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
	MHL064-161	A. BUILDING: ______ B. WING ______	R 05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOODY HEALTH CARE SERVICES INC II	**601 COLBY COURT ROCKY MOUNT, NC 27803**

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 5/30/24. The complaint was substantiated (Intake #NC00217228). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. The facility is licensed for 5 but currently has a census of 5. 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 problem or need; (B) an assessment of whether or not the facility	V 105		

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V 105	Continued From page 1 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	V 105		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to adhere to its admission and discharge policies affecting 1 of 3 audited clients (#4). The findings are:

Review on 5/22/24 of client #4's record revealed:
- Admitted: 2/22/24
- Diagnoses: Schizoaffective Disorder, Type 2 Diabetes, and Hypertension
- Admission summary with no date or signature but did have clients strengths, diagnoses, level of supervision needed, and an admission date of 2/23/23
- no discharge summary for client #4 being discharged on 8/30/23
- no admission assessment for client #4 being admitted on 2/22/24

Review on 5/23/24 of the facility's admission and discharge policy revealed:
- "...The client assessment will be completed in no more than 72 hours..."
- "...Fill out a discharge summary..."

Interview on 5/23/24 the Group Home Manager reported:
- client #4 was admitted to the facility February 2023
- client #4 was discharged and moved to a Family Care Home in August 2023
- client #4 came back and was admitted in this facility February 2024
- no admission or discharge summaries were completed

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V 105	Continued From page 3 Interview on 5/29/24 the Qualified Professional (QP) reported: - she had been the QP since March 2024 - she was responsible for admission and discharge summaries but hadn't had an admission since being employed Interview on 5/30/24 the Administrator reported: - she had a problem with the previous QP not doing what she was supposed to do and had to change QP's - she would make sure that all admissions and discharges were completed	V 105		
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	V 112		

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V 112	Continued From page 4 provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement strategies for 1 of 3 audited clients (#5). The findings are: Review on 5/22/24 of client #5's record revealed: - Admitted: 2/4/22 - Diagnoses: Schizoaffective Disorder-unspecified, Coronary Artery Disease, Hyperlipidemia, Hypertension, and Diabetes Mellitus II - Treatment plan dated 3/16/24 revealed: - no strategies to address clients' behavior of elopement from the facility Interview on 5/22/24 client #4 reported: - client #5 would pack his bags and just leave - police had brought client #5 back when he left - client #5 ran away a lot because he had mental problems and wanted to get out of the facility Interview on 5/29/24 client #5's guardian reported: - she had been his guardian for about 3-4 years - she knew that he started having issues of going outside, walking away and not coming back	V 112		

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V 112	Continued From page 5 to the facility - the facility was concerned about client #5 leaving and didn't have the help to provide a 1:1 staff Interview on 5/23/24 the Qualified Professional (QP) reported: - told the Administrator that she didn't have enough supervision for client #5 to remain in this facility - the Administrator told her that she couldn't get another staff in the facility to watch client #5 - client #5 needed to be kept busy and supervised - client #5 was not one to just sit there and be content Interview on 5/30/24 the Administrator reported: - client #5 had a history of wandering - client #5 had been with the facility since it opened in early 2022 and started eloping/wandering late last year 2023 and as time was going on, it was getting worse - the QP was responsible for completing treatment plans - she had problems with the previous QP not doing what she was supposed to do and that was why she had to get a new one - she would speak with the QP about re-evaluating client #5's treatment plan to address his elopements	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local	V 114		

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V 114	Continued From page 6 authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure fire and disaster drills were conducted quarterly and on each shift. The findings are: Review on 5/23/24 of the facility's fire and disaster log from May 2023 - May 2024 revealed: - only one disaster drill was conducted on 7/14/23 - no fire drills were conducted on 3rd shift Interview on 5/22/24 client #3 reported: - did fire drills and went out front or out back of the facility - didn't do disaster drills - staff didn't wake them up to do fire drills Interview on 5/22/24 client #4 reported: - they tried to do fire drills but they didn't because everyone didn't always want to go out of the house - if there was a fire, he would go outside Interview on 5/23/24 the Group Home Manager	V 114		

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V 114	Continued From page 7 reported: - it was her responsibility to check over fire and disaster drills to make sure they were being completed and on different shifts - she told staff to do one around 6:30am since the client's got up anyway so that one was done on the 3rd shift - shifts were 7am - 3pm, 3pm - 11pm, and 11pm - 7am - she hadn't checked the fire and disaster drill log book this month and just told the staff to make sure they were done	V 114		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a clean, attractive and orderly manner. The findings are: Observation on 5/22/24 at approximately 2:40pm revealed: - kitchen counter had tan spackle spread on it closest to the sink - client's nightstand and dressers had peeling wood on the top and sides and the drawers were not aligned - several areas throughout the house and client bedrooms had multiple strips of black tape on it - walls throughout the client bedrooms had black scuff marks and peeled paint on them - an old mattress/boxspring was being stored	V 736		

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V 736	Continued From page 8 in a client's closet Interview on 5/23/24 the Group Home Manager reported: - Called the landlord yesterday, 5/22/24, and put in a work order - The landlord stated that he would try and get someone out to the facility	V 736		