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
	MHL012085	A. BUILDING: ______ B. WING ______	09/11/2018

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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 limited follow up survey for the Type A1 was completed on September 11, 2018. This was a limited follow up survey, only 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109), 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110), 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112), 10A NCAC 27G .5603 Operations (V291) and 10A NCAC 27G .5601 Scope-Supervised Living for Individuals of All Disability Groups (V289) were reviewed for compliance. The following were brought back into compliance: 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109), 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110), 10A NCAC 27G .5603 Operations (V291) and 10A NCAC 27G .5601 Scope-Supervised Living for Individuals of All Disability Groups (V289). 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		
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:	V 112		

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(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 provider stating why such consent could not be obtained.

This Rule is not met as evidenced by:
Based on record review, observation and interview, the facility failed to follow a physician order for 1 of 3 sampled clients (Client #1). The findings are:

Review on 9/4/18 of Client #1's record revealed:
Date of Admission: 10/1/04
Diagnoses: Profound Intellectual Developmental Disability, Schizophrenia, Osteoarthritis, Gastritis, Gastroesophageal Reflux Disease (GERD), Hiatal Hernia, Hyperlipidemia, Allergic rhinitis, unspecified, Transient Visual Loss (bi-lateral blindness), Constipation, Degenerative Joint Disease, Failure to Thrive
-8/18/18, a physician-contact form signed by Client #1's Primary Care Physician (PCP) revealed:
-reason for the appointment was weight loss;

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-a diagnosis of Failure to Thrive;
-a referral to GI (gastrointestinal);
-8/28/18, physician order for clear liquid nutritional supplement, 296 milliliter (ml), drink one bottle by mouth 3 times daily with meals, and drink one bottle, midmorning and midafternoon (total 5 times daily);
-9/1/18 updated treatment plan for Client #1 that contained a statement that Client #1 was to follow a special diet and needed full assistance to ensure she ate the foods within her diet.

Review on 9/6/18 of Client #1's July 2018-September 2018 Medication Administration Records (MARs) revealed:
-7/14/18-7/31/18, 8/1/18-8/31/18, staff initials reflected Client #1's intake of 1 bottle of clear liquid nutritional supplement, 296 ml at 7 am, 12 pm, 2 pm, 5 pm and 8 pm;
-9/1/18-9/3/18, staff initials reflected Client #1's intake of 1 bottle of clear liquid nutritional supplement, 296 ml at 7 am, 12 pm, 2 pm, 5 pm and 8 pm;
-9/4/18 and 9/5/18, no staff initials that Client #1 had an intake of 1 bottle of clear liquid nutritional supplement, 296 ml at 12:00 pm;
-No documentation that Client #1 refused intake of the liquid nutritional supplement;
-No documentation of Client #1's intake amount from each bottle of the clear liquid nutritional supplement.

Review on 9/5/18 of Client #1's Food Tracker Log from 8/1/18 to 9/4/18 revealed:
-A statement at top of each food tracker page that the liquid nutritional supplement was to be recorded as "food";
-3 meal times (Breakfast, Lunch and Dinner) and 2 snack times (1 snack between breakfast and lunch and 1 snack after dinner);

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-8/1/18, 8/2/18, 9/1/18-9/4/18, Client #1's consumption of the physician-ordered liquid nutritional supplement varied between 2-3 times per day and varied amounts that ranged from 4 ounces, 8 ounces and 1 can;
-No documentation that reflected whether Client #1's foods (oatmeal and yogurt for examples) were blended with the liquid nutritional supplement to increase calorie intake.

Review on 9/4/18 of a written Nutrition Consult Report dated 7/23/18 for Client #1 revealed:
-A nutritional assessment by a Registered Dietitian (RD) and resulted in a written report;
-Client #1's Primary care Physician (PCP) had printed a copy of the written report;
-The facility received a copy of the report from Client #1's PCP;
-Client #1 was assisted by group home staff to attend the nutritional assessment;
-Client had 33% weight loss over 3 years and 8% weight loss over 9 months;
-Client #1's intake of the liquid nutritional supplement 5 times daily was 50-100% varied depending on whether Client #1 had a bowl movement;
-A nutritional diagnosis of "Malnutrition-moderate";
-Client #1's nutritional problem related to:
-Food choices or preferences;
-" ... predicted inadequate energy intake in setting of intellectual disability w/hx (history) dysphagia requiring altered diet w/reliance on others for the provision of food/fluids";
-Client #1 had "moderate to severe muscle wasting" in temples, shoulder blade, and clavicles;
-Nutritional recommendations included:
-Space fluids 30 minutes around meal time;
-Fortify pureed foods with gravy, additional fats,

