

Division of Health Service Regulation

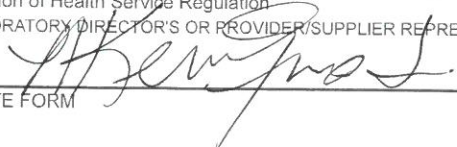
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-243	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 09/28/2023
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NAME OF PROVIDER OR SUPPLIER HOUSE OF CARE, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 5800 LAKE ELTON ROAD DURHAM, NC 27713
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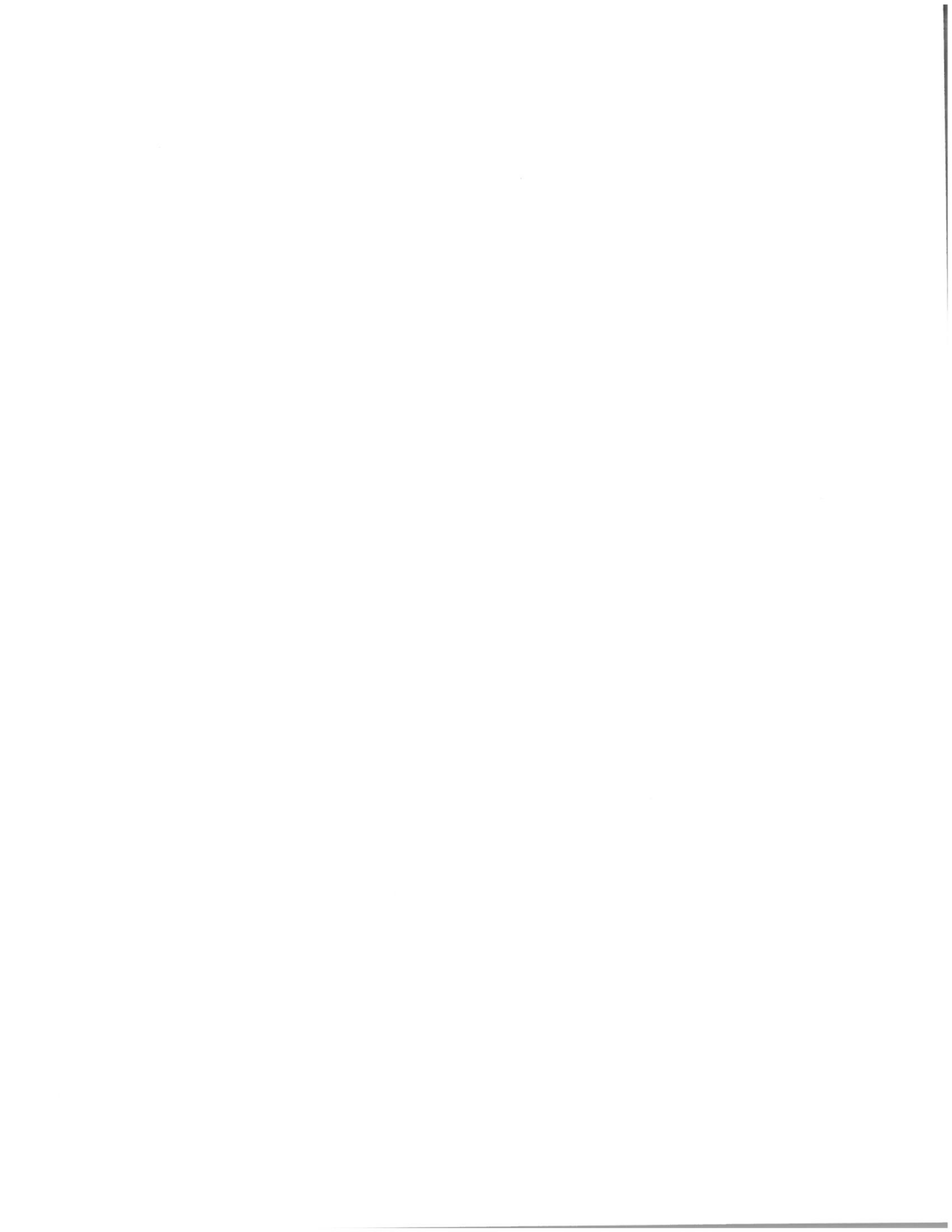
V 000	<p>INITIAL COMMENTS</p> <p>A complaint and follow-up survey was completed September 28, 2023. The complaint (intake #NC00205969) was substantiated. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G. 5600C Supervised Living for Adults with Developmental Disabilities</p> <p>The facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 105	<p>27G .0201 (A) (1-7) Governing Body Policies</p> <p>10A NCAC 27G .0201 GOVERNING BODY