

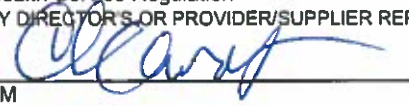
Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL067-209	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/24/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 409 SOUTH SHORE DRIVE JACKSONVILLE, NC 28540
--	--

(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	<p>INITIAL COMMENTS</p> <p>A complaint survey was completed on April 24, 2020. The complaint was substantiated (intake #NC00161767). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p>	V 000		
V 112	<p>27G .0205 (C-D) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(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.</p> <p>(d) The plan shall include:</p> <p>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;</p> <p>(2) strategies;</p> <p>(3) staff responsible;</p> <p>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;</p> <p>(5) basis for evaluation or assessment of outcome achievement; and</p> <p>(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.</p>	V 112		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE	(X6) DATE
---	-------	-----------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL067-209	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 409 SOUTH SHORE DRIVE JACKSONVILLE, NC 28540
--	--

(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 112	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement strategies based on assessment affecting one of one audited clients (#1). The findings are:</p> <p>Review on 04/22/20 of client #1's record revealed: -47 year old male. -Admission date of 11/18/19. -Diagnoses of Moderate Intellectual Developmental Disability, Attention Deficit Hyperactivity Disorder, Schizoaffective Disorder-Depressive Type, Parkinson's Disease, Hyperlipidemia and Ulcerative Colitis.</p> <p>Review on 04/22/20 of client #1's Individual Support Plan (ISP) dated 02/01/20 revealed: -"What Others Need To Know To Best Support Me ...[Client #1] requires close supervision due to risk of wandering away. [Client #1] will elope from his Residential home when he gets upset-usually he is upset about money and yogurt. Staff attempts to redirect [Client #1] prior to his elopement but are not always successful ...[Client #1] requires support due to inability to make safe choices when in the community (e.g. crossing street safely, refusing ride from a stranger, etc.) ...[Client #1] requires support because he/she is unable to avoid being taken advantage of financially(e.g. not giving his money to strangers, not giving out personal financial information to strangers etc.) [Client #1] requires 24 hour supervision to ensure safety. [Client #1] currently receives 24 hour supervision with his Residential Supports ...[Client #1] is a risk of wandering away and needs close supervision while out in the</p>	V 112		
-------	--	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL067-209	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 409 SOUTH SHORE DRIVE JACKSONVILLE, NC 28540
--	--

(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 112	<p>Continued From page 2</p> <p>community. [Client #1] is also at risk of tripping and falling due to his inability to maintain his balance and coordination during ambulation ..." -"Medical/Behavioral: ...[Client #1] has Parkinson-like symptoms and needs constantly monitored for trips/falls during ambulation due to his inability to maintain his balance and coordination ..." -Behavioral: ...[Client #1] has a tendency to walk away from others when he is in the community. Respondents report that it is imperative he be supervised at all times while in the community because he will attempt to wander away ..." -"What's Not Working And Needs To Change ... [Client #1] will elope from his home if he gets upset ...[Client #1] requires monitoring due to wandering off/elopement ..." -No specific strategies to address client #1's ongoing elopement issues.</p> <p>Review on 04/24/20 of the North Carolina Incident Response Improvement System website from February 2020 thru present revealed the following documented level II elopements for client #1: -04/21/20 - Client #1 eloped from his window at 6:30pm and 911 was notified. "The treatment team continues to discuss and implement strategies to prevent elopement issues to include providing addition support staff when available and will assess the need for an alert system on the bedroom window to alert the staff when the bedroom window is being opened." -04/05/20 - Client #1 eloped from the facility at 9:30am. -03/27/20 - Client #1 eloped from the facility at 7am. -02/28/20 - Client #1 eloped from the facility at 12:45am.</p> <p>Review on 04/23/20 of facility incident reports</p>	V 112		
-------	---	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL067-209	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/24/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 409 SOUTH SHORE DRIVE JACKSONVILLE, NC 28540
--	--

(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 112	<p>Continued From page 3</p> <p>from February 2020 thru present revealed a level I incident report dated 02/22/20 for elopement.</p> <p>Interview on 04/22/20 client #1 stated: -He worked at a local restaurant. -He had eloped from the facility but was not able to recall the details.</p> <p>Interview on 04/23/20 staff #1 stated: -He had worked at the group home for 16 years. -Client #1 had attention seeking behaviors and staff try to redirect him as needed. -Client #1 usually walks off on 2nd shift and will also go out of his window. -Client #1 will start to put on clothes when he is about to leave the facility. -Staff get the other clients and try to keep client #1 in eyesight due to safety issues. -The Qualified Professional (QP) is notified and will search for client #1.</p> <p>Interview on 04/22/20 staff #2 stated: -She had worked at the facility for approximately 8 months. -Client #1 has a history of walking away from the facility. -Staff contact the QP and the police when client #1 elopes. -Facility staff try to get other clients in the car to look for client #1.</p> <p>Interview on 04/22/20 the QP stated: -She had recently began supervising the facility staff. -Client #1 has a care coordinator through the Local Management Entity. -Client #1 has a history of elopement. -If client #1 elopes the facility staff attempt to get other clients in a vehicle and search for him.</p>	V 112		
-------	---	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL067-209	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 409 SOUTH SHORE DRIVE JACKSONVILLE, NC 28540
--	--

(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 112 Continued From page 4
 -The police are contacted.
 -The facility has one staff on 2nd and 3rd shift.
 -The treatment team is reviewing the need for possibly a second staff.
 -Staff are trained on strategies to provide redirection for client #1.

