Victor & ASSOCIATES INC.

Provider of MH/DD/SA Services

1600 South Third St. , Sanford, NC 27330 Tel: (919)718-4988 Fax: (919)718-4990

Fax

To: Frances Hicks MSW DHSR **From:** Jones Hocus, QP/MPT

Fax: 919-715 8078 **Pages:** including Fax Sheet

Phone: **Date:** 11/2/20

Re: Harmony POC **CC:**

Urgent **For Review** **Please Comment** **Please Reply** **Please Recycle**

- **Comments: If you have any questions or concerns, please feel free to contact me at (919)718-4988. Thanks!**

Hard copy of POC went out today in the mail.

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November 2, 2020

Ms. Frances E. Hicks, MSW
Facility Compliance Consultant I
Mental Health Licensure and Certification Section
N.C. Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Complaint Survey completed October 27, 2020
Harmony Home
808 North McKay Avenue
Dunn, NC 28334
MHL#043-075
Intake #NC00170233 & #NC00170400

Dear Ms. Hicks:

See attached hard copy of the plan of correction (POC) for the Harmony Home's complaint survey, completed 10/27/20. We hope that you will find the attached POC acceptable. If you have questions, feel free to contact myself or Vidya Persad, Director of Operations. Otherwise, we very much look forward to your follow-up visit.

Kindest regards,

James Harris, Director Quality Management

PRINTED: 10/28/2020
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
	MHL043-075	A. BUILDING: _____ B. WING _____	C 10/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HOME	808 NORTH MCKAY AVENUE DUNN, NC 28334

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V 000	INITIAL COMMENTS A complaint survey was completed on October 27, 2020. The complaint (intake #NC00170233) was unsubstantiated and complaint (#NC00170400) was substantiated. Deficiency cited.	V 000		
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision plan upon hiring each associate professional. (g) The associate professional shall be	V 109		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Director Quality Management 11/2/21

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V 109	Continued From page 1 supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record reviews and interviews the Associate Professional failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Review on 10/20/20 of Client #3 ' s record revealed: -Admission date of 7/1/20. -Diagnoses of Intellectual Developmental Disorder, Moderate and Autism Spectrum Disorder. -Treatment plan dated 7/2/20 revealed the following goals: -client will interact appropriately with staff and peers (including tone of voice and not interrupting. -client will refrain from exhibiting disruptive behaviors when frustrated. -client will learn to cope with her frustration by talking it through with staff. -Behavior Support Plan dated 8/15/20 included the following target behaviors: "-For the purposes of this behavior support plan Challenging behaviors will be defined as including aggression, property destruction, severe disruptive behavior, self-injurious behavior, taking items that do belong to her and failure to make responsible choices. "	V 109	The facility will ensure the Associate Professional (AP) demonstrates the knowledge, skills and abilities necessary to support the population served in the home. More specifically, the AP will exercise appropriate decision-making in situations where client behavior challenges present consideration for admission to the hospital and/or a specialized behavior unit. The AP will seek final disposition from the hospital before separating herself from the client in question. The Quality Management Director will provide training to the AP in areas of case management to include but not limited to documentation, clinical interventions, communication, resolution, and specific situations of crisis such as admission to a hospital and affirming the disposition status before separation from the client. The Quality Management Director and/or Director of Operations will review the AP documentation in client records weekly to ensure compliance. The Quality Management Director and/or Director of Operations will consult with the AP weekly to assess her competencies and abilities to provide appropriate clinical support to the caseload to ensure compliance.	12/26/20 12/26/20 12/26/20

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V 109	Continued From page 2 Review on 10/27/20 of client #3 ' s Physician orders included the following: -7/2/20 - " Sertraline 100mg - take two tablets by mouth at bedtime. " - " Melatonin 5mg - take two tablets by mouth at 8p.m. " - " Low-ogestrel tabs - take one tablet every day as directed. " - " Multivitamin - take one tablet by mouth - " Quetiapine 50mg - take one tablet in the morning, take one at 2p.m. and one at 8p.m. - 8/12/20 - " change afternoon dosing of Quetiapine to 2 p.m. continue Sertraline. " - 8/12/20 - " Added Ativan 2mg prn for extreme irritability. " -9/8/20 - " Ativan 2mg PRN - not picked up last month due to issues with RX. " -9/22/20 - " Quetiapine 50 mg - take two tablets in the morning, one at 2p.m. and 2 at 8p.m. " - There was a FL-2 in the record dated 7/2/20. - There was no evidence a PRN was administered to client. -There was no entry on the medication administration record or controlled drug record. Review on 10/27/20 of Client #3 ' s Facility ' s Incident Report included behaviors to self/others: -7/4/20 at 4:30 p.m. - self-inflicted/bruise - 7/22/20 at 7:45 a.m. - property destruction. - 7/22/20 at 7:00 p.m. - physical aggression. - 8/7/20 at 11:45 a.m. - verbal and physical aggression. -8/7/20 at 4:30 p.m. - physical aggression. -8/14/20 at 4:45 p.m. - physical aggression and verbal aggression. -8/19/20 at 11:30 a.m. - verbal and physical aggression, injury and behavior.	V 109		