POLICIES</p> <p>(a) The governing body responsible for each facility or service shall develop and implement written policies for the following:</p> <p>(1) delegation of management authority for the operation of the facility and services;</p> <p>(2) criteria for admission;</p> <p>(3) criteria for discharge;</p> <p>(4) admission assessments, including:</p> <p>(A) who will perform the assessment; and</p> <p>(B) time frames for completing assessment.</p> <p>(5) client record management, including:</p> <p>(A) persons authorized to document;</p> <p>(B) transporting records;</p> <p>(C) safeguard of records against loss, tampering, defacement or use by unauthorized persons;</p> <p>(D) assurance of record accessibility to authorized users at all times; and</p> <p>(E) assurance of confidentiality of records.</p> <p>(6) screenings, which shall include:</p> <p>(A) an assessment of the individual's presenting</p>	V 105	<p>DHSR - Mental Health</p> <p>OCT 13 2023</p> <p>Lic. & Cert. Section</p>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE (X6) DATE

Assistant Director

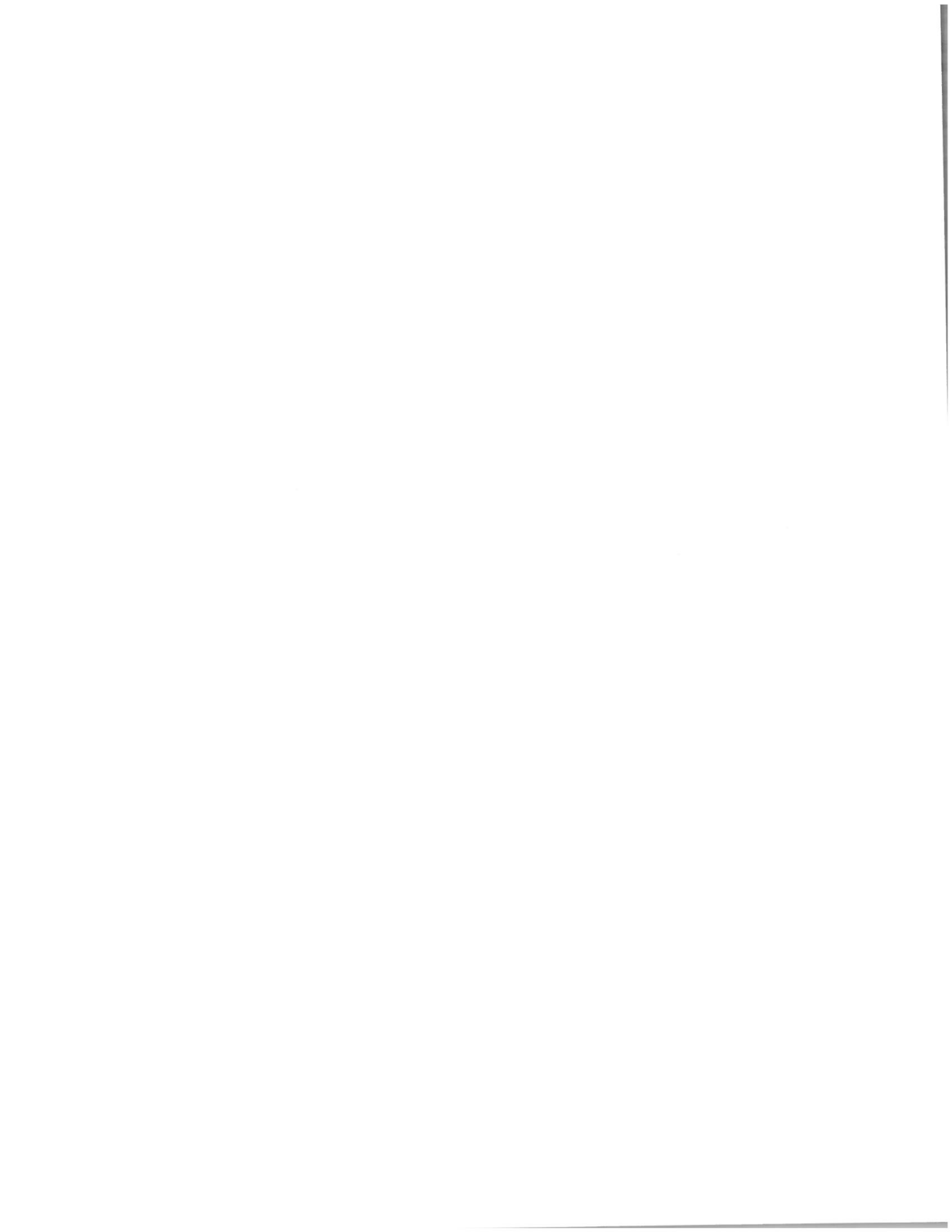


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V 105	<p>Continued From page 1</p> <p>problem or need;</p> <p>(B) an assessment of whether or not the facility can provide services to address the individual's needs; and</p> <p>(C) the disposition, including referrals and recommendations;</p> <p>(7) quality assurance and quality improvement activities, including:</p> <p>(A) composition and activities of a quality assurance and quality improvement committee;</p> <p>(B) written quality assurance and quality improvement plan;</p> <p>(C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services;</p> <p>(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;</p> <p>(E) strategies for improving client care;</p> <p>(F) review of staff