STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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126 AIR PARK DRIVE APT. C	126C AIR PARK DRIVE MORGANTON, NC 28655

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V 000	INITIAL COMMENTS A complaint survey was completed on July 13, 2018. The complaint was substantiated (Intake #NC 00139842). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000	DHSR - Mental Health AUG 06 2018 Lic. & Cert. Section	
V 109	27G .0203 Privileging/Training Professionals 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONALS (a) There shall be no privileging requirements for qualified professionals or associate professionals. (b) Qualified professionals and associate professionals shall demonstrate knowledge, skills and abilities required by the population served. (c) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (d) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (e) Qualified professionals as specified in 10A NCAC 27G .0104 (18)(a) are deemed to have met the requirements of the competency-based employment system in the State Plan for MH/DD/SAS. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of an individualized supervision	V 109	See attached	

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V 109	Continued From page 1 plan upon hiring each associate professional. (g) The associate professional shall be supervised by a qualified professional with the population served for the period of time as specified in Rule .0104 of this Subchapter. This Rule is not met as evidenced by: Based on record review, observation and interviews, the facility's fomer and current Qualified Professionals (QPs) failed to demonstrate knowledge, skills and abilities required by the population served for 1 of 1 Former QP (FQP #2) and 1 of 1 current QP (QP #1). The findings are: Review on 6/22/18-6/25/18 of Client #2's record revealed: -Admission date: 10/1/04 -Diagnoses: Profound Intellectual Disability, Unspecified Reactive Psychosis, Schizophrenia, Allergic rhinitis, Congenital Blindness, History of Pneumonia and Respiratory Failure, Degenerative Joint Disease, Gastroesophageal Reflux Disease (GERD), History of Gastritis, H Pylori Infection, Hiatal Hernia, Hypertension, Hyperlipidemia, Melanosis, Osteoporosis, Spasticity, Dysphagia, History of Urinary Tract Infection, Constipation, weight loss -A 7/5/17 Modified Barium Swallow Study (MBSS) Evaluation report revealed: -Client #2's prior diet was regular solid food; -Client #2 aspirated food on 7/3/17; -Client had a MBSS to assess swallowing function due to cough and probable pneumonia; -Recommended diet was pureed with nectar consistency;	V 109		

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V 109	Continued From page 2 -A 7/10/17 email from the FQP #2 to Client #2's guardian that Client #2 had a swallow study and had orders for ground food; - Physician's written order dated 7/13/17 for a "pureed diet with nectar thick consistency with head in neutral position"; -Treatment plan dated 9/1/17 revealed: -A statement that Client #2 followed a special diet and needed full assistance to ensure she ate foods within her diet; -Client #2 had nutritional supports due to a risk of choking; -The nutritional supports were that food and liquid be of a particular consistency, all foods be "chopped into quarter-sized portions", a low cholesterol and no-salt added diet; -Medication Administration Records (MARs) from 1/2018-6/2018 revealed: -A low Cholesterol, no added salt, 1800 calorie diet. Review on 6/22/18-6/25/18 of Deceased Client #4 (DC #4)'s record revealed: -Admission date: 12/31/02 -Date of Death: 6/11/18 -Diagnoses: Moderate Mental Retardation, Schizoaffective Disorder, Seizure Disorder, Chronic Obstructive Pulmonary Disease, Chronic Constipation, Osteoarthritis, Right eye blindness, Hyperlipidemia, Urinary incontinence, and History of left hip surgery -Multiple hospital visits in 2018 for a knee fracture, additional medical diagnoses and recurrent medical issues: -1/31/18, Hospital admission for treatment of a fractured knee joint due to a fall out of bed; -3/15/18, Emergency room (ER) treatment of pneumonia; -4/2/18-4/13/18, Hospital admission for septic shock, severe seizures, Methicillin-resistant	V 109		

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V 109	Continued From page 3 Staphylococcus aureus (MRSA) pneumonia and coronavirus (a virus that affects the respiratory system); -5/2/18, ER visit for treatment of a urinary tract infection that had altered DC #4's mental status; -5/11/18-5/17/18, Hospital admission for treatment and management of encephalopathy (a disease or damage to the brain that can range from mild memory loss or personality changes to severe conditions such as dementia and seizures), pneumonia, and Hypokalemia (low potassium); -6/11/18, DC #4 pronounced dead at the ER visit after having been in full cardiac arrest and medical procedure performed to remove a bread mass from DC #4's trachea area and efforts to resuscitate DC #4; -The 6/11/18 emergency department report revealed: -DC #4's decubitus ulcer had worsened to a Stage 4 decubitus ulcer (the pressure sore had reached into muscle and bone and caused extensive tissue damage); -DC #4 presented in the hospital emergency department in full cardiac arrest with a bread mass that had packed her trachea below the vocal cords; -DC #4 died at the hospital after multiple medical procedures (from suctioning, use of forceps, to an incision to widen the vocal cord membranes) to remove the bread mass from DC #4's trachea area and after placed on ventilation; -Emergency Department Attestation statements in the 6/11/18 revealed: -DC #4 had a psychiatric condition that caused her to take large bites of food; -She had a known history of choking hazard; -There was question that DC #4 may have stored food at the back of her mouth, seemingly swallowed, and swallowed it all that resulted in	V 109		

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V 109	Continued From page 4 the mass of food in the trachea. Review on 6/22/18 of DC #4's Person-Centered Plan (PCP) revealed: -DC #4's Person-Centered Plan was updated on 3/16/18 by Former Qualified Professional #2 and DC #4's guardian; -Statements that DC #4 required assistance with some activities of daily living (ADLs) due to limited mobility and DC #4 had tendency to allow others to do for her even when she can carry out tasks; -DC #4's 11 treatment goals included: -Access her closets and drawers to choose appropriate clothing according to the plans for the day and not wear same clothing several days in a row; -Cover her mouth with her hands independently when coughing or sneezing and disinfect her hands with hand sanitizer; -Slow down while eating and place her eating utensil down on the table after taking a bite of food to chew and swallow before taking another bite of food; -Place pillows on top of her bed daily after her bed is made; -Will obtain and maintain a comfortable, upright position in her wheelchair and face forward; -Make a list of food items needed at the grocery store; -Will have no more than 2 daily incidents of impatience while waiting her turn; -Choose an activity at least once a week other than coloring to do within her home; -Practice sharing items with housemates; -Assist staff at least once a week with meal preparation; -Her personal care goals included: -A statement that DC #4 would have as much or as little staff assistance to complete daily	V 109		

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V 109	Continued From page 5 personal care tasks of blow drying her hair, bathing, swabbing mouth and gums, caring for feet, and dressing; -Full staff assistance for DC #4 to get to the sink to wash her hands before and after meals, and after toileting; -Full staff assistance approximately every 2 hours with transferring, undressing, wiping and re-clothing in DC #4's attempts to use the restroom; -There were no updated treatment strategies or service goals after 3/16/18 that addressed DC #4's strengths and needs, increased functional limitations and increased medical care needs. Review on 6/22/18 of DC #4's documented progress in meeting her residential treatment and personal care goals for the periods 5/16/17-5/22/18 and 6/6/18-6/10/18 revealed: -DC #4 did not meet 7-8 of her 11 treatment goals for each period of time; -In 5/2018's time frame, DC #4's goals of washing hands at sink and staff assistance with transferring in DC #4's attempt to use the restroom was not met at all; -In 6/2018's time frame, the aforementioned goal of DC #4's attempt to use the restroom with full staff assistance was met daily; -5/19/18-5/20/18 contained staff statements that DC #4's goals were not being ran because DC #4 was very sleepy and staff had difficulty feeding her meals and administering her medications; -There was no explanation about the cause of DC #4's sleepiness. Further review of DC #4's hospital discharge summaries from 4/13/18 to 5/17/18 revealed: -A 4/2/18 hospital admission note revealed: -DC #4 had a hypoxic episode (DC #4's oxygen level had dropped unexpectedly and caused her	V 109		

