THE CARTER CLINIC, P.A
2151 SKIBO ROAD
FAYETTEVILLE, NORTH CAROLINA 28314
PHONE: (910) 491-2352 FAX #: 910-491-2383

Fax Cover Sheet

To: NC Department of Health and Human Services	**From:** Melody Thomas, Program Director Carter Clinic, PA
Attention: Kimberly C McCaskill, MSW	Date: 12/17/2020
Office Location: Raleigh, NC	Office Location: Fayetteville, NC
Fax Number: ~~(919) 855-3795~~ (919) 715-8078	Phone Number: (910) 813-7968

- ☐ Urgent
- ☐ Reply ASAP
- ☐ Please Comment
- ☐ Please Review
- ☐ For your information

Should you have any questions, please feel free to contact me.

Thanks,
Asia Parker, QP

Total pages, including cover sheet:12

December 17, 2020

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

Re: Recertification Completed 12/04/2020
The Carter Clinic Residential Home, 235 Kinlaw Road, Fayetteville, NC 28311
Provider Number #:34G177
MHL# 026-948

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G177	A. BUILDING _____ B. WING _____	12/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARTER CLINIC RESIDENTIAL HOME	235 KINLAW RD FAYETTEVILLE, NC 28301

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W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the qualified intellectual disabilities professional (QIDP) failed to ensure clients' individual program plans (IPP's) were reviewed and revised as necessary. This affected 3 of 3 audit clients (#2, #5, #6). The findings include: A. Review on 12/3/20 of client #2's IPP dated 3/27/20 revealed he had formal programs to identify money with 60% verbal prompts for 2 review periods (implemented 3/1/20), Will brush teeth with 50% independence for 2 review periods (implemented 3/1/20), Will package 12 objects with 100% independence for 2 consecutive review periods (implemented 3/1/20) and his behavior support program to display appropriate social behaviors implemented 1/2/20. Review on 12/3/20 of the QIDP progress summaries for these programs revealed they had not been reviewed since 4/3/30. Interview with the QIDP on 12/3/20 confirmed these programs had not been reviewed since 4/3/20 to determine client #2's progress. B. Review on 12/3/20 of client #5's IPP dated 4/21/20 revealed he had formal programs to identify money with 50% progress for 2 review periods (implemented 3/1/20), Will improve attention span 100% of time for 2 consecutive months (implemented 3/1/20), brush his teeth thoroughly with 50% independence for 3	W 159		

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

QP | 12-17-2020

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ner safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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W 159	Continued From page 1 consecutive months (implemented 3/1/20), and improve his social behaviors (BSP) implemented 2/1/20. Review on 12/3/20 of the QIDP progress summaries for client #5's programs revealed they had not been reviewed since 4/3/30. Interview with the QIDP on 12/3/20 confirmed these programs had not been reviewed since 4/3/20 to determine client #5's progress. C. Review on 12/3/20 client #6's IPP dated 3/3/20 revealed she had formal programs to brush her thoroughly with 100% independence for 2 consecutive reviews (implemented 3/1/20), identify money with 100% accuracy for 2 consecutive reviews (implemented 3/1/20), and her behavior support program which addressed begging for food, stealing food, inappropriate sexual behaviors (implemented 2/1/20). Review on 12/3/20 of the QIDP progress summaries for client #6's programs revealed they had not been reviewed since 4/3/30. Interview with the QIDP on 12/3/20 confirmed these programs had not been reviewed since 4/3/20 to determine client #6's progress.	W 159	W159: The QIDP will ensure client's individual program plans are reviewed and revised as necessary on client's #2, #5, #6 and all other clients. QP will monitor monthly.	02/04/2021
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	W 249		