qualifications and a determination made to grant treatment/habilitation privileges;</p> <p>(G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death;</p> <p>(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;</p>	V 105		



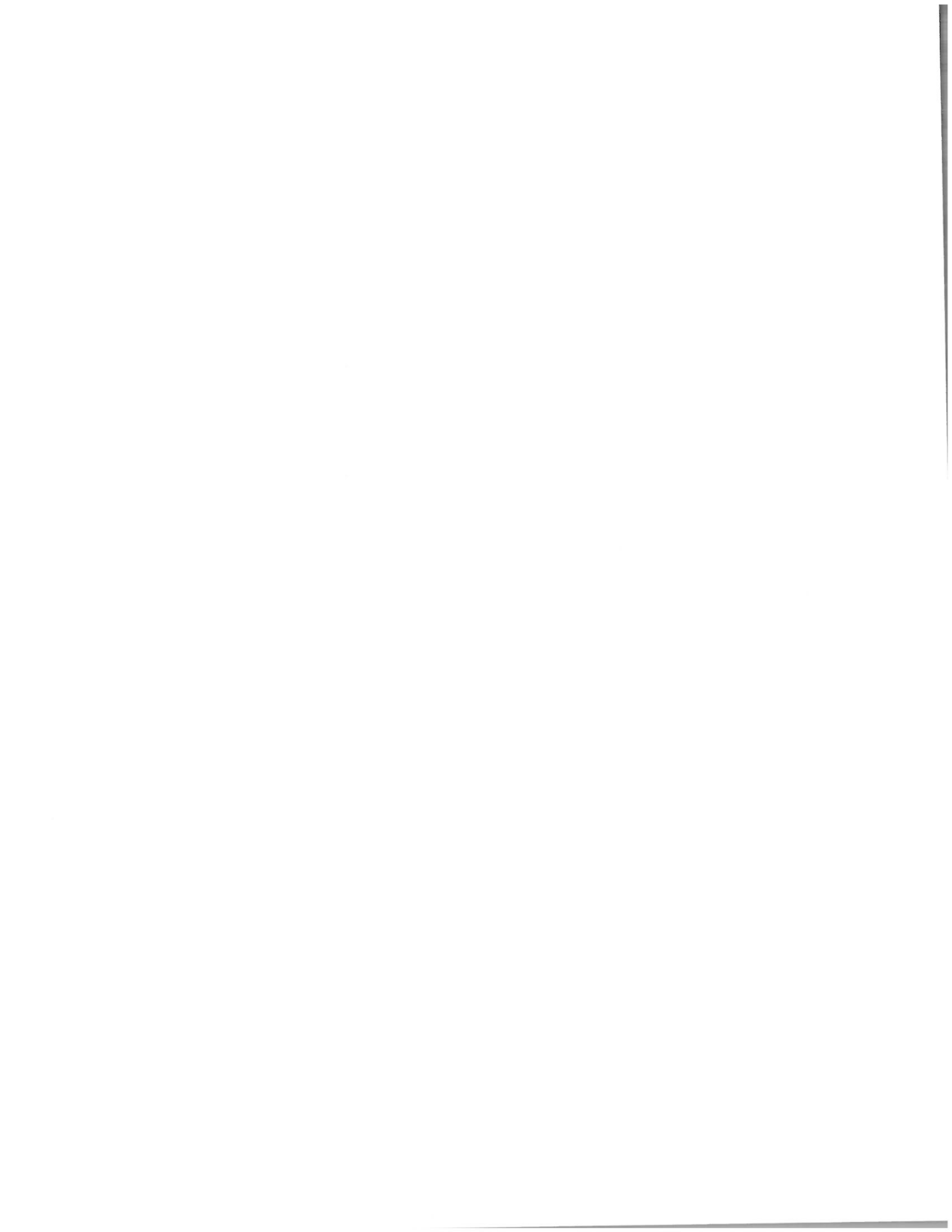
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V 105	<p>Continued From page 2</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to adhere to its discharge policy for one of three audited clients (#1). The findings are:</p> <p>Review on 9/26/23 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.</p> <p>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."</p>	V 105	See page #7	
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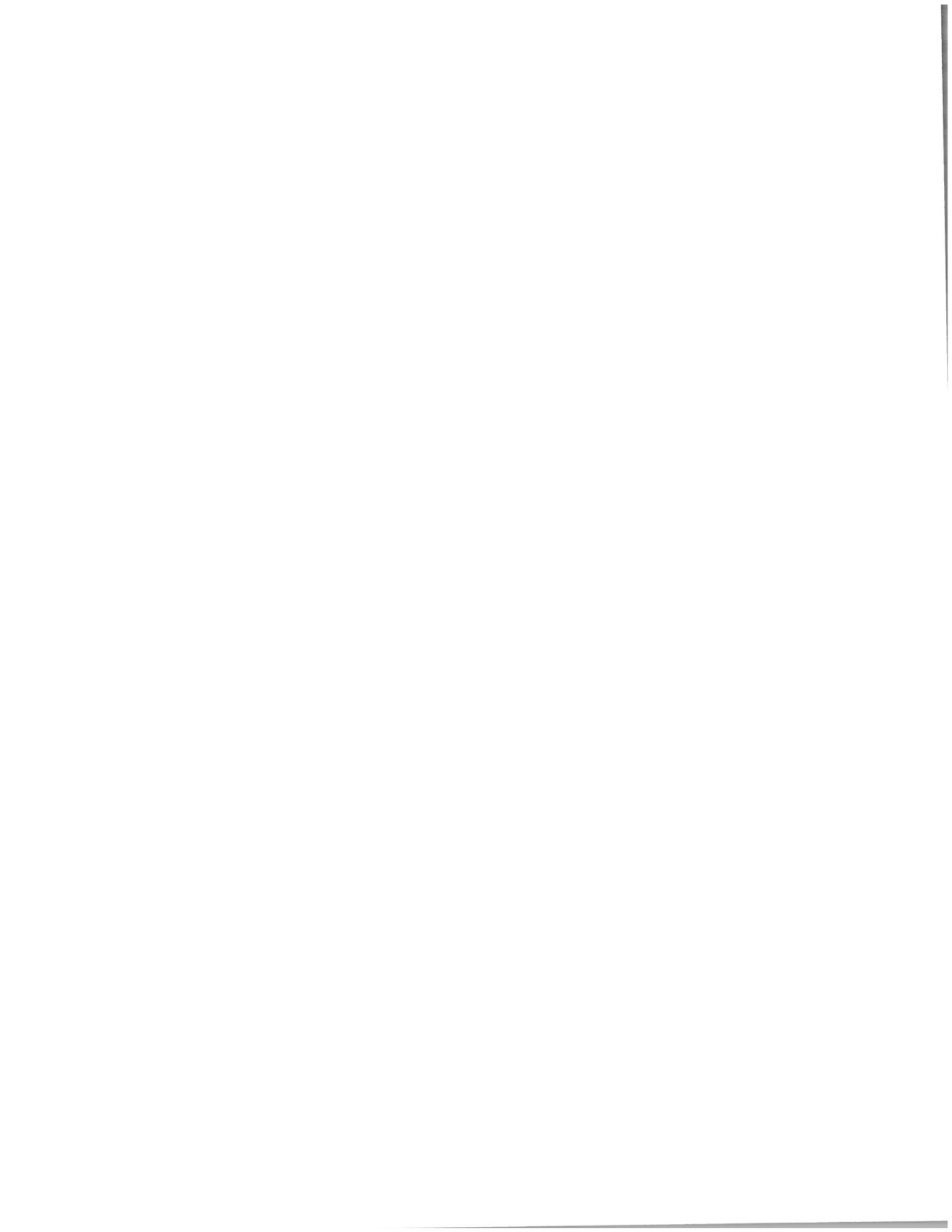
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V 105	<p>Continued From page 3</p> <ul style="list-style-type: none"> -She liked living in the group home with two male