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
	MHL059-110	A. BUILDING: _____ B. WING _____	02/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRIS HOME	2400 US 70 EAST MARION, NC 28752

(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 complaint survey was completed on February 24, 2023. The complaint was substantiated (intake #NC00198249). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600F Supervised Living for Alternative Family Living. This facility is licensed for 2 and currently has a census of 2. The survey sample consisted of audits of 2 current clients and 1 deceased client.	V 000	RECEIVED MAR 28 2023 DHSR-MH Licensure Sect	
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	V112 CCHC CEO held a training with Qualified Professionals. Training consisted of documentation standards as it relates to the treatment plan, supervisions of staff, and documentation of care coordination. QPs were instructed to keep plans up to date when any issues arise medically or behaviorally. QPs will provide all client specific training to staff as new issues arise. Compliance Officer will periodically audit treatment plans and compare medical notes, contact notes, and behavior notes to ensure updates were completed.	3/7/2023

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [redacted] TITLE CEO (X6) DATE 3/7/2023

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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 to meet the individualized needs for 1 of 3 audited clients (Deceased Client (DC) #1). The findings are: Review on 2/22/23 of DC#1's record revealed: -Date of Admission: 10/22/21. -Diagnoses: Moderate Intellectual Disabilities; Severe Intellectual Disabilities; Unspecified Mood Disorder; Intermittent Explosive Disorder; Dystonia, Unspecified. -Date of Death: 2/3/23. -Health Risk Assessment dated 8/15/22: "...If ambulatory she (DC#1) would need assistance if unsteady to prevent falling...she is unsteady on her feet at times...[DC#1] needs some support with postural drainage...during dystonia drainage is worse, needs assistance with mucus buildup, potential for choking..." Review on 2/24/23 of DC#1's Individual Support Plan (ISP) revealed: -ISP Start Date: 1/1/23. -"Supports I need: ...She needs support when walking, [DC#1] tends to put her head down when walking and leans out which causes her to be unsteady..." -No specific goals, or intervention strategies to	V 112		

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V 112	Continued From page 2 address DC#1's unsteadiness while walking, or issues with mucus buildup. Review on 2/23/23 of DC#1's Action Plan for 1/1/23 through 12/31/23 revealed: -No specific goals, or intervention strategies to address DC#1's unsteadiness while walking, or issues with mucus buildup. Interview on 2/23/23 with Staff#1 revealed: -DC#1 had an upgraded wheelchair, a hospital bed with rails, a shower chair with rails, and a potty chair with rails to prevent falls. -He had not heard about postural drainage. -He was not aware of DC#1 having any issues with mucus build up, or being unable to clear her throat. Interview on 2/23/23 with Staff#2 revealed: -DC#1's "falls were 99 percent of the time behavioral, where she would throw herself on the floor out of anger." -DC#1 had a wheelchair that reclined to prevent her from tossing herself out of the chair and it helped a lot. -DC#1 "had fallen in the shower before. She would sit in the shower chair and then lean forward and fall on purpose." -Her falls never resulted in an injury where she needed medical attention. -She never heard of the term postural drainage. -She was not aware of DC#1 having any issues with mucus build up. Interview on 2/23/23 with DC#1's Guardian revealed: -She visited the home DC#1 was residing in multiple times. -She had no concerns about the home. -She was involved in treatment teams for DC#1.	V 112		

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V 112	Continued From page 3 -She was not aware if measures were in place to prevent falls. -"The issues that I knew of was that she (DC#1) would throw herself onto the floor, or just slump over on the wheelchair and eventually get so far over that you can't correct yourself." -During her last visit to the home, she observed Staff#2 assisting DC#1 from the living room to the kitchen table. -She never witnessed DC#1 ambulating on her own. Interview on 2/23/23 with the Qualified Professional (QP) revealed: -"...the treatment plan...is probably what came from [local management entity (LME)]. My plan is the provider plan where I develop the goals. The treatment plan is developed by the LME. We have teams' meetings monthly and can have input to change goals." -DC#1 had a wheelchair, and a hospital bed with half rails to prevent falls. -DC#1 may have used a gait belt at her prior assisted living facility. -"...we all knew that [DC#1] could be unstable at times, and then there were other days she was walking, and other days she was more lethargic and you just never really knew with her. She was capable of walking when she wanted to..." -DC#1 did not require a suction machine, or suction bulb, or anything. -DC#1 never had issues with clearing her throat.	V 112		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all	V 367	V367 CEO will update our incident policy to reflect that Quality Assurance will check open incident reports every three days for requirements needed by LME/MCO. CEO will conduct training with Quality Assurance to ensure she understands the new protocol in regards to incident reporting.	3/30/2023