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W 249	Continued From page 2 objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure 1 of 3 audit clients (#2) received a continuous active treatment program consisting of needed interventions and services as identified in the individual program plan (IPP) in the areas of dining guidelines. The finding is: Observation on 12/3/20 of supper at 5:40pm client #2 had a regular dining plate with a plateguard. He was assisted to serve pre-cut chicken nuggets, french fries, coleslaw, bread with koolaid, water and milk. His plateguard was facing the table and not in front of his placesetting. Staff verbally cued him to slow his rate of eating several times during the meal and to take a sip of his beverages. Client #2 also had a built up fork and built up spoon. Client #2 used his left hand to scoop and pierce his food. He was not cued to put his right hand in his lap or to pause before each bite putting his utensil down. There were 3 direct care staff at the dining room table. Review on 12/3/20 of client #2's dining guidelines dated 3/1/20 revealed he is to use a plateguard and during his dining routine he is to put his utensil down after each bite of his meal putting his non-preferred hand in his lap. Interview on 12/4/20 with the qualified intellectual disabilities professional (QIDP) confirmed the plateguard should be in front of client #2 and	W 249	W249: The facility ensure client #2 all other client that are on dining goals needs are met by active treatment and dining guidelines. QP will monitor Monthly. Home manager Bi-weekly.	02/04/2021

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W 249	Continued From page 3 direct care staff should be following client #2's dining guidelines.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record/document review and interviews, the facility failed to ensure data relative to the accomplishment of objective criteria was documented in measurable terms. This affected 2 of 3 audit clients (#5, #6). The findings include: A. Review on 12/3/20 of client #5's individual program plan (IPP) dated 4/21/20 revealed he had several formal programs which included: Identifying money with 50% progress for 2 review periods (implemented 3/1/20), improving attention span 100% of time for 2 consecutive months(implemented 3/1/20), brushing his teeth thoroughly with 50% independence for 3 consecutive months (implemented 3/1/20) and improving his social behaviors (BSP) implemented 2/1/20. Review of the data for these objectives revealed: Identify money: (data to be taken 2 times weekly) October: 2 times November 7 times December: 0	W 252	W252: The facility will ensure data relative to the accomplishment of objective criteria documentation in measurable terms for client #5, #6, and all other clients. QP will in-service staff on completing program documentation as instructed in program. QP will monitor Bi-Weekly and Home Manager will monitor weekly.	02/04/2021

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W 252	Continued From page 4 Brush teeth (data to be taken 3 times weekly) October: 4 times November: 9 times December: 0 B. Review on 12/3/20 of client #6's IPP dated 3/3/20 revealed she had formal programs to brush her thoroughly with 100% independence for 2 consecutive reviews (implemented 3/1/20), identify money with 100% accuracy for 2 consecutive reviews (implemented 3/1/20), and her behavior support program which addressed begging for food, stealing food, inappropriate sexual behaviors (implemented 2/1/20). Review of the data for these objectives revealed: Identify Money: (data to be taken twice weekly) October: 7 times November 6 times December: 0 Brush Teeth (5 times per week) October: 15 times November: 11 times December: 0 Set dining room table (2 times per week) October: 0 November: 0 December: 0 Interview on 21/3/20 with the residential manager and the QIDP revealed they usually check the data books at least weekly however during the COVID-19 Pandemic, data books had not been checked as frequently.	W 252		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 263	Continued From page 5	W 263		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive behavior support plans were only conducted with the written informed consent of all legal guardians. This affected 3 of 3 audit clients (#2, #5, #6). The findings include: A. Review on 12/3/20 of client #2's individual program plan (IPP) dated 3/27/20 revealed a behavior support program dated 1/2/20 which addressed the target behaviors of non-compliance, feces smearing, physical aggression, pulling at his gastrostomy tube and spitting. This program incorporates an abdominal binder and mittens that restrict client #2 from pulling at his gastrostomy tube and the following psychotropic medications: Guanfacine 1 mg. and Diazepam 2mg. Further review on 12/3/20 of the IPP revealed client #2's has a legal guardian which is his Mother. Review on 12/3/20 of client #2's physician orders dated 10/1/20 confirmed the use of Guanfacine 1 mg. and Diazepam 2 mg. Review on 12/3/20 of the written consent for this BSP revealed only the guardian's signature with no effective date, no witness, no listing of the	W 263	W263-The facility will ensure all written consent for client #2, #5, #6 and all other clients have effective date, witness signature, and listening of the psychotropic medication and side effects. QP and RN will monitor monthly. Medical Coordinator will monitor weekly.	02/04/2021