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V 109	Continued From page 6 to pass out) at the facility on 4/2/18 and was transported by local emergency medical services (EMS) to DC #4's physician's office; -DC #4's physician noted DC #4's SP 02 (the amount of oxygen in the blood) was 70% on room air with an increase to 85% with nasal oxygen; -DC #4 was transported from her physician's office to the local hospital for further evaluation and admitted into the intensive care unit for treatment of septic shock, severe seizures, MRSA pneumonia and coronavirus; -4/13/18, DC #4 was discharged from the hospital back to the facility with a doctor's order for low flow oxygen at 3 liters per minute; -5/17/18, DC #4 was discharged from the hospital back to the facility with doctor orders for a continuous bladder elimination device due to a Stage 3 Sacral Decubitus Ulcer (a pressure sore near the tailbone that extended beneath the skin in the form of a crater) and follow-up order for wound care at a local wound clinic; -A 5/17/18 statement that DC #4's home oxygen regimen was 2 liters of oxygen per minute with use of nose cannula. Review of the facility's clinical supervision plans dated from 4/2018 through 6/25/18 by the QP #1 for Staff #5 through Staff #8 revealed: -Staff #5-8 were paraprofessional staff; -The House Manager (Staff #5) would receive supervision from QP #1; -The House Manager would review individual client goals monthly and check staff documentation for accuracy; -Staff #6 was to review the clients' most recent Individualized Support Plan, evaluations, diagnosis, behavior history and medical information and meet with QP #1 quarterly to discuss concerns or recommendations; -Staff #7 was to review client records to learn the	V 109		

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V 109	Continued From page 7 clients' history, psychological evaluations, medication needs and functional needs and meet with QP #1 quarterly to discuss concerns or recommendations; -The Lead Direct Support Staff (Staff #8) was to focus weekly on learning the new goals of each individual he served and review the client goals with QP #1 quarterly and suggest any necessary changes; -There were no client-specific concerns documented in the clinical supervision logs between QP #1 and Staff #5-8. Review of Facility Staff meetings from 4/26/18 to 5/29/18 revealed: -No client-specific information provided to staff or staff training pertaining to Clients #1-3; -A 4/26/18 written note that staff were instructed by the House Manager to get DC #4 to be more mobile and staff re-trained on how to transfer DC #4's portal oxygen to unit oxygen and the dosage; -There was no written note that specified DC #4's oxygen dose level as of 4/26/18; -5/29/18, QP #1 and House Manager discussed with staff DC #4's wound care, DC#4's situation moving forward, and DC #4's oxygen and proper treatment; -No written note that specified information on DC's wound care other than a new patch and no written note that specified DC #4's oxygen dose level as of 5/29/18. Observation of Client #2 on 6/22/18 between 4:10-4:30 pm at the facility revealed: -Client #2 was fed at dining room table by Staff #8 placing solid food on an eating utensil and verbally prompting Client #2 to open her mouth and eat; -Staff #8 then placed a drinking cup to Client #2's mouth twice and prompted her to drink after	V 109		

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V 109	Continued From page 8 swallowing her bite of food; -Client #2 coughed up white-colored liquid both times with the liquid spilling onto Client #2's feeding bib; -Staff #8 stated "She does this sometimes"; -Client #2 was removed from the table in her wheelchair by Staff #8 and relocated to the living room; -Approximately 75% of food remained on Client #2's plate which was left sitting on the dining table. Attempted interview and observation on 6/22/18 at 4:30 pm with Client #2 revealed: -She sat alone in center of facility living room with her head positioned down toward her chest; -Client #2 would not make eye contact or respond verbally. Interview on 6/22/18 with Client #2 and DC #4's Primary Care Physician (PCP) revealed: -She had provided primary medical care to Clients #1, #2, #3 and DC #4; -DC #4 was not healthy, had multiple medical conditions and needed skilled nursing care; -The Primary Care Physician stated she relied on staff to communicate with her about any concerns or changes in her patients to determine her findings as her patients were mostly non-verbal and the staff were the daily caregivers to her patients. Interview on 6/21/18-6/25/18 with the QP #1 revealed: -She began work for the licensee as the QP in 4/2018; -Her job duties included clinical supervision of the facility's paraprofessional staff to ensure staff knowledge of client diagnoses, care needs, and service goals; service coordination with other	V 109		

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V 109	Continued From page 9 individuals and agencies providing client services, and updating client treatment plans; -Client #2's treatment plan was completed by the Former Qualified Professional (FQP) #2 and the guardian; -Client #2's diet might have changed at some point from a pureed diet to a low cholesterol, no-salt added and chopped food diet based on Client #2's Medication Administration Records; -The Qualified Professional was responsible for ensuring accuracy of client information in the client records; -She had not updated Client #4's treatment plan from the 3/16/18 date but staff were kept informed of changes in DC #4's care and service needs through communication with the House Manager and monthly facility staff meetings. Interview on 6/25/18 with the Regional/Community Services Director revealed: -She supervised the FQP #2 and Current QP #1; -The QP was responsible for reviewing clients' medical information for any changes in care and to follow up with the physician to clarify any discrepancies between physician orders and client care provided by the facility; -The QP was responsible for working with and supervising the House Manager to ensure staff followed physician orders in providing client care; -She was told by the House Manager that Client #2 would not eat the pureed foods and the FQP #2 was supposed to have informed Client #2's physician of this information; -She was unable to find a physician's order that changed Client #2's diet from pureed to chopped food in Client #2's record; -A call had been placed to Client #2's physician during the survey to clarify Client #2's diet; This deficiency is cross referenced into 10A	V 109		

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V 109	Continued From page 10 NCAC 27G .5601 SCOPE (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 109		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.	V 110		

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V 110	Continued From page 11 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 5 of 5 paraprofessional staff (Staff # 5-9) demonstrated knowledge, skills and abilities required for the population served. The findings are: Review on 6/22/18-6/25/18 of Deceased Client #4 (DC #4)'s record revealed: -Admission date: 12/31/02 -Date of Death: 6/11/18 -Diagnoses: Moderate Mental Retardation, Schizoaffective Disorder, Seizure Disorder, Chronic Obstructive Pulmonary Disease, Chronic Constipation, Osteoarthritis, Right eye blindness, Hyperlipidemia, Urinary incontinence, History of left hip surgery -Multiple hospital visits in 2018 for a knee fracture, additional medical diagnoses and recurrent medical issues: -1/31/18, Hospital admission for treatment of a fractured knee joint due to a fall out of bed; -3/15/18, Emergency room (ER) treatment of pneumonia; -4/2/18-4/13/18, Hospital admission for septic shock, severe seizures, Methicillin-resistant Staphylococcus aureus (MRSA) pneumonia and coronavirus (a virus that affects the respiratory system); -5/2/18, ER visit for treatment of a urinary tract infection that had altered DC #4's mental status; -5/11/18-5/17/18, Hospital admission for treatment and management of encephalopathy (a disease or damage to the brain that can range from mild memory loss or personality changes to severe conditions such as dementia and seizures), pneumonia, and hypokalemia (low potassium);	V 110		

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V 110	Continued From page 12 -6/11/18, DC #4 was pronounced dead at the ER visit after having been in full cardiac arrest and medical procedure performed to remove a bread mass from DC #4's trachea area and efforts to resuscitate DC #4; -The 6/11/18 emergency department report revealed: -DC #4's decubitus ulcer had worsened to a Stage 4 decubitus ulcer (the pressure sore had reached into muscle and bone and caused extensive tissue damage); -Emergency Department Attestation statements in the 6/11/18 revealed: -DC #4 had a psychiatric condition that caused her to take large bites of food; -She had a known history of choking hazard; -There was question that DC #4 may have stored food at the back of her mouth, seemingly swallowed, and swallowed it all that resulted in the mass of food in the trachea. Review on 6/22/18 of DC #4's Person-Centered Plan (PCP) revealed: -DC #4's Person-Centered Plan was updated on 3/16/18 by Former Qualified Professional #11 and DC #4's guardian; -Statements that DC #4 required assistance with some activities of daily living (ADLs) due to limited mobility and DC #4 had tendency to allow others to do for her even when she can carry out tasks; -DC #4's 11 treatment goals included: -Access her closets and drawers to choose appropriate clothing according to the plans for the day and not wear same clothing several days in a row; -Cover her mouth with her hands independently when coughing or sneezing and disinfect her hands with hand sanitizer; -Slow down while eating and place her eating	V 110		