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powdered milk, half and half cream, nut butters;
-The liquid nutritional supplement blended with frozen fruit, nut butters or vegetables to alter taste and improve consumption;
-Staff educated about fortification of Client #1's meals to maximize calorie intake.

Review on 9/5/18 of an additional, written nutritional consult dated 8/29/18 for Client #1 revealed:
-The written consult was titled "[Licensee] Nutritional Consult";
-The consult was signed by a Registered Dietitian;
-Recommendations to increase Client #1's calorie intake and provide Client #1 with variety of foods and include an increased caloric version of the liquid nutritional supplement and give medications to Client #1 with the nutritional supplement in the form of pudding;
-A statement that Client #1 was scheduled for repeat barium swallow test in 9/2018.

Review on 9/5/18 of facility staff training notes in 7/2018 and 8/2018 revealed:
-7/26/18 staff training that included:
-Client #1's pureed diet consistency;
-An informational handout titled "Pureed Diet" that included use of the liquid nutritional supplement to pureed foods;
-A statement "It is very important to follow any doctor's orders or recommendations supervisor or QP puts in place. If you do not it is considered a violation of resident's rights";
-8/23/18 staff meeting that included:
-Client #1 had a new treatment plan with diet consistency;
-Instructions for staff to follow Client #1's diet.

Interview on 9/4/18 with Client #1 revealed:

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-Client #1 responded to questions with vocal sounds that were not understandable.

Observation on 9/4/18 between 4:23 pm- 4:29 pm of Client #1 offered her dinner meal by staff revealed:
-Client #1's food appeared pureed consistency;
-Client #1 consumed sips of the liquid nutritional supplement.

Interview on 9/4/18 with Direct Support Residential (DSR) staff (Staff #4) revealed:
-Client #1's amount of liquid nutritional supplement had increased from 3 times day in 2017 to 5 times a day;
-Stated staff were trying to "get as much fatty foods in" Client #1 like peanut butter and more of the liquid nutritional supplement;
-"We try to get as much in her as possible."

Interview on 9/4/18 with Lead DSR staff (Staff #1) revealed:
-He and other staff continued to offer Client #1 the liquid nutritional supplement every day;
-Client #1 was getting used to the pureed food and her appetite seemed better;
-Client #1 had not gained significant weight;
 -Client weighed 75 pounds on 8/29/18;
 -He and other staff weighed Client #1 at the day program and recorded her weight on the weight log to track;
 -Client #1's doctor's office also weighed Client #1 at her doctor visits.

Interviews from 9/4/18-9/11/18 with the Qualified Professional revealed:
-She acknowledged Client #1's Food Tracker needed clarification by staff about the consistency of Client #1's food;
-She stated that Client #1's Food Tracker was still

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V 112	Continued From page 6 sent to Client #1's physician; -The staff initials on Client #1's MARs reflected that the liquid nutritional supplement was "offered and not consumed" by Client #1; -Client #1 had a Gastrointestinal consult scheduled 9/14/18 to determine her ongoing dietary needs. Due to the failure to accurately document the amount and times of Client #1's intake of the liquid nutritional supplement 5 times a day, it could be determined if Client #1 received the nutritional supplement as ordered by her physician.	V 112		
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is	V 537		

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V 537	Continued From page 7 demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions. (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures.	V 537		

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V 537	Continued From page 8 (h) Service providers shall maintain documentation of initial and refresher training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course;	V 537		

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(C) evaluation of trainee performance; and
(D) documentation procedures.
(7) Trainers shall be retrained at least annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule.
(8) Trainers shall be currently trained in CPR.
(9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach.
(10) Trainers shall teach a program on the use of restrictive interventions at least once annually.
(11) Trainers shall complete a refresher instructor training at least every two years.
(k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years.
(1) Documentation shall include:
(A) who participated in the training and the outcome (pass/fail);
(B) when and where they attended; and
(C) instructor's name.
(2) The Division of MH/DD/SAS may review/request this documentation at any time.
(l) Qualifications of Coaches:
(1) Coaches shall meet all preparation requirements as a trainer.
(2) Coaches shall teach at least three times, the course which is being coached.
(3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction.
(m) Documentation shall be the same preparation as for trainers.