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V 367	Continued From page 4 level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information;	V 367		

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V 367	Continued From page 5 (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.	V 367		

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V 367	Continued From page 6 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to submit updated information for a level II incident as requested by the Local Management Entity (LME). The findings are: Review on 2/22/23 of Deceased Client (DC) #1's record revealed: -Date of Admission: 10/22/21. -Diagnoses: Moderate Intellectual Disabilities; Severe Intellectual Disabilities; Unspecified Mood Disorder; Intermittent Explosive Disorder; Dystonia, Unspecified. -Date of Death: 2/3/23. Review on 2/23/23 of the North Carolina (NC) Incident Response Improvement System (IRIS) revealed: -Report of DC#1's death had been submitted into IRIS on 2/3/23. -Requests dated 2/8/23 from the LME for the following: -"If there are any other health conditions beside the three listed in the Consumer-Treatments section, please add them (to the 'Medical Diagnosis' field)." -"Report reflects individual was at [local hospital] in early December -what was that hospitalization for?" -No response from the provider was documented in IRIS. Interview on 2/23/23 with the Qualified Professional (QP) revealed: -When an incident occurred at the facility, the	V 367		

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V 367	Continued From page 7 staff at the facility were required to fill out an incident report and take it directly to the main office of Community Companion Home Care, LLC. -She and the Quality Assurance staff member were responsible for submitting the report into IRIS and updating information as needed. -She had not submitted any updates regarding the death of DC#1 into IRIS. -"I haven't been back in there (IRIS), we usually get email notifications if we need to do something, but I haven't got any. I never received any notification from [local LME] that we had to update it. If we got a notification, I most certainly would have followed up on it. It's very disturbing that I had no notification of this." Interview on 2/24/23 with Quality Assurance revealed: -She entered incident reports into IRIS and kept "checking back" if things needed to be updated. -Providers did not always get an email notification when information needed to be updated in IRIS. -She did not enter the incident of DC#1's death into IRIS. -She had been on vacation that week, but she was aware of the incident. -"I did hear there were a couple of updates that needed to be put in, so I updated it in IRIS yesterday (evening). I think the LME was asking for 4 different things...all of those things are fixed, or update in IRIS now, except for the death certificate because that has not been obtained yet..."	V 367	V742 Compliance Officer completed audit of the home to ensure that a covering was placed over the bathroom window to ensure member's privacy. Compliance Officer will add checking for window coverings to his audit list. CO routinely completes safety and compliance audits of every AFL licensed home.	3/30/2023
V 742	27G .0304(a) Privacy 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT	V 742		

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V 742	Continued From page 8 (a) Privacy: Facilities shall be designed and constructed in a manner that will provide clients privacy while bathing, dressing or using toilet facilities. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to be constructed in such a manner to provide clients with privacy while bathing, dressing or using toilet facilities. The findings are: Observation on 2/23/23 at approximately 8:15 am of the facility revealed: -The window in the clients' bathroom did not have a curtain, blinds, or any type of covering. Interview on 2/23/23 with Staff#1 revealed: -There used to be a curtain on the bathroom window. -One of the clients would pull on the curtain when she was using the toilet. -The curtain "got pulled down so many times that we (staff) just never put it back up." -He was not aware the bathroom window needed to have a covering for privacy. Interview on 2/23/23 with Staff#2 revealed: -She was not aware the bathroom window needed to have a covering. -"There's no homes, or anything back behind the house, so it's never been an issue. I will get a covering for the window today."	V 742		