STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mh1095-043	A. BUILDING: _____ B. WING _____	C 01/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THREE FORKS HOME	392 CAMP JOY ROAD ZIONVILLE, NC 28698

(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 A complaint survey was completed on January 5, 2021. The complaint was substantiated (intake #NC001171600). 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 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. (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.	V 112		

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement treatment goals and strategies that addressed the presenting needs and restrictions for 2 of 2 audited clients (Client #1 and Client #2). The findings are: Record reviews on 12/18/20 and 12/21/20 for Client #1 revealed: -Admission date: 9/4/07 -Diagnoses: Moderate Mental Retardation, Anxiety, Epilepsy, Diabetes Mellitus, High Cholesterol, Acid Reflux, and Visual Impairment -His Individual Support Plan (ISP), which was developed by his Care Coordinator with the Local Management Entity (LME) and had a start date of 12/1/20, revealed: -he presented with problems that included walking and getting in and out of the van; -no approved client rights' restriction for caffeine and/or caffeinated coffee to be restricted for him after 4:00 PM; -His facility treatment plan dated 1/16/20 revealed: -there was no goal or strategies developed that addressed his ambulation and transfer problems; -there were no statements or explanations that related to the restrictions on his intake of caffeine and caffeinated coffee after 4:00 pm; -No physician order that restricted his coffee and or caffeine intake after 4:00 PM. Review on 12/21/20 of Client #1's MARs for the months of October 2020, November 2020 and December 2020 revealed: -The first entry on each month of these MARs	V 112	QP will meet with Vaya Care Coordinator to review all short term goals to make 3/4/21 sure they align with the ISP appropriately Doctor's appointment will be made in order to obtain a Doctor's order about dietary restrictions. 3/6/21	

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V 112	Continued From page 2 was "FYI (For Your Information) No Caffeine After 4 PM; No Caffeine Coffee after 4PM;" -For each of the above months, each day on the MARs was blank; there were no staff initials and no explanation for the blanks. Record reviews on 12/23/20 and 1/5/21 for Client #2 revealed: -Admission date: 9/4/07 -Diagnoses: Schizophrenia, Moderate MR, Visual Loss-Legally Blind, High Cholesterol -His ISP, which was developed by his Care Coordinator with the Local Management Entity (LME) and a revised start date of 12/1/20, revealed: -he presented with problems and needs that included: (1) problems with walking and getting in and out of the van, (2) a need for exercise reminders and staff encouragement to continue his exercise regimen, (3) a need for reminders to adhere to a diabetic diet, and (4) no reference to an approved restriction by a client's right committee for his caffeine and caffeinated coffee to be restricted for him after 4:00 PM; -His facility treatment plan dated 12/9/20 revealed: -there were no goals or strategies developed that addressed (1) his ambulation and transfer problems, (2) maintaining his physical fitness or exercise, (3) a diabetic diet, and (4) there were no statements or explanations that related to his restrictions on his intake of caffeine and coffee after 4:00 pm and whether these restrictions had been approved by a client rights committee or were physician-ordered; -No physician order that restricted his coffee and or caffeine intake after 4:00 PM. Review on 12/21/20 of Client #2's MARs for the	V 112	QP will meet with Vaya Care Coordinator to review all short term goals to make sure they align with the ISP appropriately 3-6-21 Doctor's appointment will be made in order to obtain a Doctor's order about dietary restrictions. 3-6-21	

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V 112	Continued From page 3 months of October 2020, November 2020 and December 2020 revealed: -the 1st entry on each month of these MARs was his diet was a "regular diet" with no concentrated sweets and minimal carb snacks. These entries were "FYI" entries and did not indicate whether his diet was a "diabetic diet;" -the 2nd entry on each month of the above monthly MARs included he was to have no caffeinated coffee after 4 PM and no caffeine after 4 PM; -for each of the above months, each day on the MARs was blank; there were no staff initials and no explanation for the blanks. Interview on 12/15/20 with Client #1 revealed: -He acknowledged he had diabetes; -He was not on any diet and he could have whatever he wanted when his sugar was "down;" -He could not give a number that equaled to his sugar being "down," "high," or "normal;" -He knew he could not have any caffeine after 4:00 PM each day but did not know if it was his doctor or someone else who gave him this instruction; -He drank water after 4:00 PM in place of his "pop" (soda) and coffee; -Staff #1 told him one time he could not have his pop on a Monday but his sister worked this problem out with the staff. Interviews on 12/15/20 and 1/4/21 with the Associate Professional (AP) revealed: -12/15/20, she was temporarily filling in for the Qualified Professional (QP) who was out on medical leave; -her duties included supervising and supporting the staff in caring for the residents, ensuring staff notes were completed, and helped provide direct care to residents when needed;	V 112		

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V 112	Continued From page 4 -she believed Client #1 had a doctor's order that restricted his coffee and caffeine intake after 4:00 PM. She would have to look for the order which had been in place for "at least 3 years." -Client #2 had "recently" received a diagnosis of Diabetes and she believed he had the same restriction of no coffee and caffeine intake after 4:00 PM by the doctor; -Both Client #1 and Client #2 had a diagnosis of Diabetes and both these clients were on "diabetic diets." -1/4/21, she did not find doctor's orders in Client #1 and Client #2's records for their no coffee and no caffeinated coffee after 4:00 PM as identified on their monthly MARs; -the orders may have gotten files in the archives. Interviews on 1/4/21 and 1/5/21 with the Facility Director/ Director of IDD Ministry revealed: -1/4/21,she understood there was a doctor's order for Client #1 and Client #2 to have no coffee and caffeine after 4 pm going back to the QP over the facility before the current QP; -if no doctor's order was found and reviewed for this restriction, then she had to say there was not an order; -she provided staff training "recently" on client restrictions after a Care Coordinator visited the facility recently; -staff understood there were to be no client restrictions unless approved by a client rights' committee -1/5/21, she indicated she would follow up on Client #1's and Client #2's coffee and caffeinated coffee restrictions, as well as, get clarification on Client #2's diet.	V 112		

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V 131	Continued From page 5	V 131		
V 131	G.S. 131E-256 (D2) HCPR - Prior Employment Verification G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure that before employment of personnel, the Health Care Personnel Registry (HCPR) be accessed and each incident of access be filed in the appropriate business file affecting 1 of 3 audited staff. The findings are: Review on 12/23/20 of Staff #1's personnel record revealed: Job position: Direct Support Professional Hire date: 1/15/19 HCPR accessed: 1/31/20. Interview on 1/5/21 with the Facility Director/ Director of IDD Ministry revealed: -no response.	V 131	DHSR - Mental Health Lic. & Cert. Section Policy to be developed by Human Resources that ensures Health Care Registry is accessed before hiring. 3-6-21	