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This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure staff were trained in the use of restrictive interventions affecting 1 of 3 sampled clients (Client #2). The findings are:

Review on 9/4/18 of Client #2's record revealed:
Date of Admission: 9/25/17
Diagnoses: Moderate Intellectual Developmental Disability, Glaucoma, Type 2 Diabetes controlled with diet and exercise, Seizure Disorder, Major Depressive Disorder-recurrent and moderate with aggressive tendencies
History: Self-injurious behaviors (falling face down toward floor, throwing herself into walls, used a tack to slit throat, cut wrist with an earring, used fingernails to dig into a wound and a pencil to stab self), onset of behavior problems reportedly after the death of Client #2's parent and occurred on the date of Client #2's birthday, and past accusations of abuse against residential staff and peers in former placement;
-6/1/18 treatment plan that contained:
-a crisis plan that noted Client #2 showed precipitating physical signs prior to attempts to self-harm (crying, rude to others and behaving nervously as examples);
-crisis intervention strategies with Client #2 included journaling thoughts, talking to staff, and excusing self from a situation to "self-calm";
-close staff supervision was needed for Client #2 to prevent self- injury;
-Client #2's behavioral support plan from a former placement was used as guidelines for staff intervention with Client #2;
-no reference to staff use of restrictive interventions with Client #2's attempts to harm

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self or others;

Review on 9/5/18 of facility incident reports from 7/14/18 to 9/5/18 revealed:
-8/29/18 at 7:45 am, 2 Level I written incident reports:
-1 of the 2 incident reports was signed and dated by the Group Home Manager (GHM);
-1 of the 2 incident reports was signed and dated by the Qualified Professional (QP);
-Client #2 presented on 8/29/18 with underarm bruises to the GHM and QP;
-No written statements in either report that Client #2 verbalized how the bruises occurred;
-Contained statements that:
-Client #2 could have gotten the bruises from staff assistance with getting off the floor due to Client #2's falling;
-Client #2 was "assisted" at home on 8/24/18 and again on 8/28/18 at day program during a fire drill;
-No explanation or description that defined what "assisted" meant;
-Client #2 was informed "staff had already told them" about Client #2 having fell and was "assisted";
-If Client #2 were to assist staff "in getting up, bruising may not occur";
-A treatment team was working on implementing a formal behavioral plan that addressed Client #2's falling behavior;
-A written entry on a staff communication log attached to 1 of the 2 incident reports and dated 8/24/18 that revealed:
-Client #2 was shaking "around bath time";
-Client #2 fell out of the kitchen chair and "onto her knees";
-Client #2 resisted staff assistance to "get up" and Client #2 "flailed around";
-Client #2 "spit in staff's face" when requested

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to get up off floor and sit on the couch;
-The GHM was contacted about the incident;
-Unable to determine what staff was involved with Client #2 when she fell on 8/24/18;
-There were multiple staff signatures beside the written communication log entry;
-9/4/18 at 5:00 pm, a Level I written incident report revealed:
-Client #2 fell on floor at the facility after showering and Client #2 got herself up from the fall;
-Client #2 had no reported injuries.

Further review on 9/5/18 of Client #2's record revealed:
-8/24/18 at 5:30 pm, 8/25/18 at 5:00 pm, 8/27/18 3:40 pm, 8/28/18 at 5:30 pm, 8/29/18 at 4:30 pm, 8/30/18 (no time) and 8/31/18 at 5:30 pm, Daily Body Check forms that contained a human diagram, the statement "Nothing to Report", with each form signed and dated by staff.

Review on 9/6/18 of Staff #2 and Staff #3's personnel record revealed:
-Both staff had received Part A formal training on alternatives to restrictive interventions.

