STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G146	A. BUILDING _____ B. WING _____	C 09/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXTRA SPECIAL CARE	6214 KILMORY DRIVE FAYETTEVILLE, NC 28304

(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) COMPLETION DATE
E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an *all-hazards approach*. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.	E 004		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] QP | TITLE: QP | (X6) DATE: 10/22/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 004	Continued From page 1 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Emergency Preparedness (EP) plan was reviewed and updated at least annually. The finding is: The facility's EP plan was not reviewed and/or updated at least annually. Review on 9/1/20 of the facility's EP plan (dated 1/16/19) revealed the plan was reviewed by the Emergency Management Coordinator from the County Department of Emergency Services. Further review of the plan did not include evidence of an annual review or update. Interview on 9/1/20 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the EP plan had not been reviewed or updated.	E 004	E004-The facility will ensure the Emergency Preparedness (EP) plan be reviewed and updated at least annually. QP and Residential will monitor annually.	11/2/2020
W 000	INITIAL COMMENTS A recertification and complaint survey was completed on 9/2/2020. Deficiencies were not cited as a result of the complaint survey for Intake #NC00161790. The complaint allegations were unsubstantiated.	W 000		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure clients were afforded privacy during personal care. This	W 130		

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W 130	Continued From page 2 affected 2 of 3 audit clients (#3, #6,) and one non-audit client #2. The findings include:: A. Audit client #3 was not afforded privacy while getting dressed. During observations on 9/2/20, client #3 came out of the bathroom, after her bath, wearing a robe. She requested assistance from staff at 5:22am and was standing in her bedroom with her bedroom door open with only her panties on for 5 minutes until staff F could assist her. Staff F came into her room at at 5:27am and closed the bedroom door. Interview on 9/2/20 with the qualified intellectual disabilities professional (QIDP) revealed client #3 needs assistance in maintaining her privacy when dressing. Additional interview revealed staff should assist her by verbal cueing her to close the bedroom door. B. Audit client #6 was not given privacy and dignity regarding his toileting needs. During observations on 9/2/20 at 5:49am client #6 was seated in a chair on a chux pad that extended out across the chair. During interview on 9/2/2020, the Residential Manager stated she was uncertain why the chux pad was in the chair. Further interview confirmed that client #6 does not have a toileting program but had one in the past. Review on 9/1/2020 of client #6's IPP revealed he does have a toileting program that requires for staff to take him to the bathroom frequently during the day and check him for wetness and	W 130	**W130-A** The facility will ensure client #3 and all clients afforded privacy while getting dressed. Staff will be in-serviced about Privacy. QP will monitor bi-weekly. Home Manager weekly.	11/2/2020
			W130-B The facility will ensure client #6 and all clients have privacy and treated with dignity with any toileting needs. IPP will reflect client #6 toileting needs. Staff will be in-serviced on IPP, Programs, Dignity and Privacy. QP will monitor bi-weekly. Home Manager weekly.	11/2/2020

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W 130	Continued From page 3 dryness. Data was reviewed for this program for June, July and August 2020. Interview on 9/2/20 with the QIDP revealed direct care staff should not be seating client #6 on a chux pad in the facility to ensure his dignity is protected. Additional interview revealed staff may need additional training on audit client #6's programs. C. Non-Audit client #2 was not assisted with ensuring his privacy during toileting. During observations at the facility on 9/1/20 at 12:35pm, audit client #2 went into the bathroom, did not close the door and began toileting. Staff A came into the bathroom and did not shut the door . Staff A prompted him to pull up his shorts, flush the toilet and wash his hands. Interview on 9/2/20 with the QIDP revealed client #2 requires assistance from staff to safeguard his privacy during toileting and dressing.	W 130	W130-C The facility will ensure client #2 and all clients is assistant with ensuring their privacy during toileting. Staff will be in-serviced. QP will monitor bi-weekly. Home Manager weekly.	11/2/2020
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by:	W 249	W249-The facility will ensure client #3 and #4 and all client's money management programs are implemented. Staff in-service. QP will monitor monthly. Home Manager monitor bi-weekly.	11/2/2020

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXTRA SPECIAL CARE	5214 KILMORY DRIVE FAYETTEVILLE, NC 28304

(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) COMPLETION DATE
W 249	Continued From page 4 Based on observations, record reviews and interviews, the facility failed to ensure 2 of 3 audit clients (#3, #4) received a continuous active treatment plan consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of money management. The findings include: *Staff did not consistently implement identified* money management programs for clients #3 and #4 as described in their individual program plans (IPP). a. Review on 9/1/20 of client #3's IPP dated 3/3/2020 revealed she has a money management objective to identify money with 75% accuracy for 2 review periods. This is to be trained on second shift. During observations in the facility on 9/1/20 from 4:40pm-6:30pm, client #3 was not involved in training on money management. Review on 9/2/20 of client #3's data revealed no data taken for June, July or August 2020. Interview on 9/2/20 with the qualified intellectual disabilities professional (QIDP) revealed this program had not been consistently implemented and may have "slipped through the cracks." b. Review of client #4's IPP dated 4/1/2020 revealed she has a money management objective *to increase money management* with 75% accuracy for 2 consecutive review periods. This is to be trained on second shift. During observations in the facility on 9/1/20 from 4:40pm-6:30pm, client #4 was not involved in	W 249		

