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
	MHL049-169	A. BUILDING: _____ B. WING _____	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOLICK HOME	248 GRANDVIEW DRIVE STATESVILLE, NC 28677

(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 3/18/24. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living. The facility is licensed for 2 and currently has a census of 1. The survey sample consisted of audits of 1 current client and 1 former client.	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug.	V 118	RECEIVED APR 15 2024 DHSR-MH Licensure Sect	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Ashley Seny TITLE Regional Manager (X6) DATE 4/10/24

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V 118	Continued From page 1 (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure a Medication Administration Record (MAR) was completed, affecting 1 of 1 client (#1). The findings are: Review on 3/13/24 of client #1's record revealed: -An admission date of 12/28/22 -Diagnoses of Major Depressive Disorder Single Episode Mild; Posttraumatic Stress Disorder (includes Posttraumatic Stress Disorder for Children 6 Years and Younger); Intermittent Explosive Disorder; Autism Spectrum Disorder; Intellectual Disability, Mild -Physician's order dated 3/7/24 for: Aripiprazole 15 milligrams (mg), take 1 tablet (tab) every evening (mood). Trazodone 100 mg, take 1 tab, every evening for 90 days (sleep). Dicyclomine 10 mg, take 1 capsule (cap) four times a day (gas). Topiramate 50 mg, take 1 tab twice a day (pain/weight loss). Lactose 9,000 unit, take 1 tab a day (gas/vitamin). Mupirocin 2% topical ointment, apply four times a day (bug bite).	V 118		

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V 118	Continued From page 2 Review on 3/13/24 of client #1's MAR from 1/1/24-3/13/24 revealed: -There was no signature that indicated any of the above medications had been administered from 3/1/24-3/13/24. -There was no documentation that any of the medications listed above had been administered 3/1/24-3/13/24. Interview on 3/13/24 with client #1 revealed: -Staff gave her medication and she had never missed a dose. Interview on 3/13/24 with the Alternative Family Living (AFL) Provider revealed: -Client #1 was administered her medications as prescribed. -She had not completed the MAR for the month of March "because they (agency) keep sending it (the MAR form) to me wrong."	V 118	Correct Action: AFL staff will be retrained on Medication Administration 2 which includes proper documentation and initals when medications are administered per medication administration requirements. Staff will be retrained on how to properly use error correct methods until they have recieved an updated MAR. Quality Assurrance: MARs will be checked monthly by QPs using MAR checklist. QP will review MARs during monitoring visits and will look to ensure MARS are documented correctly and initaled per medication administration requirements. Who will monitor: AFL is responsible for documenting MARS each time a medication is administered per medication administration requirements. QP is responsible for monitoring MAR checklists. How often: QP will monitor MAR checklists monthly.	4/26/24
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such	V 291		

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V 291	Continued From page 3 means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to coordinate services for 1 of 1 former client (FC#2). The findings are: Review on 3/14/24 of the agency's Internal "Level 1 Incident Reports" revealed: -Date of incident: 12/24/23; Start-End time of incident: 3:00 pm-6:30 pm. - Description of incident: "While joining in Christmas Eve festivities with AFL's (AFL Provider's) family at AFL (Alternative Family Living Provider) mother's house ...[FC#2] had severe behaviors that included property destruction, verbal aggression and her (FC#2) trying to attack the AFL's daughter. Sheriff (Deputy Sheriff) was called out 3 times. Once at AFL's mothers house and twice when back home at AFL's home. Each time [FC#2] calmed down when the sheriff arrived and then started behaviors again once they (Deputy Sheriff) left. After the 3rd time the sheriff came out she	V 291	Corrective Action: QP will review crisis plan and client specific competencies with staff annually and when revisions are needed to ensure our team is well versed to provide coordination of care with other providers and LRP. Coordination of care during team meetings will determine appropriateness of care based upon plan, preference, what crisis plan allows and what is least restrictive. Preventative Measures: QP will review crisis plan and client specific compentencies annually and when revisions are needed. QP will review supportive documentation from team meetings, strategies that were used and data needed for Behavior Support Plan. Who will monitor: QP is responsibile for ensuring coordination of care efforts are documented. How often: QP will monitor to ensure documentation is completed when coordiantion of care occurs.	4/10/2024