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V 110	Continued From page 13 utensil down on the table after taking a bite of food to chew and swallow before taking another bite of food; -Place pillows on top of her bed daily after her bed is made; -Will obtain and maintain a comfortable, upright position in her wheelchair and face forward; -Make a list of food items needed at the grocery store; -Will have no more than 2 daily incidents of impatience while waiting her turn; -Choose an activity at least once a week other than coloring to do within her home; -Practice sharing items with housemates; -Assist staff at least once a week with meal preparation; -Her personal care goals included: -A statement that DC #4 would have as much or as little staff assistance to complete daily personal care tasks of blow drying her hair, bathing, swabbing mouth and gums, caring for feet, and dressing; -Full staff assistance for DC #4 to get to the sink to wash her hands before and after meals, and after toileting; -Full staff assistance approximately every 2 hours with transferring, undressing, wiping and re-clothing in DC #4's attempts to use the restroom. Review on 6/22/18 of DC #4's documented progress in meeting her residential treatment and personal care goals for the periods 5/16/17-5/22/18 and 6/6/18-6/10/18 revealed: -DC #4 did not meet 7-8 of her 11 treatment goals for each period of time; -In 5/2018's time frame, DC #4's goals of washing hands at sink and staff assistance with transferring in DC #4's attempt to use the restroom was not met at all;	V 110		

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V 110	Continued From page 14 -In 6/2018's time frame, the aforementioned goal of DC #4's attempt to use the restroom with full staff assistance was met daily; -5/19/18-5/20/18 contained staff statements that DC #4's goals were not being ran because DC #4 was very sleepy and staff had difficulty feeding her meals and administering her medications; -There was no explanation about the cause of DC #4's sleepiness. Review on 6/21/18 of two incident reports on DC #4 in the North Carolina Incident Response Improvement System (IRIS) revealed: -A 1/31/18 report revealed: -DC #4 had fallen out of her bed during the night and injured her knee; -Staff assisted DC #4 back to bed after providing assistance to DC #4 with toileting and applied an ice pack to DC #4's knee due to complaint of knee pain; -Staff waited until the next morning to report DC #4's fall to the House Manager; -The House Manager found DC #4's knee swollen the next morning, sent DC #4 to the local hospital for x-rays which determined DC #4's knee was broken in 2 places and resulted in DC #4 having a brace placed from her ankle to above the knee; -The 6/11/18 report revealed: -DC #4 was immobilized from the 1/31/18 knee injury; -DC #4's had multiple hospital visits (3 hospital admissions and 2 emergency room visits) that occurred from 1/31/18 through 5/17/18 due to medical conditions that included sepsis, pneumonia, urinary tract infections, encephalopathy and hypokalemia; -A statement that the licensee felt the facility could no longer provide adequate care to DC #4; -Skilled nursing facility (SNF) placement had	V 110		

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V 110	Continued From page 15 been recommended by DC#4's physician but the hospital would not place DC #4 in a SNF; -DC #4 required 2-3 staff at the facility to meet her care needs and had home health nursing once a week since 1/2018. Further review of DC #4's hospital discharge summaries from 4/13/18 to 5/17/18 revealed: -A 4/2/18 hospital admission note revealed: -DC #4 had a hypoxic episode (DC #4's oxygen level had dropped unexpectedly and caused her to pass out) at the facility on 4/2/18 and was transported by local emergency medical services (EMS) to DC #4's physician's office; -DC #4's physician noted DC #4's SP 02 (the amount of oxygen in the blood) was 70% on room air with an increase to 85% with nasal oxygen; -DC #4 was transported from her physician's office to the local hospital for further evaluation and admitted into the intensive care unit for treatment of septic shock, severe seizures, MRSA pneumonia and coronavirus; -4/13/18, DC #4 was discharged from the hospital back to the facility with a doctor's order for low flow oxygen at 3 liters per minute; -5/17/18, DC #4 was discharged from the hospital back to the facility with a continuous bladder elimination device due to a Stage 3 Sacral Decubitus Ulcer and follow-up order for wound care at a local wound clinic; -5/17/18, DC #4's doctor's order on her oxygen order had changed from low flow 3 liters per minute to continuous 2 liters per minute. Review on 6/25/18 of medical notes from the local wound clinic on DC #4 revealed: -5/11/18, DC# 4 was provided a wedge to place behind her in an attempt to relieve pressure on the buttock area; -A statement during DC #4's wound assessment,	V 110		

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V 110	Continued From page 16 "Caregiver stated patient will not turn at the group home." Review on 6/21/18-6/25/18 of facility staff training revealed: -Staff training and certification of client care competency by licensee at the beginning of staff employment occurred in areas that included: -Core competencies; -Lifts, carries, and transfers; -Incident/Accident reporting; -Competency training that was client-specific, provided by the licensee and included check marks that denoted individual staff competency in the following areas: -Client preferences of likes and dislikes; -Diagnoses and needs with note to review all with special note of primary diagnoses; -Medical concerns with noted examples such as dietary requirements and seizure activity; -Medications with a note to review all medications, how and when to administer, and side effects; -Specific goals and outcomes identified in the client's individual service plan; -Behavioral programs related to use of approved interventions and preventions; -Crisis plan and risk factors with contact names and numbers; -On 4/26/18 and 5/29/18, staff received in-house facility training on DC #4's oxygen and oxygen dosage; -On 5/29/18, staff received in-house facility training on DC #4's wound care. Interview on 6/22/18 with Staff #6 revealed: -She was a Direct Support Residential Staff (DSR); -She had worked at the facility almost 2 years; -Her job duties included giving clients their	V 110		

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V 110	Continued From page 17 medications, assisting clients with meal preparation, dressing, grooming, house cleaning, and any specific care the clients needed; -She learned her job duties by shadowing other staff providing client care and reviewed client service and medication record; -She had been provided with client-specific training called G-15 by the licensee which was competency based on client-specific needs; -She took a recertification class on staff care to clients a couple of months ago; -The House Manager, her supervisor, also informed the staff verbally of any client changes in either a house meeting once a month or individually; -She did not usually review client records unless there had been something that changed with the clients such as a medical condition, medical appointment or medication; -The House Manager was to be notified immediately whenever a client had an accident or incident; -DC #4's health declined after DC #4 fell out of bed and broke her leg in 1/2018; -It was hard on staff to help DC #4 transfer to and from her bed and wheelchair because she was a physically heavy person; -She had received training on lifts that were mostly 2-person lifts; -DC #4 was placed on oxygen full time after DC #4 had pneumonia in 4/2018; -Local emergency medical service (EMS) personnel had taught staff who were working at the time of DC #4's hospital discharge in 4/2018 how to use the oxygen and what level of oxygen DC needed; -DC #4's oxygen was kept on between "2-3 points: but majority of the time she was on "2.5 points" which was a level of oxygen; -She provided DC #4 with wound dressing	V 110		

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V 110	Continued From page 18 changes and verbalized specific steps in changing the wound dressings; -DC#4's wound dressing was changed once daily and whenever DC #4 soiled the dressing from using the bathroom on herself which varied day by day; -She and Staff #7 had assisted DC #4 on 6/11/18 with getting up from bed, bathing, dressing and to the dining table in her wheelchair for breakfast as DC #4 had a medical appointment for her wound care; -She and Staff #7 assisted DC #4 with returning to bed after DC#4's medical appointment as DC #4 appeared exhausted; -Staff #6 left the facility to take paperwork on 6/11/18 to Qualified Professional (QP) #1 at the facility's office, which left Staff #7 alone with the clients at the facility; -Staff #7 yelled her name as she returned to the facility and she (Staff #6) observed DC #4's face had turned a grayish-blue color and DC #4 made no sounds or noises; -Staff #6 observed food around DC #4's mouth and could not determine if it was vomit or was just there; -She assisted Staff #7 with Cardiopulmonary Resuscitation (CPR) on DC#4 until local emergency medical services (EMS) arrived at the facility and took over CPR efforts; -Staff #6 stated that the facility was staffed as follows: -3-4 staff on first shift (7:00 am-3:00 pm); -2 staff on second shift with 1 staff that worked 3:00 pm to 8:00 pm and one staff that worked 4:00 pm to 11:00 pm; -1 staff on third shift (11:00 pm-7:00 am). Interview on 6/22/18 with Staff #7 revealed: -She was a DSR Staff; -She had worked at the facility 1-2 years;	V 110		

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V 110	Continued From page 19 -Her job duties included giving clients their medications, meal preparation; assisting clients with feeding and bathing, transporting clients to the day program, changing client's adult diapers when needed; -DC #4 was Bi-Polar or had Schizophrenia and experienced hallucinations; -DC #4 was initially independent in her wheelchair transfers and feeding self when Staff #7 started work at the facility 1-2 years ago; -After DC #4 broke her leg in 1/2018, DC #4 began having medical complications that included pneumonia, an irritable cough and a large ulcer on her buttock that was almost to the bone; -DC #4 had a hospital bed with side rails at the facility to prevent further falls after she fell and broke her leg; -DC #4 was put on oxygen after hospitalization for pneumonia; -Staff #7 stated she had no specific training in using oxygen with clients; -"Just pressed the button and turned it on"; -DC #4 was no longer able to transfer to and from her wheelchair without staff assistance after her leg broke; -She had received training on lifting clients during her employment orientation with the licensee; -It took 2 staff to assist DC #4 with toileting because she was heavy in weight; -She changed the dressing on DC #4's decubitus wound as needed; -She was trained how to change the wound dressings by the Lead Direct Support Staff (Staff #8) and another Direct Support Residential Staff who had past work experience in changing wound dressings; -Staff #7 stated that DC #4 had to be re-positioned every 2 hours in bed as part of relieving pressure on the wound but DC #4 would not always cooperate in turning to re-position;	V 110		

