents. Guardians, Physicians and/or Natural Support Care Givers will collaborate to provide information that includes but not limited to:

A. The client's presenting problem
B. The client's needs/strengths
C. The client's presenting diagnosis
D. Pertinent social, family and medical history
E. Evaluations or assessments such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs
F. When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "PCP" strategies to address the client's presenting problem shall be documented.

Training will be provided to the Qualified Professional by the Executive Director immediately and once per month thereafter. This will be documented through supervision notes and maintained in the office of the Executive Director.

Qualified Professional and Executive Director will meet quarterly to discuss medical necessity, progress on plans, pertinent life changes and any other changes that may need to be implemented at that time in the Person Centered Plans (PCP's).

Completion Date: April 30, 2020

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V 111	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to complete an assessment prior to the delivery of services for 1 of 4 audited clients (#1). The findings are: Record review on 3/4/20 for Client #1 revealed: -Admitted on 3/30/19 with diagnoses of Moderate Intellectual Disability and unspecified communication disorder. -No admission assessment documented. Interview on 3/10/20 with the Executive Director revealed: -An assessment was done for Client #1, but it could not be located. -The Qualified Professional and former Director met with Client #1 and the guardian prior to admission to complete the assessment. His medical history was reviewed. -She could not identify the format used by the facility to document the assessment.	V 111		
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.	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 112	Continued From page 2 (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. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to develop specific strategies and interventions to address the treatment needs for 2 of 4 audited clients (#2, #4). The findings are: Client #2: Record review on 3/10/20 for Client #2 revealed: -Admitted on 2/20/97 with diagnoses of Impulse Control Disorder, Mild Mental Retardation, Anxiety Disorder and problems related to social environment. -Medical notes indicated that the primary care physician had recommended counseling for Client #2 on multiple occasions. -The treatment plan did not include goals or strategies to address the anxiety experienced by Client #2.	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 112	Continued From page 3 Client #4: Record review on 3/5/20 for Client #4 revealed: -Admitted on 11/1/83 with diagnoses of Moderate Intellectual Disability, Fragile X Syndrome, and leaky heart valve. -February service notes indicated 6 emergency room visits during a six-month time period. Client #4 was scheduled for a heart procedure that was scheduled and cancelled. He was currently scheduled to see another physician. He had experienced eating and drinking difficulties and was expressing more anger. -The treatment plan for Client #4 had not been updated to reflect the current health/medical and behavioral issues that Client #4 had experienced. Interviews on 3/5/20 and 3/10/20 with Staff #1 revealed: -Client #4 had visited the emergency room in December. He also saw a Cardiologist. He was diagnosed with mitral valve regurgitation. He experienced edema. He had multiple hospital visits and medication changes. He had improved but had experienced a significant health event. -The sister/guardian for Client #2 passed away within the last few months. His brother in law became his guardian in September 2019. -Client #2 had experienced an increase in anxiety and negative behaviors since the death of his sister. Interview on 3/10/20 with Staff #2 revealed: -Client #2's anxiety levels had been up and down since the death of his sister. Interview on 3/5/20 with the Executive Director revealed: -The Qualified Professional was responsible for completing the treatment plan.	V 112		

VII2 27G .0205 (C-D) ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN

A. Person Centered Plans (PCP's) will be revised as client's needs change
B. The PCP will be reviewed quarterly or before, should there be significant changes in client's life
C. PCP's will be updated to address progress or any other life changes such as but not limited to medical, behavioral, social
D. All PCP's will be individualized to meet the individual needs

Training will be provided to the Qualified Professional by the Executive Director immediately and once per month thereafter. This will be documented through supervision notes and maintained in the office of the Executive Director.