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W 249	Continued From page 5 training on money management. Review on 9/2/20 of client #4's data revealed no data taken for June, July or August 2020. Interview on 9/2/20 with the qualified intellectual disabilities professional (QIDP) revealed this program had not been consistently implemented and may have "slipped through the cracks."	W 249		
W 420	CLIENT BEDROOMS CFR(s): 483.470(b)(4)(iv) The facility must provide each client with functional furniture, appropriate to the clients needs. This STANDARD is not met as evidenced by: Based on observation and confirmed by interviews with staff the facility failed to consider functional furniture for 1 of 3 audit clients(#1) and non-audit client (#2). The finding is: The facility failed to adapt dining furniture for clients #1 and #2's stature. During observations of dining on 9/1/20 at lunch and supper and on breakfast on 9/2/20 client #1 and client #2 were sitting at a regular dining room table and chair. Both clients jumped up into their dining room chairs. Client #1's legs were dangling about 1 foot from the floor, he pulled his legs and feet into his chair. Client #2's legs were dangling about 2-3 feet from the floor. Both clients frequently changed their seating positions pulling up closer to the dining room table. Interview with the qualified intellectual disabilities	W 420	W420-The facility will ensure client #1, #2, and all other client will be provided with function furniture that are appropriate to the clients needs. QP will monitor as needed.	11/2/2020

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W 420	Continued From page 6 professional (QIDP) on 9/2/20 revealed client #1 is 10 years old and client #2 is 8 years old and both clients are small in stature, approximately less than 4 feet in height. Further interview indicated that both clients had utilized booster seats in the past. The QIDP stated both client #1 and client #2's seating at the dining room table needed to be reassessed.	W 420		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure the potential for cross-contamination was prevented. This potentially affected 6 of 6 audit clients (#4). The finding is: Staff failed to implement facility policy during a state mandated requirement to wear face masks during the COVID-19 pandemic. Throughout observations on 9/1/20 at the facility from 12:10pm-1:35pm (85 minutes) and from 4:30pm-6:30pm (120 minutes), the Residential Manager, Direct care staff A, Direct care staff B, direct care staff D and direct care staff E lowered their masks below their nasal passages, below their chins and at some points, even removed their facial masks while they were working directly with the six clients in the facility. For example, direct care staff B at 5:01pm took his mask completely off while working in the facility with the clients.	W 454	W454-The facility will ensure all staff provide a sanitary environment by wearing face mask as mandated by the CDC. Staff will be in-serviced. QP will monitor weekly. Home Manager monitor daily.	11/2/2020

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W 454	Continued From page 7 During observations in the facility on 9/2/20 from 5:22am-7:45am (143 minutes), the Residential Manager and staff D had their masks lowered below their nasal passages but covered their mouth. Interviews on 9/1/20 with the Residential Manager revealed staff are required to wear facial masks in the facility when working with clients. Review on 9 2/20 of the facility's policy from the Centers for Disease Control and Prevention (CDC) revealed, Put on face mask or respirator, " if the respirator has a nose piece, it should be fitted to the nose with both hands, not bent or tented.... Face mask/respirator should be extended under the chin. Both your mouth and nose should be protected. Do not wear respirator/facemask under your chin or store in scrubs pocket between patients." Interview on 9/2/20 with the qualified intellectual disabilities professional (QIDP) and the Program Director revealed direct care staff should consistently be wearing masks in the facility so that their nasal passages and mouth are covered at all times in conjunction with the state mandate to wear facial masks.	W 454		

THE CARTERCLINIC
CONTINUING A LEGACY OF EXCELLENCE IN BEHAVIORAL HEALTH

October 22, 2020

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Recertification Completed 09/02/2020
Extra Special Care, 6214 Kilmory Drive, Fayetteville, NC 28304
Provider Number #34G146
MHL# 026-947

Dear Kimberly C. McCaskill:

Enclosed you will find corrections of the deficiencies cited listed on the Statement of Deficiencies Form.

If you have any questions, please contact our office at (910) 491-2352 or mobile phone (910) 978-3675 or email: asia_parker@yahoo.com

Sincerely,

Asia Parker
Qualified Professional