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V 109	Continued From page 3 -8/19/20 at 9:00 p.m. - verbal and physical aggression. -8/20/20 at 5:00 p.m. - verbal and physical aggression, elopement and property destruction. -8/20/20 at 5:40 p.m. - verbal and physical aggression, elopement and property destruction. -8/20/20 at 6:20 p.m. - verbal and physical aggression and property destruction. -8/21/20 at 7:55 a.m. - verbal and physical aggression. -9/1/20 at 11:25 a.m. - verbal aggression and property destruction. -9/3/20 at 4:30 p.m. - verbal and physical aggression. -9/9/20 at 8:30 p.m. - verbal and physical aggression. -9/10/20 at 6:45 p.m. - verbal and physical aggression. -9/23/20 at 6:40 p.m. - verbal and physical aggression and property destruction. -9/29/20 at 4:50 p.m. - verbal and physical aggression. Review on 10/26/20 of the Hospital Nurse Note dated 7/26/20 revealed: " Chief Complain: Verbal and Physical Outburst in Group Home " - " 4:30 p.m. - making room changes to accommodate [client #3] at this time. " - " 6:37 p.m. - [Client #3 ' s] father, power of attorney; [client #3 ' s] mother. Call before making any care decisions regarding [client #3]. " - " 6:54 p.m. - spoke with [client #3 ' s] father, [client #3 ' s] father states he spoke with the supervisor at [client # 3 ' s] group home and he would like [client #3] sent back there. " - " 6:57 p.m. - aware of father ' s desire to discharge [client #3] back to the group home. EKG order to be cancelled as per Nurse Practitioner. [Client #3 ' s] group home [AP] at	V 109		

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V 109	Continued From page 4 bedside, protective observation maintained by sitter. " - " 7:53 p.m. - Meal tray to [client #3]. Provider at bedside to update [AP] that we are awaiting [local psychiatric consult]. [Client #3] is calm currently. Interacts with this nurse by stating what choice meal tray and beverage [client #3] wants. " - " 8:32 p.m. - [Associate Professional] left, stated [AP] could not stay any longer. Left two names and numbers [Director of Quality Management] and [Director of Operations]. - " 8:35 p.m. - Provider made aware at this time [AP] that came in with [client #3] from group home left emergency department stated [AP] could not stay any longer and left two phone numbers. - " 11:04 p.m. - ...took medications without coughing. " - " 11:08 p.m. -Spoke with [client #3 ' s] father and mother approximately 45 minutes ago. [Client #3 ' s] father reports being confused because facility is telling them that they did not tell emergency room staff they would not take [client #3] back. Reported to [client #3 ' s] father that per multiple conversations documented that the group home have stated they will not take [client #3] back. Father and mother will be in route from [outside county] to pick [client #3] up from emergency room and take [client #3] to their home until they can handle this situation. " Interview on 10/23/20 with Client #3 ' s Guardians revealed: -Client #3 had behavioral issues on 7/26/20. -They got a call from the hospital regarding the behavior. -Client #3 reportedly hit staff and was aggressive. -Client #3 was left in the hospital by herself, without staff from the group home. -When client #3 got there, they decided there was	V 109		

