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
	MHL067-210	A. BUILDING: _____ B. WING _____	05/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUFFOLK HOUSE	131 SUFFOLK CIRCLE JACKSONVILLE, NC 28546

(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 May 24, 2022. Deficiencies were 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 3 and currently has a census of 3. The survey sample consisted of audits of 3 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 JUN 17 2022 DHSR-MH Licensure Sect	

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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 a treatment/habilitation or service plan in partnership with the legally responsible person at least annually for 1 of 3 audited clients (#1) and to get written consent or agreement from the legally responsible person for 2 of 3 audited clients (#1 and #3). The findings are: Finding #1: Review on 5/18/22 of client #1's record revealed: - 50 year old female admitted 12/30/19. - Diagnoses included Intellectual/Developmental Disability, moderate; Schizophrenia; and Seizure Disorder. - Guardianship established 1/03/05. - Individual Support Plan (ISP) with "Meeting Date 12/18/20;" implementation date of 2/01/22; target date for goals 1/31/22; Qualified Professional (QP) signature dated 1/04/21. - "Unable to get signature due to COVID" was written on the legally responsible person's signature line. Finding #2: Review on 5/18/22 of client #3's record revealed: - 51 year old male admitted 11/18/19. - Diagnoses included Intellectual/Developmental Disability, severe; Schizophrenia, paranoid type; Traumatic Brain Injury; Dementia due to anoxia. - Guardianship established 11/17/10. - ISP with "Meeting Date 9/17/21;"	V 112		

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V 112	Continued From page 2 implementation date 11/01/21; signed and dated by the QP and guardian 10/28/20. - No updated or current guardian signature. During interviews on 5/18/22 and 5/24/22 the Residential Administrator stated: - Client #1's plan developed 12/18/20 was continued without a new meeting due to restrictions related to the COVID pandemic. - Guardian signatures were not updated because of restrictions related to the COVID pandemic. - She would ensure guardian signatures were obtained.	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; (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;	V 113		

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V 113	Continued From page 3 (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 interviews, the facility staff failed to maintain a complete client record to include consent for emergency treatment for one of three audited clients (#3). The findings are: Review on 5/18/22 of client #3's record revealed: - 51 year old male admitted 11/18/19. - Diagnoses included Intellectual/Developmental Disability, severe; Schizophrenia, paranoid type; Traumatic Brain Injury; Dementia due to anoxia. - Guardianship established 11/17/10. - "Permission to Seek Emergency Care" signed by the Assistant Program Director 1/13/22 with "Unable to obtain signature due to COVID" written	V 113		

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V 113	Continued From page 4 on the legally responsible person's signature line. During interviews on 5/18/22 and 5/24/22 the Residential Administrator stated: - The guardian's signature was not obtained because of restrictions related to the COVID pandemic. - She would ensure the guardian's signature was obtained.	V 113		

Appendix 1-B: Plan of Correction Form

Plan of Correction	
Please complete <u>all</u> requested information and mail completed Plan of Correction form to:	**In lieu of mailing the form, you may e-mail the completed electronic form to:**

Provider Name:	**A Caring Heart Case Management, Inc. – Suffolk House**	**Phone:**	**910-455-6724**
Provider Contact Person for follow-up:	**Siobhan Miranda, Residential Administrator**	**Fax:**	**910-346-5489**
		Email:	**smiranda@acaringheartinc.com**
Address:	131 Suffolk Circle, Jacksonville, NC 28546	**Provider #** 3419141	MHL-067-210

Finding	Corrective Action Steps	Responsible Party	Time Line
27G .0205 (C-D) Assessment/Treatment/Habilitation Plan **10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN** This Rule is not met as evidenced by: Based on record review and interview the facility failed to develop a treatment/habilitation or service plan in partnership with the legally responsible person at least annually for 1 of 3 audited clients (#1) and to get written consent or agreement from the legally responsible person for 2 of 3 audited clients (#1 and #3).	1. Operations Director has updated ACHCM's signature policy requiring guardian signatures on documents prior to the end of the COVID pandemic. 2. Quality Assurance Specialist will revamp ACHCM's current auditing protocol, to ensure deficiencies are corrected within a designated timeframe. 3. Qualified Professional will obtain updated signatures/written consent from legal guardian on Short Range Goals as the annual plan was adopted from the previous year due to COVID flexibilities.	1. Qualified Professional 2. Operations Director, Program Director, Assistant Program Director, Qualified Professional 3. Quality Assurance Specialist, Program Director, Assistant Program Director, Qualified Professional	Implementation Date: 1. 05/16/2022 and ongoing Projected Completion Date: 2. 07/23/2022 or before 3. 07/23/2022 or before
27G .0206 Client Record **10A NCAC 27G .0206 CLIENT RECORDS** This Rule is not met as evidenced by: Based on record review and interviews, the facility staff failed to maintain a complete client record to include consent for emergency treatment for one of three audited clients (#3).	1. Operations Director has updated ACHCM's signature policy requiring guardian signatures on documents prior to the end of the COVID pandemic. 2. Quality Assurance Specialist will revamp ACHCM's current auditing protocol, to ensure deficiencies are corrected within a designated timeframe. 3. Qualified Professional will obtain updated signatures for permission to seek emergency care from legal guardian.	1. Qualified Professional 2. Operations Director, Program Director, Assistant Program Director, Qualified Professional 3. Quality Assurance Specialist, Program Director, Assistant Program Director, Qualified Professional	Implementation Date: 1. 05/16/2022 Projected Completion Date: 2. 07/23/2022 or before 3. 07/23/2022 or before