STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL033-052	A. BUILDING: _____ B. WING _____	R 01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOMEONE DOES CARE	601 WEST WALNUT STREET TARBORO, NC 27886

(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, complaint and follow up survey was completed on 1/26/22. Intake (NC # 00184044) was unsubstantiated. Deficiencies were cited. The facility is licensed for the following service category 10A NCAC 27G .5602 Supervised Living for Adults with Developmental Disabilities. The survey sample consisted of three current clients.	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	RECEIVED FEB 16 2022 DHSR-MH Licensure Sect	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Dana Reddick TITLE Administrator (X6) DATE 2/8/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 ensure strategies were implemented for three of three audited clients (#2, #4 and #6). The findings are: Review on 1/25/22 of client #2's record revealed: -Admission date of 1/14/12 -Diagnoses of Mental Retardation, Head Injury, Alcohol Abuse, Seizure Disorder, Depression and Hypertension. -No treatment plan available for review Review on 1/25/22 of client #4's record revealed: -Admission date of 7/28/21 -Diagnoses of Moderate Mental Retardation, Diabetes Type 2 and Hypertension. -Treatment Plan dated 11/1/21 Review on 1/25/22 of client #6's record revealed: -Admission date -none available -Diagnoses of Intermittent Explosive Disorder, Neurodevelopment Disorder, Intellectual Development- Moderate, Disorder of Adult Personality and Behavior. -Treatment Plan dated 5/1/21 Record reviews were completed after the Licensee brought them to the home from her office. During interview on 1/25/22 staff #1 stated: -The only record she had in the home was their	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 112	Continued From page 2 Medication Administration Record (MARs). -They had a folder with some physician information that the clients take to their appointments. During interview on 1/25/22 the Licensee stated: -Not sure why client #2's treatment plan was not in his book. -The Qualified Professional (QP) should have a copy of it, as it was done with his MCO. -Will try to get a copy and have it at the house from now on. -She kept all of the records at her office due to the accreditation agency instructing them to do so. -Did not realize there was not information in the home for the clients. -Will make copies and keep a copy of their books in the home.	V 112		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan;	V 113		

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V 113	Continued From page 3 (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure three of three audited client's (#2, #4 and #6) records were present in the facility. The findings are: Review on 1/25/22 of client #2's record revealed: -Admission date of 1/14/12 -Diagnoses of Mental Retardation, Head Injury, Alcohol Abuse, Seizure Disorder, Depression and	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 113	Continued From page 4 Hypertension. Review on 1/25/22 of client #4's record revealed: -Admission date of 7/28/21 -Diagnoses of Moderate Mental Retardation, Diabetes Type 2 and Hypertension. Review on 1/25/22 of client #6's record revealed: -Admission date -none available -Diagnoses of Intermittent Explosive Disorder, Neurodevelopment Disorder, Intellectual Development- Moderate, Disorder of Adult Personality and Behavior. Record reviews were completed after the Licensee brought them to the home from her office. During interview on 1/25/22 staff #1 stated: -The only record she had in the home was their Medication Administration Record (MARs). -They had a folder with some physician information that the clients take to their appointments. During interview on 1/25/22 the Licensee stated: -She kept all of the records at her office due to the accreditation agency instructing them to do so. -Did not realize there was not information in the home for the clients. -Will make copies and keep a copy of their books in the home.	V 113		

Someone Does Care LLC

601 W. Walnut Street Tarboro, NC 27886

Provider's Plan of Correction for survey completed on 1/26/2022

Prefix Tag	Summary statement of deficiencies	Provider's plan of correction	Who is responsible	Completion date
V 112 27G. 0205 (C-D)	This rule is not met as evidenced by: Based on the record review and interview the facility failed to ensure strategies were implemented for three of the audited clients	Provider will assure that an assessment and PCP is completed and signed by all treatment team members within 30 days of admission, to include all services/strategies/staff responsibilities, etc. The assessment and PCP will be kept at the site in which the client/s resides and the corporate office.	Administrator Qualified Professional	2/28/2022
V 113 27G.0206	This rule is not met as evidenced by: Based on record review the facility failed to ensure three of three audited client's records were present in the facility.	Provider will review all client files to ensure that a complete record of client/s information (i.e. client demographics, treatment plan, updates to treatment plans, history, Fl-2, assessments, medical information, client emergency contact information etc. will be kept at the site in which the client/s resides as well as the corporate office. All records will be reviewed on a quarterly basis to assure compliance in this area.	Administrator Qualified Professional	2/28/2022

Administrator/Owner Doris Spooner Date 2/8/2022