Qualified Professional and Executive Director will meet quarterly to discuss medical necessity, progress on plans, pertinent life changes and any other changes that may need to be implemented at that time in the Person-Centered Plans (PCP's)

Completion Date: April 30, 2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 112	Continued From page 4 -Treatment plans should be revised and changed as needs change. -Treatment plans should be reviewed quarterly for progress. -The treatment plans for Client #2 and Client #4 had not been updated to reflect current medical or behavioral issues. -Treatment plans should be individualized.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to complete fire and disaster drills quarterly on each shift. The findings are: Review on 3/5/20 of fire and disaster drill documentation for 1/2019-12/2019 revealed: -No disaster drills conducted for the weekday shift during the 1st quarter (1/2019-3/2019) or 4th	V 114		

V 114 27G.0207 EMERGENCY PLANS AND SUPPLIES

A. A minimum of two Fire and two Disaster drills, one each per shift, will be ran quarterly

Qualified Professional and Executive Director will alternate monthly monitoring in each home. On the third month Qualified Professional and Executive Director will meet and discuss what drills were ran and how effectively they were carried out as well as discuss any issues that need more attention.

Completion Date: April 30, 2020

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V 114	Continued From page 5 quarter (10/2019-12/2019). -No fire drills conducted for the weekday shift for the 2nd quarter (4/2019-6/2019) and the 4th quarter (10/2019-12/2019). Interview on 3/10/20 with the Executive Director revealed: -There were 2 shifts, a weekday shift and a weekend shift. -Additional drills could not be located. -No clear system of oversight in place to ensure drills had been conducted.	V 114		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the	V 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 290	Continued From page 6 emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to assess and document in the treatment plan that a client was capable of being unsupervised in the community effecting 2 of 4 audited clients (#2, #3). The findings are: Client #2: Record review on 3/10/20 for Client #2 revealed: -Admitted on 2/20/97 with diagnoses of Impulse Control Disorder, Mild Mental Retardation, Anxiety Disorder and problems related to social environment. -Treatment plan did not include goals or strategies to address unsupervised time in the community for Client #2.	V 290		

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V 290	Continued From page 7 -There was no documentation to indicate that Client #2 had been assessed regarding his capability to be unsupervised for periods of time in the community. Client #3: Record review on 3/4/20 for Client #3 revealed: -Admitted on 6/10/97 with diagnoses of Spina Bifida, VP Shunt #1, chronic lower extremity edema, neiorgenia bladder/bowel, Major Depressive Disorder, other specified Impulse Control Disorder, Conduct Disorder, borderline to mild Intellectual Disability, and cellulitis. -Treatment plan did not include goals or strategies to address unsupervised time in the community for Client #3. -There was no documentation to indicate that Client #3 had been assessed regarding his capability to be unsupervised for periods of time in the community. Interview on 3/4/20 with Client #3 revealed: -He was dropped off at church and picked up when he called staff. No staff were present with him at church. He had a cell phone and called staff when ready to be picked up. Interview on 3/4/20 with Staff #2 revealed: -She took Client #2 and Client #3 to church on Sundays and dropped them off. She did not stay with the clients at church. -The clients had attended this church for years and the church members kept an eye on them. -The church members had her phone number if needed. -Client #2 had a cell phone and knew to call her when needed. -She stated there had never been an issue. Interview on 3/10/20 with the Executive Director	V 290		

V 114 27G.5602 SUPERVISED LIVING-STAFF

A. Client's will be assessed regarding their ability to be left unsupervised for specific periods of time in the community by their service team, which may include guardians, QP, Executive Director, Group Home Managers, Family and or Natural Supports. Alone time will be assessed during each quarterly team meeting.
   Results of these meetings will be documented in the Person Centered Plans.
B. Person Centered Plans will include goals and/or strategies to address unsupervised time in the community for Clients

Qualified Professional and Executive Director will meet with the client's service team to determine client's ability to be left alone for a specified period. Strategies will always be put in place at that time to ensure client's health and safety during alone time. These strategies may include but are not limited to, length of time, natural supports, means of communication and the location of nearby staff.

