STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL099-027	A. BUILDING: _____ B. WING _____	08/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YADKIN HOME PLACE ONE	160 RIVER ROAD BOONVILLE, NC 27011

(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 An annual survey was completed on 8/12/21. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults whose Primary Diagnosis is a Developmental Disability.	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	DHSR - Mental Health SEP 01 2021 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julia Cowan — TITLE: Group Home Director — (X6) DATE: 8/26/2021

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to develop and implement strategies in the treatment/habilitation plan to address the clients' needs affecting 1 of 3 (client #3) surveyed clients. The findings are: Review on 8/13/21 of client #3' s record revealed: - Admission date: 8/24/2007 - Diagnoses: Moderate Mental Retardation; Diabetes; Hypertension; Depressive Disorder and Anxiety - There was no diagnosis of dementia in her record. - There were no goals or strategies in her treatment plan to address her dementia and falls. Review on 8/12/21 of the shift note dated 6/25/21 revealed: - "Entered by: [staff #2]..." - "Summary: [client #3's] fall" - "this is the second time [client #3] has fallen in the shower this week ..." Interview on 8/12/21 with Staff #2 revealed: - She felt client 3's dementia was getting worse. - Client #3 had started calling clients and staff the wrong names. - She had noticed client #3 at times did not know where her bedroom was in the group home. - She had further noticed client #3 would talk about the past and repeat the same story. - She and other staff would have to remind client #3 to go to the bathroom. - She felt client #3 needed a higher level of care.	V 112	Client #3 had a scheduled physician's appointment on Thursday, August 26th to discuss issue with her Primary Care Physician. In reviewing past physician notes on her patient portal, Client #3 does not have a diagnosis of Dementia. It only states Memory Disturbance. She was seen at her PCP on 9/20/20 for this concern. Client #3 PCP reduced several medications and added Remeron. On follow-up appointment on October 13, 2020, physician states medication appears to be working. Client #3's PCP was not in the office today so she was seen by another provider in the office that was not familiar with her care. Staff will schedule another follow-up appointment with Dr. Parrish. Client #3 fall was attributed to getting her feet tangled in the shower hose causing her fall. Client #3 has had NO falls since June 2021. Person Centered Plan will be updated to include physician recommendations from Client #3. Staff will receive training in regards to Client #3's PCP to ensure compliance with special instructions, strategies and or goals including but not limited to showering guidelines etc as written.	Sept 30, 2021

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V 112	Continued From page 2 Interview on 8/12/21 with the Qualified Professional revealed: - Client #3 had two falls in June 2021 and she had told staff to watch client #3 in the shower. - Last year she started looking for a higher level of care for client #3 "due to her dementia." Client #3's doctor had indicated client #3's dementia was progressing. - She had been unable to locate another placement because client 3's doctor would not sign off that client #3 needed a higher level of care. - She had not updated client #3's treatment plan to include information, goals and strategies that addressed client #3's falls and diagnosis of dementia.	V 112		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements	V 366		

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V 366	Continued From page 3 set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed;	V 366		

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V 366	Continued From page 4 (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.	V 366		

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V 366	Continued From page 5 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to implement written policies governing their response to level I incidents. The findings are: Finding #1 Review on 8/11/21 of incident reports revealed: - There was no incident report regarding a medication error for client #4. Interview on 8/12/21 with the Staff # 1 revealed: - Sometime in February 2021, she had given Client #4, Client #5's 7 am medications. - She contacted the Qualified Professional (QP) to let her know about the medication error. - She then contacted the pharmacist. The pharmacist instructed her to keep an eye on client #5 all day and take the client's blood pressure every two hours. - She took client's blood pressure every two hours and there were no concerns. The client did not require medical attention. - The QP reviewed how to administer medications. - She did not complete an incident report. Interview on 8/12/21 with the Qualified Professional revealed: - Sometime between February 2021 and April 2021 staff #1 gave client #4, client #5's 7 am medication (Amlodipine 5 mg (milligrams), Lisinopril 10 mg, and Vitamin D3 1000 IU (international units)). - Staff #1 inadvertently gave client #4, client #5's medication because their names start with the same letter.	V 366	Staff will be re-trained on Incident Reporting via Relias Learning. The two trainings will be Incident and Death Response System and Writing Effective Incident Reports. Staff Supervisor will review incident reporting with group home staff. Incident reports will be completed when incidents occur.	September 30, 2021

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V 366	Continued From page 6 - Right after the medication error, staff #1 contacted her and let her know what happened. - She instructed staff #1 to contact the pharmacist and follow the instructions of the pharmacist. The pharmacist instructed her to watch client #4 throughout the day. - Staff #1 also contacted client #4's legal guardian to make her aware of what occurred. - She retrained staff #1 and observed several of staff #1's medication passes after the incident. - In the two years that staff #1 had worked in the group home, this was the only medication error she had made. - She could not find the incident report. - She contacted the owner, and the owner could not find an incident report. Finding #2 Review on 8/11/21 of incident reports revealed: - There was no incident report regarding client #3 falling in the shower on 6/22/21. Interview on 8/12/21 with the Qualified Professional revealed: - Client #3 had a fall prior to her second documented fall on 6/24/21. Client #3's first fall occurred on 6/22/21. - Staff #2 never witnessed client #3 fall the first time (6/22/21). - The was no incident report written up about client #3's first fall. Review on 8/12/21 of the shift note dated 6/25/21 revealed: - "Entered by: [staff #2]..." - "Summary: [client #3's] fall" - "this is the second time [client #3] has fallen in the shower this week ..."	V 366		

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V 366	Continued From page 7 Interview on 8/11/21 with client #3 revealed: - She initially indicated that she had fallen one time but then stated she had fallen two times. - During one fall staff #3 "helped picked me back up." Interviews on 8/11/21 and 8/12/21 with staff #2 revealed: - In addition to client #3's documented fall on 6/24/21, client #3 had another fall on 6/22/21. - When client #3 fell on 6/22/21, staff #3 was working. Attempted interview on 8/12/21 with staff #3 revealed: - He never returned phone calls.	V 366		

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

August 17, 2021

Mr. Jerry Carlton, President
Yadkin Home Place Six, Inc.
PO Box 252
Yadkinville, NC 27055

Re: Annual Survey completed August 12, 2021
Yadkin Home Place One, 160 River Road, Booneville, NC 27011
MHL # 099-027
E-mail Address: jcarlton@yadtel.net

Dear Mr. Carlton:

Thank you for the cooperation and courtesy extended during the annual survey completed August 12, 2021.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is October 11, 2021.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION
LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718
www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

August 17, 2021
Yadkin Home Place Six, Inc
Mr. Jerry Carlton

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

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Barbara Perdue at (336) 861-6283.

Sincerely,

Angela Medlin

Angela C. Medlin, MSW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: QM@partnersbhm.org
Pam Pridgen, Administrative Assistant