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V 110	Continued From page 20 -DC #4's wound kept getting large in size; -She stated that there were some staff who were not comfortable changing the dressing on DC #4's wound because of the smell; -"It had a foul smell like a dead animal because of the dead tissue;" -There had been a house staff meeting in 5/2018 by the House Manager telling staff everyone had to participate in DC #4's care; -Staff #7 provided the following account of her care to DC #4 on 6/11/18: -She and Staff #7 assisted DC #4 with bathing, dressing and moving to the dining room table where DC #4 ate her breakfast; -DC #4 was helped back to bed by staff after DC #4 returned to the facility from her morning appointment at the local wound clinic; -When Staff #6 went to pick up paperwork, she (Staff #7) was the only one at the facility with the 4 clients; -When Staff #7 did not return close to 12:00 noon, Staff #6 went ahead and fed Clients #1-3 first; -She decided to feed DC #4 last because it took more time for DC #4 to chew her food; -DC# 4 had a goal to eat slowly and swallow her food before taking another bite of food; -She stated DC #4 may have had a problem in the past with choking on food or it took her more time to chew her food with no teeth; -She fed DC #4 a ham and cheese sandwich and pasta that was prepared by 2nd shift staff the day before; -The ham was packaged thin-sliced ham with a square piece of cheese on white bread; -She pinched off small pieces of the sandwich and put to DC #4's mouth to eat; -She had to remind DC #4 to chew her food and swallow before eating another bite of food; -DC #4 was sitting up in bed at a 90 degree	V 110		

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V 110	Continued From page 21 angle, had her oxygen cannula in use, and was watching television while eating; -Staff #7 stated DC #4's oxygen was between 2-3 liters but was uncertain of the exact level; -DC #4 chewed her food and swallowed before Staff #7 gave her another bite of food; -DC #4 ate half the ham and cheese sandwich; -She knew DC #4 had swallowed her last bite of food before going to get DC #4's medication because she told DC #4 she was going to get her medication and drink and DC #4 responded "OK" and no longer showed a chewing motion with her mouth; -Staff #7 stated she returned to DC #4's room after leaving the room about 2 minutes and found DC #4's face had turned a bluish color and DC #4 did not respond to her; -She stated that while out of DC #4's room, she had not heard any coughing or gagging sounds; -Staff #7 heard Staff #6 outside the facility and yelled for her help; -She and Staff #7 patted DC #4's back and food came out of DC #4's mouth; - 9-1-1 and called she and Staff #7 were given CPR instructions; -The House Manager was also called about DC #4; -Local EMS arrived at the facility within 10 minutes and took over CPR efforts; -She was current on her First Aid and CPR certification; -Staff #7 stated that DC #4 was not on a pureed diet but 3-4 weeks before 6/11/18, the House Manager told her and other staff that DC #4's food needed to be almost pureed; -Staff #7 stated that on a later date, she saw DC #4 fed solid foods by other staff so she went along with feeding DC #4 solid foods because she thought there had been a change and DC #4 could have solid foods again;	V 110		

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V 110	Continued From page 22 -Staff #7 stated that client changes are usually discussed in the monthly house staff meetings and individually with staff; -She was absent at last month's staff meeting because she was sick and had worked the 3rd shift the night before the meeting; -The House Manager updated her the next day on DC #4's care with the oxygen and wound dressings. Interview on 6/22/18 with the House Manager revealed: -She had worked for the licensee for 13 years and worked at the facility for 10 years; -She was the House Manager at the facility; -Her job responsibilities included supervision and training of the direct support staff to ensure staff are knowledgeable about each client's diagnoses, personal care plan and history, reviewing staff notes to check for accuracy, ensuring staff coverage on all shifts, conducting facility meetings at least once a month with staff to review any client changes or changes in policy; -She had worked with DC #4 for 14 years and was familiar with her health, care needs and treatment plan; -DC #4 broke the bone in her knee on 1/31/18 when trying to transfer herself during the night from the bed to the wheelchair without staff assistance; -She was notified about DC #4's fall when she walked into the facility the next morning and saw DC #4's knee swollen and sent her to the hospital for x-rays; -DC #4 became less mobile after she broke her knee and 3 staff were placed in the facility to provide DC #4 assistance with daily care activities; -DC #4 also had a hospital bed with bedrails to prevent her from further falls;	V 110		

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V 110	Continued From page 23 -DC #4 was placed on oxygen in 4/2018 after she was discharged from the hospital for treatment of pneumonia which did not fully resolve and DC#4 returned to the hospital multiple times for conditions that included pneumonia, a urinary tract infection, sepsis and the decubitus ulcer that would not clear up; -DC #4's oxygen was prescribed in 5/2018 for continuous oxygen 2 liters per minute; -She communicated any changes DC #4's care in house staff meetings, training, and individually with staff; -DC #4 was not on a special diet but she had given staff instructions to grind up some of DC #4's meats like pork chops because DC #4 complained for about a month that her gums hurt her when she tried to chew meat; -DC #4 had been without teeth or dentures for about 8 years; -She denied DC #4 had any problems swallowing food; -She stated that DC #4 had lost her ability to feed herself but ate well when fed by staff; -The House Manager stated that while DC #4 resided at the facility, the staffing was follow: -4 staff during the day on first shift; -1 staff worked 1st shift and part of 2nd shift until 8:00-8:30 and another staff until 11:00 pm; -1 staff on third shift; -2 staff on 1st shift and 2 staff on 2nd shift on the weekends; -She stated staff were trained in use of wheelchairs and client transfers in and out of wheelchairs; -She stated there was a G-15 competency training provided to staff that informed staff about each client's diagnoses, care, service goals, treatment plan and history and then a follow up annual refresher training on each client; -She stated that she and the Qualified	V 110		

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V 110	Continued From page 24 Professional #1 were responsible for the training new employees and whenever there was a change in a client's plan; -The House Manager stated that she had a staff protocol that if any incidents occur at the facility, staff are to notify her immediately; -6/11/18, The House Manager stated she was called by staff to come to the facility because DC #4 was choking and the local EMS was already at the facility working to resuscitate DC #4; -She talked with the emergency room doctor at the local hospital and was told a small amount of sandwich had been stuck in the lower part of DC #4's throat. This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 110		
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	V 112		

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V 112	Continued From page 25 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. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to develop and implement updated strategies in a client's treatment and habilitation plan affecting 1 of 1 deceased clients (DC#4). The findings are: Review on 6/22/18-6/25/18 of DC #4's record revealed: -Admission date: 12/31/02 -Date of Death: 6/11/18 -Diagnoses: Moderate Mental Retardation, Schizoaffective Disorder, Seizure Disorder, Chronic Obstructive Pulmonary Disease, Chronic Constipation, Osteoarthritis, Right eye blindness, Hyperlipidemia, Urinary incontinence, and History of left hip surgery -Multiple hospital visits in 2018 for a knee fracture, additional medical diagnoses and recurrent medical issues: -1/31/18, Hospital admission for treatment of a fractured knee joint due to a fall out of bed; -3/15/18, Emergency room (ER) treatment of pneumonia; -4/2/18-4/13/18, Hospital admission for septic shock, severe seizures, Methicillin-resistant	V 112		