clients. -She was unable to provide how long or reason she was at the hospital. <p>Interview on 9/26/23 with Staff #1 revealed:</p> <ul style="list-style-type: none"> -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. <p>Attempted interview on 9/27/23 with complainant:</p> <ul style="list-style-type: none"> -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. <p>Interview on 9/27/23 with Client #1's guardian revealed:</p> <ul style="list-style-type: none"> -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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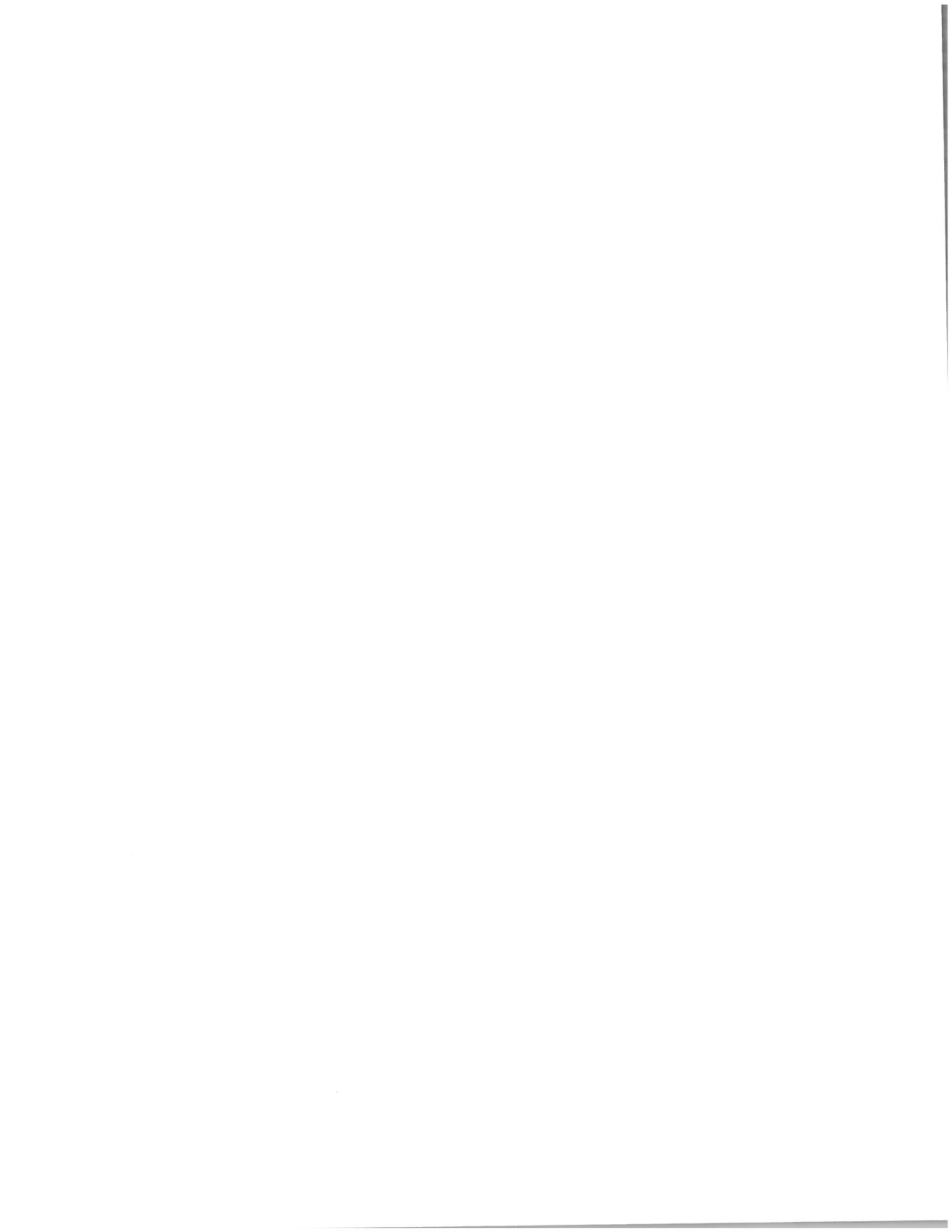
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V 105	<p>Continued From page 4</p> <p>until the following day.</p> <ul style="list-style-type: none"> -The hospital wanted to discharge client #1 after she arrived. -He was able to work out a transition plan with the group home. -They had another facility 