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V 291	Continued From page 4 calmed down." Review on 3/14/24 of the Local County Sheriff Office reports revealed: - "Date: 12/24/23 Sunday, 19:37 (7:37 pm); Location of Incident: 200-BLK Grandview Dr, Statesville NC 28677; Crime Incident: Assault-Simple Physical Assault ASPA; Victim: AFL Provider; Involved Other: Client#1; Injury: None." Interview on 3/15/24 with FC#2's Department of Social Services Legal Guardian (DSS LG) revealed: -On 12/24/23, the DSS LG's supervisor was on-call and answered a call from the AFL Provider during 12/24/23 incident, while Deputy Sheriff was present at the facility. DSS supervisor recommended involuntary commitment to both the AFL Provider and the Deputy Sheriff who was present with the AFL Provider. - On 1/24/24, she received a call from the Qualified Professional (QP) stating, "something needed to be done about [FC#2]." The QP reported client was threatening classmates (in the community) and had threatened the AFL Provider in the facility. -On 1/24/24, the DSS LG called the AFL Provider who stated she was concerned that FC#2's behavior continued to be worse, and that FC#2 was threatening harm to Client#1. The AFL Provider reported (FC#2) was sitting at the window waiting for [Client #1] to come home from the Day Program so she (FC#2) could beat her (Client#1) up. The DSS LG told the AFL Provider that she needed to involuntarily commit FC#2 and the AFL Provider agreed. The AFL Provider stated that only DSS or the LG could do it (involuntary commitment). When the DSS LG asked why the involuntary commitment did not	V 291		

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V 291	Continued From page 5 occur on 12/24/23, the AFL Provider stated that the DSS supervisor didn't push for the involuntary commitment, so nothing was done. The DSS LG provided the AFL Provider with information to either visit the Magistrate office or call local mental health crisis line for mobile support to observe client's behaviors. "I told her, if you're that worried, call now" and DSS LG again recommended involuntary commitment. -On 1/25/24, she contacted the AFL Provider to find out if FC#2 had been involuntarily committed. She learned that FC#2 was still in the facility, "She (AFL provider) didn't do it (the involuntary commitment) because she didn't want to be blamed for it (having FC#2 committed) ...it was frustrating." - " I can't drive 2 hours to involuntarily commit when they (client) may not be doing the behavior when I get there." Interviews on 3/13/24 and 3/14/24 with the QP revealed: -FC#2 had not been involuntarily committed on 12/24/23 nor on 1/24/24. "I was on FMLA (Family Medical Leave of Absence)" from December 2023 to January 2024. -Law enforcement would not involuntarily commit. "They refuse even if you request it of them." -DSS presented involuntary commitment as an "option." - She discussed (with her agency) the possibility of having a collaboration with the Local County Sheriff Department about having a "coordination class" of what to expect with facilities working with adults with disabilities and how to coordinate a "service" (involuntary commitment) when there are "behaviors." Interview on 3/18/24 with the AFL Provider revealed:	V 291		

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V 291	Continued From page 6 -On 1/24/24 she recalled that FC#2 threatened to beat up Client#1 and "kill everyone." -FC#2's DSS LG presented an involuntary commitment as "an option." -On 1/25/24 she called the local mental health crisis line and was told she would have to complete the paperwork for the involuntary commitment since she witnessed FC#2's behaviors. -The AFL Provider did not initiate or submit an involuntary commitment. Interview on 3/18/24 with Network Support revealed: -When deciding if a client needs to be involuntarily committed, it is a "team decision." -Unable to provide documentation of the 1/24/24 incident -When clients were involuntarily committed it is usually done by their legal guardian or law enforcement.	V 291		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider	V 366		