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126 AIR PARK DRIVE APT. C	126C AIR PARK DRIVE MORGANTON, NC 28655

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V 112	Continued From page 26 Staphylococcus aureus (MRSA) pneumonia and coronavirus (a virus that affects the respiratory system); -5/2/18, ER visit for treatment of a urinary tract infection that had altered DC #4's mental status; -5/11/18-5/17/18, Hospital admission for treatment and management of encephalopathy (a disease or damage to the brain that can range from mild memory loss or personality changes to severe conditions such as dementia and seizures), pneumonia, and Hypokalemia (low potassium); -6/11/18, DC #4 pronounced dead at the ER visit after having been in full cardiac arrest and medical procedure performed to remove a bread mass from DC #4's trachea area and efforts to resuscitate DC #4; -The 6/11/18 emergency department report revealed: -DC #4's decubitus ulcer had worsened to a Stage 4 decubitus ulcer (the pressure sore had reached into muscle and bone and caused extensive tissue damage); -DC #4 presented in the hospital emergency department in full cardiac arrest with a bread mass that had packed her trachea below the vocal cords; -DC #4 died at the hospital after multiple medical procedures (from suctioning, use of forceps, to an incision to widen the vocal cord membranes) to remove the bread mass from DC #4's trachea area and after placed on ventilation; -Emergency Department Attestation statements in the 6/11/18 revealed: -DC #4 had a psychiatric condition that caused her to take large bites of food; -She had a known history of choking hazard; -There was question that DC #4 may have stored food at the back of her mouth, seemingly swallowed, and swallowed it all that resulted in	V 112		

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V 112	Continued From page 27 the mass of food in the trachea. Review on 6/21/18-6/25/18 of DC #4's hospital discharge summaries and medical notes from the local wound clinic revealed: -4/13/18, DC #4 was placed on oxygen that resulted from a medical diagnosis of pneumonia; -4/30/18, DC #4 was provided written instructions with diagrams from the local wound clinic on how to cleanse and change the decubitus wound dressing; -5/17/18 DC #4 had a continuous bladder elimination device due to the Stage 3 Sacral Decubitus Ulcer. Review on 6/25/18 of approved restrictions by DC # 4's guardian and the licensee's human rights committee revealed: -A low calorie diet by a physician's order, a hospital bed with bedrails for fall prevention, and clothing protector at mealtime. Review on 6/22/18 of DC #4's Person-Centered Plan (PCP) revealed: -DC #4's Person-Centered Plan was updated on 3/16/18 by Former Qualified Professional (FQP) #2 and DC #4's guardian; -Statements that DC #4 required assistance with some activities of daily living (ADLs) due to limited mobility and DC #4 had tendency to allow others to do for her even when she can carry out tasks; -DC #4's 11 treatment goals included: -Access her closets and drawers to choose appropriate clothing according to the plans for the day and not wear same clothing several days in a row; -Cover her mouth with her hands independently when coughing or sneezing and disinfect her hands with hand sanitizer;	V 112		

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V 112	Continued From page 28 -Slow down while eating and place her eating utensil down on the table after taking a bite of food to chew and swallow before taking another bite of food; -Place pillows on top of her bed daily after her bed is made; -Will obtain and maintain a comfortable, upright position in her wheelchair and face forward; -Make a list of food items needed at the grocery store; -Will have no more than 2 daily incidents of impatience while waiting her turn; -Choose an activity at least once a week other than coloring to do within her home; -Practice sharing items with housemates; -Assist staff at least once a week with meal preparation; -Her personal care goals included: -A statement that DC #4 would have as much or as little staff assistance to complete daily personal care tasks of blow drying her hair, bathing, swabbing mouth and gums, caring for feet, and dressing; -Full staff assistance for DC #4 to get to the sink to wash her hands before and after meals, and after toileting; -Full staff assistance approximately every 2 hours with transferring, undressing, wiping and re-clothing in DC #4's attempts to use the restroom. Review on 6/22/18 of DC #4's documented progress in meeting her residential treatment and personal care goals for the periods 5/16/17-5/22/18 and 6/6/18-6/10/18 revealed: -DC #4 did not meet 7-8 of her 11 treatment goals for each period of time; -In 5/2018's time frame, DC #4's goals of washing hands at sink and staff assistance with transferring in DC #4's attempt to use the	V 112		

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V 112	Continued From page 29 restroom was not met at all; -In 6/2018's time frame, the aforementioned goal of DC #4's attempt to use the restroom with full staff assistance was met daily; -5/19/18-5/20/18 contained staff statements that DC #4's goals were not being ran because DC #4 was very sleepy and staff had difficulty feeding her meals and administering her medications; -There was no explanation about the cause of DC #4's sleepiness. Interview on 6/22/18 with the QP #1 about DC #4's treatment goals and personal care goals for the May and June 2018 time periods as indicated by "N/A" on her goal sheet revealed: -DC #4 was not physically able to meet her service goals and required full assistance from staff. Interview on 6/21/18-6/25/18 with Qualified Professional (QP) #1 revealed: -She began work as the QP in 4/2018; -Her job duties included supervision of the House Manager, clinical supervision of the Direct Care Support Residential staff to ensure staff knowledge of client diagnoses and care needs, coordination of client care with staff, guardians and professionals in the community providing services to clients, and updating client treatment plans; -FQP #2 had completed DC #4's residential treatment plan (Person-Centered Plan); -She had not updated Client #4's treatment plan from the 3/16/18 date but staff was kept informed of changes in DC #4's care and service needs through communication with the House Manager and monthly facility staff meetings. This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1	V 112		

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V 112	Continued From page 30 rule violation and must be corrected within 23 days.	V 112		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which	V 289		

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V 289	Continued From page 31 serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7)(A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1)(i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e)(1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL). This Rule is not met as evidenced by: Based on interview, record review and observation, the facility failed to ensure needed care and rehabilitation services for individuals residing at a facility affecting 1 of 2 audited clients (Client #2) and 1 of 1 deceased clients (DC #4). The findings are: CROSS REFERENCE: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109). Based on record review, observation and	V 289		

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V 289	Continued From page 32 interviews, the facility's fomer and current Qualified Professionals (QPs) failed to demonstrate knowledge, skills and abilities required by the population served for 1 of 1 Former QPs (FQP #2) and 1 of 1 current QPs (QP #1). CROSS REFERENCE: 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) Based on record reviews and interviews, the facility failed to ensure 5 of 5 paraprofessional staff (Staff # 5-9) demonstrated knowledge, skills and abilities required for the population served. CROSS REFERENCE: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) Based on record review and interview, the facility failed to develop and implement updated strategies in a client's treatment and habilitation plan affecting 1 of 1 deceased clients (DC#4). CROSS REFERENCE: 10A NCAC 27G .5603 (b) Operations (V291) Based on record review, interview and observation, the facility failed to follow up on physician orders and medical recommendations to ensure clients receive medically prescribed and recommended levels of care affecting 1 of 3 audited clients (Client #2) and 1 of 1 deceased clients (DC #4). Review on 6/25/18 of the "126 Air Park Apt. C" initial Plan of Protection dated 6/25/18 written by the Regional/Community Services Director revealed: What immediate action will the facility take to ensure the safety of all consumers in your care? "QP	V 289		

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V 289	Continued From page 33 Will review all medical needs of individuals currently in the home and ensure that doctor's orders are in place for all medical needs. All individual's records will be reviewed for inconsistencies with any type of doctor orders. Will contact the doctor and document contact to ensure information is current and correct in the record. All discharge information from the hospital will be reviewed by the QP and any inconsistencies or recommendations will be discussed with the primary care physician for accuracy and ensure dr. orders are obtained for any changes in medical procedures and placed in the record. Train staff and House Manager on correct procedures. Ensure that documentation is maintained in the record at the home and in the record. If an individual is to be discharged from the hospital with a higher level of care than the home can provide, the QP will notify the Regional Director of the situation. The Regional Director will notify the CEO and a decision will be determined by the CEO, Regional Director, and QP. If the individual can no longer be served in the home due to medical necessity, the QP will notify the Guardian, MCO Care Coordinator and the hospital. House Manager Will ensure that medical appointments are scheduled for any type of medical concerns for the residents and inform the QP of the appointment. Will ensure that all medical information is documented and the original is given to the QP for review. Will in conjunction with the QP ensure that doctors orders are obtained for any changes in medical procedures and is placed in the record. Will ensure that staffs are trained on any type of	V 289		

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V 289	Continued From page 34 changes required for medical care. The Home Manager will ensure that the training is documented on a Person Specific Form. House Manager will ensure that staff are following all correct procedures according to dr. orders. Will review all shift notes to determine if there is any type of pattern that needs care from a doctor and inform the QP. Staff Staff will receive training on the protocol to inform the House Manager of any types of concerns regarding the residents. Staff will immediately inform the Home Manager of any concerns. Staff will ensure that all medical concerns are documented in shift notes." Signed "[Regional/Community Services Director] 6/25/18" Review on 7/2/18 of the "126 Air Park Apt. C" Addendum to the Plan of Protection dated 6/25/18 and written by the Regional/ Regional/Community Services Director on 7/2/18 revealed: -"[Regional/Regional/Community Services Director] will be responsible for the oversight of the plan to ensure that it is implemented." Review on 7/13/18 of an amended "126 Air Park Apt. C" Plan of Protection written and submitted by the Regional/Community Services Director revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? "1) An individual in question regarding her food consistency will be taken to the doctor as soon as possible to determine is she needs to go on a different consistency for her food. Doctors notes on this individual will also be obtained for the past	V 289		