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W 263	Continued From page 6 psychotropic medications or side effects. Interview on 12/4/20 with the QIDP confirmed this consent was signed by the guardian blank with no medications listed, no side effects and no date. Further interview revealed she was responsible for reaching out to the guardian to obtain written informed consent. B. Review on 12/3/20 of client #5's IPP dated 4/21/20 revealed a behavior support program dated 2/1/20 that addressed the following target behaviors: Non-compliance, food stealing, physical aggression, falling to the floor and loud vocalizations. This BSP incorporates the use of Haldol, Clonidine and Topiramate. Review on 12/3/20 of the physician orders dated 10/1/20 confirmed client #5 receives Haldol, Clonidine and Topiramate. Further review on 12/3/20 of the IPP revealed client #5 has a legal guardian which is the local Department of Social Services. Review on 12/3/20 of the written consent for this program revealed it was not signed by the legal guardian. Additional review revealed the names of the psychotropic medications were not listed, the effective date of the consent or the risks versus the benefits of the medication were not listed. A note was written on this form from the guardian " Cannot sign blank medication sheet." Interview with the QIDP confirmed this consent was not signed by the guardian as no medications were listed, no side effects were listed and there was no date listed. Further interview revealed she was responsible for	W 263		

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W 263	Continued From page 7 reaching out to the guardian to obtain written informed consent. C. Review on 12/3/20 of client #6's IPP dated 3/3/20 revealed a behavior support program dated 2/1/20 which addressed the target behaviors of: Non-compliance, stealing food, AWOL, and inappropriate sexual behavior. This program incorporates the use of the following medications: Haldol, Clonidine, Quetapine. Additional review on 12/3/20 of the IPP revealed client #6 has a legal guardian. Review on 12/3/20 of the physician orders dated 10/1/20 confirmed client #6 receives Haldol, Clonidine, Quetapine. Review on 12/3/20 of the written consent for this BSP revealed only the guardian's signature with no effective date, no witness, no listing of the psychotropic medications or side effects. Interview on 12/4/20 with the QIDP confirmed this consent was signed by the guardian blank with no medications listed, no side effects and no date. Further interview revealed she was responsible for reaching out to the guardian to obtain written informed consent.	W 263		
W 336	NURSING SERVICES CFR(s): 483.460(c)(3)(iii) Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.	W 336		

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W 336	Continued From page 8 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure quarterly nursing assessments were conducted on a regular basis by nursing. This affected 3 of 3 audit clients (#2, #5, #6). The finding is: Review on 12/3/20 of clients #2, #5 and #6 quarterly nursing assessments revealed they were last completed in April 2020. Interview on 12/3/20 with the qualified intellectual disabilities professional (QIDP) revealed there were no more recent nursing assessments since that April 2020.	W 336	W336: The facility will ensure client #2, #5, #6 and all other clients quarterly nursing assessments are conducted quarterly by RN. QP will monitor quarterly and RN will monitor monthly.	02/04/2021
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 6 clients (#1) . The finding is: During morning observations on 12/4/20 at 8:00am client #1 asked this surveyor to go to his bedroom and look at his bed. He stated the mattress would not stay on the bed frame. Upon arriving at his bedroom, his mattress was very close to the floor. Direct Care staff was able to demonstrate the mattress would not stay on the small bed frame for client #1's bed. The	W 420	W420: The facility will ensure that all furniture is functional and appropriate to clients needs. If not, the furniture will be replaced or repaired. QP will monitor monthly. Home Manager monitor weekly.	02/04/2021

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W 420	Continued From page 9 residential manager stated she thought management was looking into replacing client #1's bed. Interview on 12/4/20 with the qualified intellectual disabilities professional (QIDP) revealed client #1 had expressed his mattress was having difficulty staying on the frame and that his bed probably needed to be replaced.	W 420		