Completion Date: April 30, 2020

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V 290	Continued From page 8 revealed: -For each client the treatment team made the decision for clients to be unsupervised based on what the client wants to do and what the treatment team thinks should happen. -Unsupervised time is for specific periods of time and would only be in a safe environment. -She was not aware of identified criteria to meet for a client to be deemed capable of unsupervised time. -There was no documented evaluation of capability for Client #2 or Client #3. -There had never been a negative outcome that resulted from the clients being at church unsupervised.	V 290		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a	V 291		

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V 291	Continued From page 9 conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to coordinate with qualified professionals who are responsible for treatment for 1 of 4 audited clients (Client #2). The findings are: Client #2: Record review on 3/10/20 for Client #2 revealed: -Admitted on 2/20/97 with diagnoses of Impulse Control Disorder, Mild Mental Retardation, Anxiety Disorder and problems related to social environment. Review on 3/10/20 of the medical notes for Client #2 revealed: -On 7/17/19 " ...Referral to counseling ..." -On 8/21/19 " ...Keep working on getting him into counseling ..." -On 10/23/19 "Call [local mental health provider] for appointment ..." Interviews on 3/5/20 and 3/10/20 with Staff #1 revealed: -The sister/guardian for Client #2 passed away within the last few months. His brother in law became his guardian in September 2019. -The primary care physician had referred Client #2 for counseling. The provider would not see	V 291		

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V 291	Continued From page 10 without consent from the guardian. She contacted the provider in December to arrange for counseling, however, the appointment was not until April. She indicated that this was as soon as Client #2 could be seen. -She stated that she had been distracted by the medical issues going on with Client #4 and that is why there had been a delay in arranging counseling. -Client #2 had experienced an increase in anxiety and negative behaviors in the last year and a half since the death of his sister. -Client #2 had always taken medications for anxiety/mood disorder. -Client #2 had not yet been to see a counselor. -Client #2's brother in law had begun to get more involved. Client #2's anxiety level had improved as well as his behavior. Interview on 3/10/20 with the Executive Director revealed: -The house manager made all medical appointments. -She believed that the house manager had been very focused on the medical issues of another resident which resulted in the failure to address the counseling need of Client #2. -Client #2's anxiety levels had begun to improve because his brother in law had begun to be more involved. -The counseling appointment was overlooked and there had been a delay in the arrangement of those services.	V 291		

V 114 27G.5603 SUPERVISED LIVING-OPERATIONS

A. Group Home Managers will meet with Qualified Professionals weekly or more often, depending on the client's needs, to ensure that all client issues are reviewed and if needed, corrective measures be put in place for the health, safety and well being of the clients. Should issues be identified, the guardian will be contacted and made aware of the issue as well as have input into the resolution of the issue. These coordinated issues may include, medical appointments, psychiatric appointments as well as other relevant concerns with client's needs. Staff supervision will be documented through supervision training notes and placed in the supervision notebook located in the office of the Executive Director. Guardian contacts will be documented in the client's file under Communication notes.

Training will be provided to the Group Home Managers by the Qualified Professionals. BMGH house managers will be directed to inform Executive Director or Qualified Professionals of any concern that may arise that needs immediate attention. This will be documented through supervision notes and maintained in the office of the Executive Director.

Qualified Professional and Executive Director will meet monthly to monitor coordination of client issues.

Completion Date: April 30, 2020

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

Johnnie Everidge, Executive Director
Brushy Mountain Group Homes, Inc.
PO Box 1045
North Wilkesboro, NC 28659

Re: Annual and follow up Survey completed March 10, 2020
Swain Street Group Home, 1224 Swain Street, North Wilkesboro, NC 28659
MHL # 097-046
E-mail Address: jeveridg@outlook.com

Dear Ms. Everidge:

Thank you for the cooperation and courtesy extended during the annual and follow up survey completed March 10, 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 9, 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 Sonia Eldridge at 828-665-9911.

Sincerely,

Kem Roberts

Kem Roberts
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: dhhs@vayahealth.com
Pam Pridgen, Administrative Assistant

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL097-046 Y1	A. Building B. Wing Y2	3/10/2020 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SWAIN STREET GROUP HOME	1224 SWAIN STREET N WILKESBORO, NC 28659

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 V0121 Reg. # 27G .0209 (F) LSC	Correction Completed 03/10/2020	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
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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	DATE
			Kem Roberts	3-17-20
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
2/1/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

EVENT ID: ZK3112

STATE FORM: REVISIT REPORT (11/06)