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V 289	Continued From page 35 year within the week. 2)The supervising "Q" will review all medical needs of individuals currently in the home to ensure that doctor's order are in place for all medical needs. All records will also be reviewed for inconsistencies with any type of doctor's order. This will be completed within the week. Both #1 and #2 have been currently completed by the supervising "Q". Describe your plans to make sure the above happens. The Regional Director will ensure that this plan is followed and processes are put in place. The supervising "Q" will ensure the following: 1) All hospital discharge information will be reviewed by the supervising "Q" to determine if further information is needed from the primary care physician for clarification or if further questions are needed from the hospital regarding care of the individual. The agency nurse will be consulted if necessary. 2) The supervising "Q" will also ensure that all doctor's visit summaries are obtained and placed in the service record and reviewed. 3) Ensure that the home manager and staff are trained on correct procedures for reporting problems to the home manager. 4) Ensure that if an individual is to be discharged from the hospital with a higher level of need than the home can provide, the QP will notify the Regional Director of the situation. The Regional Director will notify the CEO and a decision will be determined by the CEO, Regional Director, supervising "Q" and if needed the agency nurse. If the individual can no longer be served, then the supervising "Q" will inform the Guardian, MCO Care Coordinator, and the hospital. 5) That all Treatment Plans are reviewed quarterly and changes made if necessary. 6) That goals are reviewed monthly and changed	V 289		

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V 289	Continued From page 36 if needed. 7) That if there is a significant change of the individual within the quarter that the plan will be updated as necessary. 8) Ensure that service coordination occurs regarding resident's needs. A treatment team will be requested through the MCO Care Coordinator in order to make all agencies and the guardian aware of any emergent or immediate need. 9) Ensure that communication is maintained regarding the individual between doctor, guardian, Care Coordinator, Home Manager, staff and supervisor. The Home Manager will ensure the following: 1) That medical appointments are scheduled for any type of resident medical concerns and inform the supervising "Q" of the appointment. 2) That all medical information is documented and that the original is given to the supervising "Q" for review. 3) Work in conjunction with the supervising "Q" to ensure that doctor's orders are obtained for any changes in medical procedures and is placed in the record. 4) That staff are trained on any type of changes required for medical care of residents and documented on a Person Specific form. 5) That staff are following all correct procedures according to dr. orders. 6) Review all shift notes to determine if there is any type of pattern has developed that may require a visit to the doctor. 7) Inform the supervising "Q" if goals are no longer appropriate for the resident. Staff will ensure the following: 1) That all medical concerns are documented in shift notes. 2) That all medical procedures are followed as trained. "	V 289		

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V 289	Continued From page 37 The facility failed to review a client's medical orders and clarify discrepancies between doctor orders and the client care provided by staff to ensure the client (Client #2) who had a history of food aspiration was safe when fed her daily meals. Client #2 received a 7/13/17 physician order for a pureed diet with nectar thick consistency but the identified nutritional supports in the client's 9/1/17 individualized treatment plan were for all foods to be chopped into quarter-sized portions and be low cholesterol with no-salt added. Additionally, Client #2's 5/2018 and 6/2018 Medication Administration Records (MARs) identified the client's diet to be low cholesterol, no-salt added and 1800 calories. Observation of the client (Client #2) on 6/22/18 revealed her expulsion of a white liquid onto her feeding bib twice while eating and drinking a beverage during her dinner meal. The facility failed to follow medical recommendations for a client to be admitted to a skilled nursing facility when the recommendations were made per hospital discharge recommendation on 4/13/18 and from the local wound clinic on 4/30/18 which resulted in Deceased Client #4 (DC #4) not receiving daily skilled nursing care to ensure her health and safety but contributed to DC #4's multiple hospital visits: 3/15/18, Emergency room (ER) treatment of pneumonia; 4/2/18-4/13/18, Hospital admission for septic shock, severe seizures, Methicillin-resistant Staphylococcus aureus (MRSA) pneumonia and coronavirus (a virus that affects the respiratory system); 5/2/18, ER visit for treatment of a urinary tract infection that altered DC #4's mental status; 5/11/18-5/17/18, Hospital admission for treatment and management of encephalopathy (a disease or damage to the brain that can range from mild	V 289		

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V 289	Continued From page 38 memory loss or personality changes to severe conditions such as dementia and seizures), pneumonia, and Hypokalemia (low potassium); and 6/11/18, ER visit for full cardiac arrest with medical procedures performed (from suctioning to incision to widen the vocal cord membranes) on DC #4 to remove a bread mass that had lodged in her trachea area from a meal she was fed at the facility and with an outcome of DC #4's death. The systemic failure of the facility to follow physician orders and medical care recommendations to ensure the health and safety of clients constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $10,000 is imposed. If the violation is not corrected within 23 days, an administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 289		
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	V 291		

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V 291	Continued From page 39 relationship with her or his family through such 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 review, interview and observation, the facility failed to follow up on physician orders and medical recommendations to ensure clients receive medically prescribed and recommended levels of care affecting 1 of 3 audited clients (Client #2) and 1 of 1 deceased clients (DC #4). The findings are: Finding 1 Review on 6/22/18-6/25/18 of Client #2's record revealed: -Admission date: 10/1/04 -Diagnoses: Profound Intellectual Disability, Unspecified Reactive Psychosis, Schizophrenia, Allergic rhinitis, Congenital Blindness, History of Pneumonia and Respiratory Failure, Degenerative Joint Disease, GERD, History of Gastritis, H Pylori Infection, Hiatal Hernia, Hypertension, Hyperlipidemia, Melanosis, Osteoporosis, Spasticity, Dysphagia, History of Urinary Tract Infection, Constipation, weight loss	V 291		

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V 291	Continued From page 40 -A 7/5/17 Modified Barium Swallow Study (MBSS) Evaluation report revealed: -Client #2's prior diet was regular solid food; -Client #2 aspirated food on 7/3/17; -Client had a MBSS to assess swallowing function due to cough and probable pneumonia; -Recommended diet was pureed with nectar consistency; -A 7/10/17 email from the Former Qualified Professional #2 to Client #2's guardian that Client #2 had a swallow study and had orders for ground food; - Physician's written order dated 7/13/17 for a "pureed diet with nectar thick consistency with head in neutral position"; -Treatment plan dated 9/1/17 revealed: -A statement that Client #2 followed a special diet and needed full assistance to ensure she ate foods within her diet; -Client #2 had nutritional supports due to a risk of choking; -The nutritional supports were that food and liquid be of a particular consistency, all foods be "chopped into quarter-sized portions", a low cholesterol and no-salt added diet; -Medication Administration Records (MARs) from 1/2018-6/2018 revealed: -A low Cholesterol, no added salt, 1800 calorie diet. Review of Client #2's daily food tracking log for 2017 revealed: -Lists of foods Client #2 ate daily and included ham and cheese sandwich, fruit salad, chopped chicken, pintos, turnip greens and potato chips; -No documentation that any of Client #2's foods were pureed with nectar consistency. Observation of Client #2 on 6/22/18 between 4:10-4:30 pm at the facility revealed:	V 291		

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V 291	Continued From page 41 -Client #2 was fed at dining room table by Staff #8 placing solid food on an eating utensil and verbally prompting Client #2 to open her mouth and eat; -Staff #8 then placed a drinking cup to Client #2's mouth twice and prompted her to drink after swallowing her bite of food; -Client #2 coughed up white-colored liquid both times with the liquid spilling onto Client #2's feeding bib; -Staff #8 stated "She does this sometimes"; -Client #2 was removed from the table in her wheelchair by Staff #8 and relocated to the living room; -Approximately 75% of food remained on Client #2's plate which was left sitting on the dining table. Attempted interview and observation on 6/22/18 with Client #2 revealed: -She sat alone in center of facility living room with her head positioned down toward her chest; -Client #2 would not make eye contact or respond verbally. Interview on 6/21/18-6/25/18 with Qualified Professional (QP) #1 revealed: -She began work as the QP in 4/2018; -Her job duties included supervision of the House Manager, clinical supervision of the Direct Care Support Residential staff to ensure staff knowledge of client diagnoses and care needs, coordination of client care with staff, guardians and professionals in the community providing services to clients, and updating client treatment plans; -QP #1 stated that Client #2's treatment plan was completed by the Former Qualified Professional (FQP) #2; -She was aware that Client #2 had a daily food	V 291		