Interview on 9/4/18 with Client #2 revealed:
-Client #2 reported bruises on both upper inside arms with a statement she was "drug on the carpet" by staff because she could would not stand up;
-Observation between 1:12-1:14 pm of Client #2 lifting up her arms and a horizontal bruise approximately 1 inch in length and bluish in color located on right upper inside arm, a horizontal bruise less than 1/2 inch in length and bluish in color located on left upper inside arm, and a scab on her left kneecap;
-Client #2 reported bruises came from Staff #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL012085	A. BUILDING: ______ B. WING ______	09/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
126 AIR PARK DRIVE APT. C	126C AIR PARK DRIVE MORGANTON, NC 28655

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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and Staff #3 lifting her up on by her arms on each side of her body;
-She had fallen after standing up from sitting on a chair at the kitchen table;
-She fell a lot because she did not have good balance;
-She did not use assistive equipment (cane, walker, wheelchair as examples) to support her balance;
-Had fallen in the living room and Staffs #2 and #3 would not let her get up;
-She was "drug on the carpet" by Staff #2 and Staff #3 the reason the carpet hurt her knee;
-She did not what day or time the aforementioned incidents occurred but recalled the incidents happened in the afternoon;
-She stated the incidents happened only one time where she was hurt;
-She had told the GHM what had happened;
-She did not feel safe at the home when Staff #2 was there;
-She was scared to say anything because "they would say I lied about it" and "I'm not lying";
-She wanted to be present with staff if anything was said about the incidents she reported;
-She agreed for the GHM to be present for remainder of the interview and Client #2 verbally disclosed the aforementioned incidents to the GHM.
 -Client #2 was consistent in her verbal disclosure of the incidents to the GHM;
 -The GHM stated that Client #2 had a history of lying on staff, throwing herself down and then blaming staff;
 -Client #2 responded that was true and the GHM was trying to help her.

Interview on 9/5/18 with the GHM revealed:
-Client #2 had a history of intentionally falling;
-Client #2 had a history of false accusations of

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	MHL012085	A. BUILDING: ______ B. WING ______	09/11/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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physical harm by staff that was "well documented" in her behavioral support plan;
-Client #2's falls had recurred after many months and the falls having escalated in last couple of months;
-Client #2 fell at her mother's home twice in 7/2018 and injured her head which resulted in a hospital emergency room visit;
-Client #2 fell on 8/28/18 at the day program and almost fell at her doctor's office;
-Client #2 was scheduled a neurology appointment in 10/2018 for assessment of an underlying medical cause of Client #2's falling;
 -The medical assessment was at the request of Client #2's guardian;
-Staff was aware that if Client #2 started shaking or appeared nervous, she was about to fall;
-Staff was only to intervene with Client #2 if the fall was "face down";
-She initially stated that Staff #2 and #3 used a "2-person assist or hold" on Client #2 and later stated it was a "2-person walk";
-The GHM demonstrated a "2-person assist or hold" by standing on one side of surveyor in a standing position and placing one arm underneath surveyor's arm;
 -She stated another staff would have been on the other side and placed one arm under surveyor's other arm;
-She stated that Staffs #2 and #3 had assisted Client #2 from the chair to sit on the sofa and had placed pillows on the floor to prevent Client #2 from injury;
-Staff #2 and #3 had called her (GHM) after they assisted Client #2;
-Staff conducted body checks on clients after client bathing times for any unusual marks;
 -Staff would not have seen Client #2's bruises because staff stand outside the bathroom when Client #2 is drying off from her shower;

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	MHL012085	A. BUILDING: ____ B. WING ____	09/11/2018

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-No response to knee scab was visual and not documented Client #2's Body Check forms in 8/2018;
-She stated that everything that Client #2 says was taken seriously by her and the group home staff.

Interview on 9/6/18 with the Qualified Professional revealed:
-Restrictive interventions were not used on the clients at the group home;
-Staff #2 and #3 called the GHM about their assistance to Client #2 after Client #2's fall;
-Staff #2 and #3 were interviewed separately and gave consistent accounts of their assistance to Client #2.

Interview on 9/11/18 with the Regional Services Director revealed:
-There were no restrictive interventions used on clients at the group home;
-The "2-person assist or hold" was not an approved intervention;
-There should have been an internal investigation of Client #2's allegation she had been harmed by staff.