PRINTED: 03/28/2022
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-766	A. BUILDING: ______ B. WING ______	R 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATTERSON HOME CARE, INC	6331 RANNOCK DRIVE FAYETTEVILLE, NC 28314

(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 and follow up survey was completed on March 17, 2022. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 6 and currently has a census of 5. The survey sample consisted of audits of 3 current clients.	V 000	Measurements have been put in place to prevent this problem from occurring Aggin. monthly monoring of the charts will be ensured it will not occur aggin The monoring will be done by the QP and Peer Review Home Health Care Team.	
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	The Same measures have Been put in place for Finding #2 The outcomes to be acheived, Strategies will all be monitored And ensured it will not occur again. Thanks so very much. CP	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charlotte Patterson TITLE: Adm/QP (X6) DATE: 3/30/22

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement goals and strategies based on assessment for 2 of 3 audited clients (#3 and #4). The findings are: Finding #1 Review on 03/17/22 of client #3's record revealed: -62 year old male. -Admission date of 05/25/07. -Diagnoses of Diabetic, Mental Retardation, Hypertension, Dementia unspecified, Mood Disorder, Chronic Kidney Disease. Review on 03/17/22 of client #3's treatment plan dated 11/10/21 revealed: -No goals or strategies that addressed client #3's needs regarding a foley catheter for monthly changing of the catheter, emptying the catheter bag and daily care of the foley catheter. Finding #2 Review on 03/17/22 of client #4's record revealed: -68 year old male. -Admission date of 09/01/08. -Diagnoses of Mental Retardation, Impulse Control, Hypertension. -Qualified Professional (QP) note dated 03/01/22 revealed: -"...requires constant verbal reminders to use the bathroom every thirty minutes."	V 112	The measures have been put in place and we corrected the deficiency by the area of practice and policy of the Patterson Home Care In The goals and strageties are implemented since 3/17/2022 for Finding #1 - Regarding Foley Cather - Training was given on keeping Foley cather replaced monthly for the Cape Fear Home Health. They have already been coming monthly to the Facility. Staff was given training on emtying the catheter bag, watching for blockage of the flow of urine in the tube.	

Charlotte Patterson, adm/QP 3/30/2022

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V 112	Continued From page 2 -"...food has to be cut up in very small pieces because he will stuff food in his mouth." -"[Client #4] continues to urinate and have bowel movements on himself. He must be cleaned several times a day." Review on 03/17/22 of client #4's treatment plan dated 12/01/21 revealed: -No goals or strategies that addressed client #4's needs for toileting and safe eating behaviors to prevent choking. During interview on 03/17/22 the QP revealed: -She had included the information in her notes and did not realize he needed to be included in the treatment plan. -She would add the information to each treatment plan. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 112	I included All the in my notes And I included All the information in the Treatment plan Also, I Added the information for both Findings #1 And Finding #2 Also Thanks sooo much QP.	

RECEIVED
By Mental Health Licensure & Cert. Section at 9:12 am, Apr 12, 2022

Charlotte Patterson Adm/QP 3/30/2022

E-mail Address:

Dear Ms. Patterson:

Thank you for the cooperation and courtesy extended during the annual and follow up survey completed 03/17/22.

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

- Re-cited standard level deficiency.

Time Frames for Compliance

- Re-cited standard level deficiency must be ***corrected*** within 30 days from the exit of the survey, which is 04/16/22.

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.