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V 291	Continued From page 42 tracking log; -QP #1 stated that Client #2's diet might have changed at some point from a pureed diet to a low cholesterol, no-salt added and chopped food diet based on Client #2's Medication Administration Records. Interview on 6/25/18 with the Regional/Community Services Director revealed: -She supervised the FQP # 2 and Current QP #1; -She was told by the House Manager that Client #2 would not eat the pureed foods and FQP #2 was supposed to have informed Client #2's physician of this information; -She was unable to find a physician's order that changed Client #2's diet from pureed to chopped food in Client #2's record; -A call had been placed to Client #2's physician during the survey to clarify Client #2's medically prescribed diet. Finding #2 Review on 6/22/18-6/25/18 of Deceased Client #4 (DC #4)'s record revealed: -Admission date: 12/31/02 -Date of Death: 6/11/18 -Diagnoses: Moderate Mental Retardation, Schizoaffective Disorder, Seizure Disorder, Chronic Obstructive Pulmonary Disease, Chronic Constipation, Osteoarthritis, Right eye blindness, Hyperlipidemia, Urinary incontinence, and History of left hip surgery -Multiple hospital visits in 2018 for a knee fracture, additional medical diagnoses and recurrent medical issues: -1/31/18, Hospital admission for treatment of a fractured knee joint due to a fall out of bed; -3/15/18, Emergency room (ER) treatment of pneumonia; -4/2/18-4/13/18, Hospital admission for septic	V 291		

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V 291	Continued From page 43 shock, severe seizures, Methicillin-resistant Staphylococcus aureus (MRSA) pneumonia and coronavirus (a virus that affects the respiratory system); -5/2/18, ER visit for treatment of a urinary tract infection that had altered DC #4's mental status; -5/11/18-5/17/18, Hospital admission for treatment and management of encephalopathy (a disease or damage to the brain that can range from mild memory loss or personality changes to severe conditions such as dementia and seizures), pneumonia, and Hypokalemia (low potassium); -6/11/18, DC #4 pronounced dead at the ER visit after having been in full cardiac arrest and medical procedure performed to remove a bread mass from DC #4's trachea area and efforts to resuscitate DC #4; -The 6/11/18 emergency department report revealed: -DC #4's decubitus ulcer had worsened to a Stage 4 decubitus ulcer (the pressure sore had reached into muscle and bone and caused extensive tissue damage); -DC #4 presented in the hospital emergency department in full cardiac arrest with a bread mass that had packed her trachea below the vocal cords; -DC #4 died at the hospital after multiple medical procedures (from suctioning, use of forceps, to an incision to widen the vocal cord membranes) to remove the bread mass from DC #4's trachea area and after placed on ventilation; -Emergency Department Attestation statements in the 6/11/18 revealed: -DC #4 had a psychiatric condition that caused her to take large bites of food; -She had a known history of choking hazard; -There was question that DC #4 may have stored food at the back of her mouth, seemingly	V 291		

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V 291	Continued From page 44 swallowed, and swallowed it all that resulted in the mass of food in the trachea. Further review of DC #4's hospital discharge summaries from 4/13/18 to 5/17/18 revealed: -4/13/18 A statement of medical discharge recommendation for DC #4 to obtain skilled nursing facility (SNF)care but DC #4 was discharged back to the facility from the hospital; -5/17/18 A statement that DC #4 required skilled nursing service to perform wound care. Review on 6/25/18 of medical notes from the local wound clinic on DC #4 revealed: -A 4/30/18 statement that recommended DC #4 be admitted to skilled nursing care for a higher level of care. Review of DC #4's 6/11/18 facility incident report in the North Carolina Incident Response Improvement System (IRIS) on 6/21/18 revealed: -DC #4 was immobilized from the 1/31/18 knee injury; -DC #4's multiple hospital visits (3 hospital admissions and 2 emergency room visits) that occurred from 1/31/18 through 5/17/18 due to medical conditions that included sepsis, pneumonia, urinary tract infections, encephalopathy and hypokalemia; -A statement that the licensee felt the facility could no longer provide adequate care to DC #4; -Skilled nursing facility (SNF) care had been recommended by DC#4's physician but the hospital would not place DC #4 in skilled nursing care; -DC #4 required 2-3 staff at the facility to meet her care needs and had home health skilled nursing once a week for wound care since hospital discharge in 5/2018.	V 291		

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V 291	Continued From page 45 Interview on 6/22/18 with DC #4's legal guardian revealed: -DC #4 was on the Innovations Waiver Program (Medicaid funding program for services and supports for people with intellectual developmental disabilities); -The Innovations Waiver on DC #4 would have switched over to regular Medicaid once DC #4 was admitted to a skilled nursing facility; -She had found SNF placement for DC # 4 prior to DC #4's death on 6/11/18 and had planned to move DC #4 at the end of the week. Interview on 6/21/18 with Qualified Professional #1 revealed: -On 4/13/18, DC #4 was discharged back to the facility from the hospital with a decubitus wound that was observed by staff while providing her with personal care; -DC# 4 had a doctor's order to receive decubitus wound care at a local wound care clinic; -She was aware that DC #4 was medically recommended for skilled nursing care placement; -DC #4's guardian was going to find skilled nursing care placement for her but DC #4 went back to the local hospital for more complications and the hospital would not place DC #4 in a skilled nursing facility (SNF); -When DC #4 came back to the facility from the hospital on 5/17/18, she (QP #1) went ahead and made referrals to SNFs to look for DC #4 a skilled nursing home placement. Interview on 6/22/18 with Client #2's Primary Care Physician (PCP) revealed: -She was the primary care physician to Client #2 and DC #4; -Client #2 had higher end care needs and could benefit from skilled nursing level of care; -DC #4 was not healthy, had multiple medical	V 291		

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V 291	Continued From page 46 conditions and needed skilled nursing care; -The Primary Care Physician stated she relied on staff to communicate with her about any concerns or changes in her patients to determine her findings as her patients were mostly non-verbal and the staff were the daily caregivers to her patients; -The PCP stated she was concerned because DC #4 fell through the system in not getting the higher care she needed and ask if there was something that could be done by the Division of Health Services Regulation (DHSR) about it. Interview on 6/25/18 with the Regional/Community Services Director and the QP #1 revealed: -DC #4 did not have a physician's order for a pureed diet and had no diet restrictions; -The QP was responsible for reviewing clients' medical information for any changes in care and to follow up with the physician to clarify any discrepancies between physician orders and client care provided by the facility; -The QP was responsible for working with and supervising the House Manager to ensure staff followed physician orders in providing client care; -DC #4's physician and wound clinic had recommended and the licensee agreed that DC #4 needed skilled nursing facility (SNF) care back to DC #4's 4/2018 and 5/2018 hospitalizations; -Facility staff were unable to provide the higher care needed by DC #4 because of the continued wound care needs and recurrent medical issues; -DC #4 continued to be discharged back to the facility from each hospital stay because the hospital said DC #4 did not qualify for skilled care; -"We had no choice but to bring her (DC#4) back home and then pursue skilled nursing care through the regular doctor;"	V 291		

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V 291	Continued From page 47 "We were committed to her (DC #4)"; -The licensee's Chief Executive Officer (CEO) made the final decision for DC #4 to return to the facility until SNF placement could be secured; -She and the CEO had discussed the liability of DC #4's return to the facility with skilled nursing level of care needs; -The licensee issued DC #4 a 60-day discharge on 5/31/18 because of DC #4's higher level of care than what the facility staff could provide; -The facility increased staffing from 2-3 staff to meet DC #4's needs when DC #4 returned from the hospital to the facility in 5/2018. This deficiency is cross referenced into 10A NCAC 27G .5601 SCOPE (V289) for a Type A1 rule violation and must be corrected within 23 days.	V 291		