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V 366	Continued From page 7 specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:	V 366		

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V 366	Continued From page 8 (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.	V 366	Type text here	

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V 366	Continued From page 9 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to report all level I or II incidents within 72 hours of becoming aware of the incident to the Local Management Entity (LME) responsible for the catchment area where services were provided as required affecting 1 of 1 client (FC#2). The findings are: Review on 3/14/24 of FC#2's record revealed: -21 year old female. -Admission date 9/20/22. -Diagnoses of Major Depressive Disorder Single Episode Mild; Posttraumatic Stress Disorder (includes Posttraumatic Stress Disorder for Children 6 Years and Younger); Intermittent Explosive Disorder; Autism Spectrum Disorder; Intellectual Disability, Mild. Review on 3/13/24 and 3/15/24 of the Incident Response Improvement System (IRIS) revealed: -No level I or II incident reports were submitted by the facility for incidents involving FC#2 that occurred on 2/18/24, 12/24/23, 10/3/23, 5/20/23 or 4/5/23 when law enforcement and/or Emergency Medical Services (EMS) were called to the facility. Interview on 3/13/24 with the Qualified Professional (QP) revealed: -"I don't do the (IRIS) reports they are done by my supervisor [Program Director]. I write the documentation to send her (Program Director)."	V 366	Corrective action:Program Director will review with the QP the NC Incident Reporting guidelines for determining level 1, 2 and 3 incidents to ensure state requirements are met for leveling, documenting, and reporting incidents within the required time frames. Preventative measure: Upon hearing of a client incident, the QP and Program Director will notify the Abound Health Compliance Department. The Compliance department will consult with the Program Director and QP to ensure all incident reporting requirements are followed. Who will monitor: the Program Director will monitor all completed incident reports and the Compliance Department monitors all Level 2 and Level 3 Incident reports to ensure requirements are met. How often: Monitoring will occur when an incident takes place.	5/1/24

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V 366	Continued From page 10 -Unsure why no IRIS report was submitted for 12/24/24, "I was on FMLA" from December 2023 to January 2024. -Internal Level I incident reports were completed for 2/18/24, 12/24/23, 10/3/23, 5/20/23, and 4/5/23. -No level I or II incident report were submitted in IRIS by the facility.	V 366		
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 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	V 367		

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V 367	Continued From page 11 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; (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	V 367		

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V 367	Continued From page 12 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. This Rule is not met as evidenced by: This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to submit level II incident reports to the Local Management Entity (LME)within 72 hours as required. The findings are: Review on 3/13/24 and 3/15/24 of the Incident Response Improvement System (IRIS) revealed: -There were no incident reports regarding incidents which occurred on 2/28/24, 12/24/23, 10/3/23, 5/20/23 or 4/5/23 Interview with QP on 3/13/24 revealed: -"I don't do the (IRIS) reports they are done by my supervisor (Program Director) ...I write the documentation to send her" -Not sure why one (IRIS report) was not done for 12/24/24, "I was on FMLA" from December 2023 to January 2024	V 367	Correct Action: Management will review leveling and timelines with all QPs in our next QP training/clinical update meeting. Preventative Measure: Staff will follow policy and procedure for reporting and notifying appropriate authorities of incident reports within the state guidelines. Abound's Compliance department should be notified when an incident occurs so the event can be reviewed, leveled correctly, and to ensure the requirements are present to meet the health and safety of the client. Who will monitor:QP and Program Director will monitor and will use the incident reporting manual as a guide each time an incident occurs. How Often: Monitoring will occur each time an incident takes place.	5/1/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL049-169	A. BUILDING: _____ B. WING _____	03/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOLICK HOME	248 GRANDVIEW DRIVE STATESVILLE, NC 28677

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V 367	Continued From page 13 -Internal Level I incident reports were completed	V 367		