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. <p>Interview on 9/26/23 with the Qualified Professional revealed:</p> <ul style="list-style-type: none"> -Client #1 called the police on 8/2/23. -The police came to the home. -Initial complaint client #1 was 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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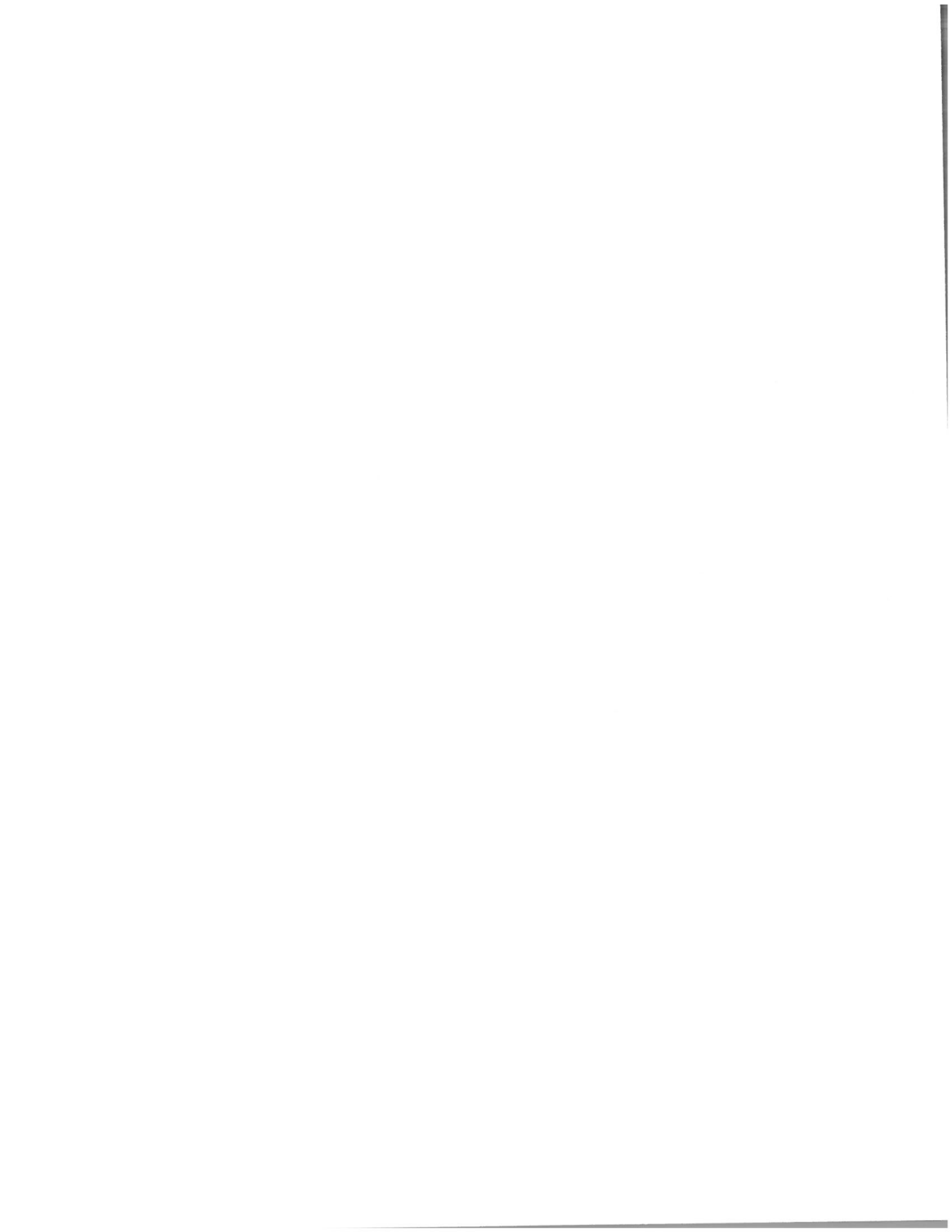
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V 105	<p>Continued From page 5</p> <p>house.</p> <ul style="list-style-type: none"> -Client #1 showed no aggression; then said "Well my stomach was hurting." -Police called the ambulance; emergency medical service assessed client #1 and vitals were 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	<p>Continued From page 6</p> <ul style="list-style-type: none"> -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
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