ComServ, Inc. Plan of Correction
126 Air Park Drive Apt. C

V 109 27 G.0203 Privileging/Training Professionals

	Completion Date
The Regional Director will ensure that the following is completed by meeting with the supervising Qualified Professional of APC every two weeks for three months, if the supervising Qualified Professional has made significant progress after three months, then monthly supervision will be implemented: 1) The Qualified Professional will receive training regarding the following: • Immediate review of doctor notes and hospital discharges following a visit or discharge. Follow-up and clarification for doctor's notes and hospital discharges. Immediate communication with the Home Manager regarding any changes medically with the resident.	7/11/18
• Obtaining doctor notes and hospital discharges for service records.	7/11/18
• Training of paraprofessionals and Home Managers regarding any changes in the plan, feeding procedures, medication, oxygen levels, behavior plans and any other issues regarding the residents.	7/11/18 7/11/18
• All trainings or in services will be documented on a Person Specific form for all staff and/or in communication logs.	7/11/18
• Different Levels of Care (ie: Skilled Nursing vs 5600 level supervised living) and procedures to follow when a higher level of care is needed.	7/27/18
2) The supervising Qualified Professional will review all service records of individuals currently residing in the home to determine if there is any needed medical consultation or clarification.	7/10/18
3) The Supervising Qualified Professional will ensure that Client #2 will be scheduled for a doctor appointment as soon as possible to ensure that the staff is following a correct diet.	6/27/18
4) The supervising Qualified Professional will review the doctor visit for Client #2 and in service staff regarding any changes to the current diet or feeding plan.	6/28/18
5) The supervising Qualified Professional will complete any follow up regarding current diet and feeding plan for Client #2.	7/16/18
6) The ComServ nurse will also review doctor visits, medication changes, hospital discharges and any other medical procedures for all individuals that live in APC. Any concerns will be communicated to the Home Manager and to the supervising Qualified Professional, documented by email. This was already in place, but was not documented by email.	7/24/18
7) All staff including the Qualified Professional and Home Manager will receive additional training in needs of the current residents in the home such as feeding (Ie: pureed diet vs grinding), failure to eat, etc. This will be developed with the Dietician of the ICF program.	9/28/18

V 110 27 G.0204 Training Supervision of Paraprofessionals

1) The Home Manager and the Supervising Qualified Professional will ensure that all staff is trained on medical procedures such as feeding, oxygen levels, wound care and that training is documented through staff meetings, communication logs, and person specific training forms. If the training requires a higher level of training then the ComServ nurse will complete the training or a home health agency.	7/1/18
2)The Regional Director will ensure that communication, training and documentation will improve between the staff, Home Manager and Qualified Professional through implementation of the following:	7/1/18
• If a discharge from a hospital occurs over the weekend, then the Home Manager will ensure that all staff scheduled to work with the individual for the weekend are informed of the discharge information. All staff will be informed of the discharge information the Monday following the discharge.	7/1/18
• The Home Manager and Qualified Professional will ensure that staff is following correct procedures according to doctor orders by weekly observation and daily review of shift notes.	7/1/18
• The Home Manager will review shift notes and communication logs daily to determine if there are any concerns for the residents expressed by staff. If concerns are addressed or a pattern of behavior is seen, then the Home Manager will communicate this information to the supervising Qualified Professional. On call procedures will be developed by the Qualified Professional to be posted in the home for staff.	7/26/18 8/2/18
• All staff will be retrained by the Qualified Professional on reporting injuries to the Home Manager in a timely manner.	7/26/18
• The ComServ nurse will review doctor visits, medication changes, hospital discharges and any other medical procedures for all individuals that live in APC. Any concerns will be communicated to the Home Manager and to the supervising Qualified Professional, documented by email. This was already in place, but was not documented by email.	7/26/18
• The ComServ nurse will visit the facility at least every two weeks and more often if needed to observe individuals, review medications and medical procedures by staff. The nurse will discuss any needed changes or problems to the Home Manager and Qualified Professional.	7/26/18
• The Home Manager will set a specific schedule for when paperwork can be taken to the other office location so as not to disrupt the daily coverage needed at the home.	8/2/18

V 112 27 G .0206 (C-D) Assessment of Treatment /Habilitation Plans

The Regional Director will ensure that the following is completed by meeting	

with the supervising Qualified Professional of APC every two weeks for three months, if the supervising Qualified Professional has made significant progress after three months, then monthly supervision will be implemented: 1) The supervising Qualified Professional will receive training regarding the following:	
• Immediate review of doctor notes and hospital discharges following a visit or discharge. Follow-up and clarification for doctor's notes and hospital discharges. Immediate communication with the Home Manager regarding any changes medically with the resident.	7/11/18
• Obtaining doctor notes and hospital discharges for service records.	7/11/18
• Training of paraprofessionals and Home Managers regarding any changes in the plan, feeding procedures, medication, oxygen levels, behavior plans and any other issues regarding the residents.	7/11/18
• All trainings or in services will be documented on a Person Specific form for all staff and/or in communication logs.	7/11/18
• Different Levels of Care (ie: Skilled Nursing vs 5600 level supervised living) and procedures to follow when a higher level of care is needed.	7/27/18
• Plans will be routinely reviewed every three months and pertinent information shared with the guardian, individual and care coordinator.	7/1/18
• If an individual has a significant change in skill level at any time the plan will be updated to reflect the changes. Staff will then be retrained on the goal changes.	7/1/18
• Goals will be reviewed monthly through completion of the monthly "Q" note. If an individual is showing little to no progress over a consistent period of time, then goals will be changed, modified or revised as needed. Staff will then be retrained on the goal changes. The Home Manager and Qualified Professional will monitor through weekly observation of staff and daily review of shift notes.	7/1/18
• Treatment team meetings will be held yearly and as needed to communicate progress, important issues, changes needed for the individual and any other pertinent issues related to the individual. The Qualified Professional will monitor to determine when a treatment team is needed.	7/1/18
• Level of Care changes for the individual will be reported to the guardian, care coordinator, and Regional Director. The Regional Director will report to the CEO and a decision will be determined by the CEO, Regional Director, Qualified Professional and the agency nurse (if needed) to transition/ to not transition the resident. If the individual can no longer be served then the Qualified Professional will inform the guardian and care coordinator according to ComServ discharge policy. Assistance with transition to a higher level of care will be provided.	7/1/18
• Ensure that communication is maintained regarding the individual between the Home Manager, staff, doctor, guardian, Care Coordinator, and supervisor in order to coordinate services.	

Communication will be documented by printed emails, call logs, person center specific and staff communication logs. **10A NCAC 27 G .5603** The Regional Director will ensure that the following is completed by meeting with the supervising Qualified Professional of APC every two weeks for three months, if the supervising Qualified Professional has made significant progress after three months, then monthly supervision will be implemented: 1)The supervising Qualified Professional will receive training regarding the following:	
• Immediate review of doctor notes and hospital discharges following a visit or discharge. Follow-up and clarification for doctor's notes and hospital discharges. Immediate communication with the Home Manager regarding any changes medically with the resident.	7/11/18
• Obtaining doctor notes and hospital discharges for service records.	
• Training of paraprofessionals and Home Managers regarding any changes in the plan, feeding procedures, medication, oxygen levels, behavior plans and any other issues regarding the residents.	7/11/18
• All trainings or in services will be documented on a Person Specific form for all staff and/or in communication logs.	7/11/18
• Different Levels of Care (ie: Skilled Nursing vs 5600 level supervised living) and procedures to follow when a higher level of care is needed.	7/27/18
• Plans will be routinely reviewed every three months and pertinent information shared with the guardian, individual and care coordinator.	7/11/18
• If an individual has a significant change in skill level at any time the plan will be updated to reflect the changes. Staff will then be retrained on the goal changes. The Qualified Professional will be responsible for monitoring for changes.	7/1/18 7/1/18
• Goals will be reviewed monthly by the Qualified Professional through completion of the monthly "Q" note. If an individual is showing little to no progress over a consistent period of time, then goals will be changed, modified or revised as needed. Staff will then be retrained on the goal changes.	7/1/18
• Treatment team meetings will be held yearly and as needed to communicate progress, important issues, changes needed for the individual and any other pertinent issues related to the individual.	7/1/18
• Level of Care changes for the individual will be reported to the guardian, care coordinator, and Regional Director. The Regional Director will report to the CEO and a decision will be determined by the CEO, Regional Director, Qualified Professional and the agency nurse (if needed) to transition/ to not transition the resident. If the individual can no longer be served then the Qualified Professional will inform the guardian and care coordinator following the ComServ Discharge Policy. Assistance with transition to a higher	7/1/18

level of care will be provided. • Ensure that communication is maintained regarding the individual between the Home Manager, staff, doctor, guardian, Care Coordinator, and supervisor in order to coordinate services. Communication will be documented by printed emails, call logs, person center specific and staff communication logs.	7/1/18