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V 109	Continued From page 5 no need to admit client #3. -There was no involuntary commitment or medication given. -According to the hospital document, client #3 was calm. -The group home refused to take client #3 back and left client #3 there. -The hospital called, and he and his wife went to the hospital and brought client #3 home. -They picked client #3 up on 7/26/20, Sunday Night. -Group home denied that they didn ' t want to take client #3 back. -There should have been someone at the hospital with the client #3. -Spoke to the top manager to the house manager. -Management called the hospital. -Reported that the facility said they would discharge client #3. -Client #3 stayed with them for about a week. -Group home said client #3 could not return until client #3 was seen by a doctor. -Client wasn ' t sleeping well. -They took client #3 to the doctor on 7/30/20. -Reported he took client #3 to see his primary care doctor. -He also had concerns about the group home giving client #3 medication that was not prescribed. -He spoke with client #3 around the beginning of October and client #3 was mumbling. -They called the facility out about giving client #3 medication. -Staff were saying they did not give client #3 PRN medication. -Client #3 was knocked out; client #3 was mumbling. -He felt client #3 was given something because of her mumbling,	V 109		

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V 109	Continued From page 6 -Reported there would be no behaviors if client #3 spent time on her iPad and internet. -Confirmed he did not know what medication client #3 was prescribed. Interview on 10/25/20 with the Associate Professional revealed: -She was called in because staff said client #3 was acting out. -She heard client #3 attacked staff. -Client was hitting staff #4 in the face; punched him in the face. -Client #3 was acting out. -Her boss called her. -She went to the house and told client #3 she had to go to the doctor. -Client #3 said ok. -She explained to client #3 what she had to do. -She did not investigate whether staff #4 had any marks on his face. -An incident report was completed. -She took client #3 to the hospital and explained what happened. -She took client #3 to the emergency room. -Client #3 had a tendency to lash out and hit others. -She sat in the room for a while; the doctor and nurse saw client #3. -They had me waiting for a long time, a few hours. -After a while a doctor came in and took client #3 ' s vital signs. -She provided the medication client #3 was taking. -They told her a social worker would come in and talk to client #3 about admitting. -Eventually about 9 p.m. or 10 p.m. the social worker never came. -Moving forward she told the nurse to call the QM.	V 109		

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V 109	Continued From page 7 -The hospital did not have a bed, or problems with client #3; no sitter; -She sat with client #3 in the casualty department downstairs. -Another nurse came in and did vital signs again. -Second nurse started asking the same questions. -She suggested to the nurse to call the QM. -She was told by management to leave client #3. -Client #3 was violent and couldn ' t go back in the house. -Client #3 was in a room downstairs on the bed in the hospital. -She told client #3 she was going to leave and client #3 said okay. -There were cubicles in pending room. -There were no other patients in client #3 ' s room. -There was a room with a door. -Client #3 was in a room by herself. -Client #3 was back in the group home a week later. -Decision made by management. -She took client #3 to the doctor; parents went to the doctor with her. -Client #3 would get very violent. -Client #3 was seen by the psychiatrist. -When client #3 was taking back to the doctor it was determined she needed a PRN. -During appointment client #3 was banging her head, biting herself, yelling and banging on furniture. -This was the second appointment on 10/6/20. -Doctor prescribed Lorazepam 2mg PRN. -Primary care doctor increased dosage. -The QP and management could only approve to give PRN. Interview on 10/27/20 with the Director of Quality Management revealed:	V 109		

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V 109	Continued From page 8 -Client #3 punched staff #4 in the face and caused bleeding. -Client #3 was sent to the hospital. -AP took client #3 to the hospital. -He and the Director of Operations spoke with Physician Assistant at the hospital. -He and the Director of Operations was communicating with the PA. -It was their understanding that client #3 would be admitted and assessed in the morning. -Client #3 needed to be assessed prior to return to the group home. -The goal was to get client #3 assessed at the hospital. -The hospital should have contacted him if client #3 needed to be picked up. -He was not aware client #3 parents picked client #3 up from the hospital. -Family accused the company of bringing in drugs to give to the client #3. -The company had own pharmacy and pharmacist. -The medication Ativan prescribed was a controlled drug and had to be recorded and accounted for. -Only him and Director of Operations/QP would authorize staff to administer the Ativan. -Ativan was never administered to client #3. -Client #3 had behaviors since admission. -Previous facility never reported client #3 ' s behaviors of property destruction and aggression. -A behavioral support plan was implemented with strategies to help decrease behaviors. -A letter was sent to the Local Management Entity requesting funds for 1:1 service. -They still had not received a response for services. -He sent the family a 60-day discharge letter via email. -Discharge will be some time in December.	V 109		

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V 109	Continued From page 9 -AP responsibility was documentation, supervised homes and scheduled and attend appointments. -AP not able to sign off on documentation. -He would provide AP with some training on specific situations. -Work with AP on communication and documentation. -He would make sure AP or any staff get disposition before leaving the hospital.	V 109		