STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-243	A. BUILDING: _____ B. WING _____	R-C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOUSE OF CARE, INC	5800 LAKE ELTON ROAD DURHAM, NC 27713

(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 A complaint and follow-up survey was completed September 28, 2023. The complaint (intake #NC00205969) was substantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600C Supervised Living for Adults with Developmental Disabilities The 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 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting	V 105	DHSR - Mental Health OCT 13 2023 Lic. & Cert. Section	

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V 105	Continued From page 1 problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to adhere to its discharge policy for one of three audited clients (#1). The findings are: Review on 9/26/23 of Client #1's record revealed: -Admission date of 3/31/23. -Diagnoses of Diagnoses Schizoaffective Disorder, Bipolar Type, Psychotic Disorder, Autism Spectrum Disorder, Intellectual Developmental Disability Nicotine Use Disorder, Self Mutilating Behavior and Social Discord. -Assessment dated 2/26/23 revealed: -"[Client #1] was admitted to the hospital for medication management and observation. [Client #1] had been placed in various group homes, transitional homes however due to [Client #1's] inability to cope with her maladaptive behaviors as it had been an issue for [Client #1]. [Client #1] was in the hospital for 3 months prior to admission. Interview on 9/26/23 with Client #1 revealed: -Client presented with no emotions. -She was well groomed, wearing all black with tags on her shirt. -She did not like the assistant director, supervisor, and other staff. -She did not provide a reason that she disliked certain staff. -Denied she was abused or mistreated. -When asked if she was moved to another group home within the facility, she stated, "yes."	V 105	See page #7	

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V 105	Continued From page 3 -She liked living in the group home with two male clients. -She was unable to provide how long or reason she was at the hospital. Interview on 9/26/23 with Staff #1 revealed: -She worked Friday-Monday at the group home. -She was client #1's one-on-one at the day program Monday-Friday. -She had no problems with client #1 since being admitted to the group home. -Client #1 needed to learn to advocate for herself instead of taking things out on herself. -Client #1 talked to her about concerns she had. -The facility gave client #1's guardian a 30-day discharge notice. -She along with the supervisor was taking client #1 to a meeting with an assistant living provider. Attempted interview on 9/27/23 with complainant: -Surveyor called the number on the complaint - number was not in service at 1:40 p.m. on 9/27/23. -Surveyor emailed the address provided. Email returned. No known email address. Interview on 9/27/23 with Client #1's guardian revealed: -He was client #1's guardian since April 2023 for an agency. -He was not the service provider. -Client #1 came from another region in North Carolina. -Client #1 was violent and aggressive towards others. -The group home filed an involuntary commitment on 8/2/23. -The group home wanted to do an emergency discharge for safety. -He was not aware of the emergency discharged	V 105	See page #7	

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V 105	Continued From page 4 until the following day. -The hospital wanted to discharge client #1 after she arrived. -He was able to work out a transition plan with the group home. -They had another facility to accommodate client #1. -The group home accepted client #1 back but gave a 30-day notice. -Hospital was planning to discharge client #1 on 8/2/23 when she arrived. -The hospital and group home were to inform him first of discharge. -There would be no place to take clients after a short stay at the hospital. -He would've had to reach out to the social worker at the hospital for placement if they did not take client #1 back. -He remembered getting the phone about client #1 call after hours. -If the call went to crisis, crisis did not inform him of the incident. -Client #1 would be discharged prior to the 30-day notice. -Client #1 was accepted at another facility. Interview on 9/26/23 with the Qualified Professional revealed: -Client #1 called the police on 8/2/23. -The police came to the home. -Initial complaint client #1was upset with a previous staff over an altercation with another client. -The altercation was verbal. -Client #1 intimidated other clients. -Client #1 swung on a previous client prior to this incident. -Police assessed the situation and explained to client #1 what the protocol was if she was upset. -Client #1 was saying she wanted out of the	V 105	See page #7	

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V 105	Continued From page 5 house. -Client #1 showed no aggression; then said "Well my stomach was hurting." -Police called the ambulance; emergency medical service assessed client #1 and vitals were good. -Initially the police and EMS were not going to take client #1. -Client #1 then started to hit her head on the wall. -EMS decided to take client to the hospital. -IVC was done because client #1 threatened the staff and what she would do to her. -Police suggested IVC. -Client #1 was IVC on 8/2/23. -Hospital tried to discharge client #1 the same day. -Incident occurred about 8 or 9 p.m. -She was asking the hospital to keep client #1 on a 72-hour hold and review medication. -She was in contact with a different hospital staff throughout the process. -Client #1 hospitalized for about 6 days before hospital made a threat to contact the State. -Hospital threaten that they would call the state if staff did not pick client #1 up. -Client #1's guardian and respite got involved. -They explained to the hospital about client #1's behavior. -Respite was going to do a crisis stay but client #1 had to be discharged to the facility. -She agreed to allow client #1 to return but with a 30-day discharged notice -Client #1 problem was at the previous home. -Client #1 was moved to the new home on 8/11/23, the day of hospital discharge. -Client #1's guardian was involved throughout the process. -She spoke with client #1's guardian every day since hospitalization. -The hospital sent client #1 to the day program via uber services.	V 105	See page #7	

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V 105	Continued From page 6 -Hospital did not provide exact time of drop off but it was during the day. -Discharged notice 8/11/23 was sent to client #1's guardian, care manager and respite. -She tried to implement an emergency discharge, but the hospital would not allow her. -Hospital told her client #1 had to be an immediate threat or hurt someone for an emergency discharged. -Hospital asked her to pick up client #1 on 8/2/23. -She confirmed that she rejected the request. -She reported they felt client #1 was a threat. -The guardian told them they had to take client #1 back because the hospital would call the State. -She reported client #1's guardian said, "we will figure it out." -She reported client #1's had behaviors prior to 8/2/23 incident including physical altercations, hitting herself; attempted to cut herself with a plastic fork, threatening behaviors towards staff and other clients. -She confirmed client #1 should not have been admitted to the facility. -Going forward she would screen and assess all potential clients prior to admission.	V 105	House of Care, Inc. will review its current Discharge Policy and Procedures with all QP's to ensure adherence and understanding of the policy	10-2-23 On-going