V 112

V 118 27G .0209 (C) Medication Requirements
 10A NCAC 27G .0209 MEDICATION REQUIREMENTS
 (c) Medication administration:
 (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs.
 (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.
 (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications.
 (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:
 (A) client's name;
 (B) name, strength, and quantity of the drug;
 (C) instructions for administering the drug;
 (D) date and time the drug is administered; and
 (E) name or initials of person administering the drug.
 (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.

V 118

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL067-209	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/24/2020
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 409 SOUTH SHORE DRIVE JACKSONVILLE, NC 28540
--	--

(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 118	<p>Continued From page 5</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to administer medications on the written order of a physician affecting one of one audited clients (#2). The findings are:</p> <p>Review on 04/22/20 of client #2's record revealed: -51 year old male. -Admission date of 11/18/19. -Diagnoses of Moderate to Severe Intellectual Developmental Disability, Schizoaffective Disorder and Diabetes.</p> <p>Review on 04/22/20 of client #2's medication orders revealed: 03/16/20 -Bentropine (treats Parkinson's Disease symptoms) 0.5 milligrams (mg) - take one tablet twice daily. -Prazosin (treats high blood pressure) 2mg - take 2 capsules at bedtime.</p> <p>01/29/20 -Enalapril (treats high blood pressure) 5mg - take one tablet daily.</p> <p>Review on 04/22/20 of client #2's February 2020 and March 2020 MARs revealed: March 2020 -Prazosin documented as "out" on 03/29/20.</p> <p>February 2020 -Prazosin indicated as not given on the back of</p>	V 118		
-------	--	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL067-209	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 409 SOUTH SHORE DRIVE JACKSONVILLE, NC 28540
--	--

(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 118	<p>Continued From page 6</p> <p>MAR on 02/23/20 and 02/24/20. -Enalapril documented as "out" on 02/01/20, 02/02/20 and 02/08/20. -Benzotropine documented as "out" on 02/08/20.</p> <p>Interview on 04/22/20 client #2 stated: -He received his medication daily. -He was not able to recall the names of his medications.</p> <p>Interview on 04/23/20 staff #1 stated: -He had training in medication administration. -There had been no missed medications. -Staff monitor the medication supply at the facility.</p> <p>Interview on 04/22/20 staff #2 stated: -She had training in medication administration. -There have been times when medications have run out. -They now do a medication inventory two times a week.</p> <p>Interview on 04/24/20 the Program Director indicated she would follow up on identified medication issues.</p>	V 118		
-------	---	-------	--	--

Appendix 1-B: Plan of Correction Form

Plan of Correction

Please complete all requested information and mail completed Plan of Correction form to: NC DHSR **In lieu of mailing the form, you may e-mail the completed electronic form to:**

Provider Name: A Caring Heart Case Management, Inc.	Phone: 252-206-1266	Time Line
Provider Contact Person for follow-up: Erin Mairs	Fax: 252-206-1268	Implementation Date: 5/13/20
Address: 1901 Tarboro St SW, Suite 102, Wilson, NC 27893	Email: emairs@acaringheartinc.com	Actual Completion Date: 5/31/20
Provider # 3419141		
Finding	Corrective Action Steps	Responsible Party
<p>10A NCAC 27G. 0205 (C-D) Assessment/Treatment/Rehabilitation Plan</p> <p>(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 client who are expected to receive services beyond 30 days.</p> <p>(d) The plan shall include:</p> <p>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;</p> <p>(2) strategies;</p> <p>(3) staff responsible;</p> <p>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;</p> <p>(5) basis for evaluation or assessment of outcome achievement; and</p> <p>(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.</p> <p>This rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement strategies based on assessment affecting one of one audited clients (#1)</p>	<p>1. Each QP will conduct a review of monthly services documentation for each client to determine any goals in which progress is not being made.</p> <p>2. GERS (Incident Reporting System) will be reviewed to determine any clients with goals and current strategies that are not working as well.</p> <p>3. The QP for each case will be responsible for developing additional strategies in order to meet goal achievement whenever there is a trend indicating that current strategies are not working. A trend will be defined as three or more incident occurrences of the same type within a two month period.</p> <p>4. If additional strategies are implemented and not successful in goal achievement, the QP will discuss with Program Director to address further either through a team meeting or a complex needs meeting within the agency.</p>	<p>QPs, Program Director</p>

<p>10A NCAC 27G .0209 (C) Medication Requirements (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This rule is not met as evidenced by: the facility failed to administer medications on the written order of a physician affecting one of one audited client (#2).</p>	<p>1. The pharmacy has provided an excel spreadsheet of all prescriptions for all clients, which provides fill date, and number of refills left on each prescription. We are also delineating PRN meds and any non-pill prescriptions (ointments, creams, spray, etc.) 2. Spreadsheet will be sorted based on fill date to determine which meds are in the last week prior to the fill cycle, so that we can monitor refills closely to eliminate the potential for meds to run out. 3. Spreadsheet will be updated on a monthly basis.</p>	<p>Agency President, Agency Nurse</p>	<p>Implementation Date: 4/28/20</p> <p>Actual Completion Date: 5/15/20</p>
--	---	---------------------------------------	--