STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-082	A. BUILDING: _____ B. WING _____	09/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWELL	2250 BALTIC STREET GASTONIA, NC 28054

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V 000	INITIAL COMMENTS A complaint survey was completed on 9/26/18. The complaint was substantiated (Intake #NC141792). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such 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	V 291		

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V 291	Continued From page 1 safety issues become a primary concern. This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to ensure coordination of care was maintained affecting 1 of 1 deceased client (DC#3). The findings are: Review on 9/11/18 of DC#3's record revealed: -admission date of 1/31/11 with diagnoses of Intellectual Developmental Disorder Severe, Cerebral Palsy and Seizure Disorder; -discharge date of 8/24/18 due to death from kidney failure; -DC#3 was confined to a wheelchair, nonverbal, limited mobility in arms and legs, seizures controlled by medications, had a feeding tube, needed food pureed, history of neglect by birth mother, contractures of multiple joints, had court appointed legal guardian. Review on 9/11/18 of a form titled "Physician Appointment Record" dated 7/20/18 and signed by a physician revealed the following documented: -DC#3 taken to a local urgent care office; -reason for appointment was "possible thrush and bladder infection;" -staff #1 took DC#3 to the appointment; -section on form titled "PHYSICIAN: Please write a brief summary of visit, including treatment/diagnoses/referrals/labs, etc.;" -under the above identified section the physician had documented the following: "1. Yeast/Thrush-Nystatin 5ml PO(onto cotton swab & apply to each side of mouth 4 times per day 2. Frequency-need urine sample(collection supplies given) 3. Fever-give Tylenol every 4-6 hrs(hours)	V 291		

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V 291	Continued From page 2	V 291		

& increase fluids 4. Low BP(Blood Pressure)-daily BP monitoring X 1 wk(week) if repeatedly < 90/60-Go to ER(Emergency Room)."

Review on 9/11/18 of DC#3's MAR for 7/2018 revealed the following documented:
-handwritten on MAR "Nystatin 100,00 units oral sup 5mls four times daily as directed, pour onto cotton ball, apply to each side of mouth 4 times daily;"
-the above listed medication was documented as administered from 7/20/18-7/31/18 as directed;
-handwritten on MAR "acetaminophen (generic for Tylenol) 500mg extra strength take 30ml every 4 to 6 hours as needed;"
-the above listed medication was documented as administered 7/21-7/24, 7/26-7/31;
-there was no documentation on the MAR for the daily monitoring of the BP for 1 week as ordered by the physician on 7/20/18.

Further review on 9/11/12 of DC#3's record revealed no documentation on another form of daily BP monitoring as ordered by the physician on 7/20/18.

Review on 9/12/18 of an internal investigation completed by the Director of Human Resources on 8/8/18 revealed the following documented:
-the QP(Qualified Professional) was reviewing medication administration records/orders on 7/28/18 and discovered the order dated 7/20/18 to monitor DC#3's BP for one week;
-the QP determined the order had not been followed;
-the QP notified Administration regarding DC#3's order to monitor BP for a week was not followed and an internal investigation was initiated;
-HCPR(Health Care Personnel Registry) was notified alleging neglect against the Former

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V 291	Continued From page 3 Group Home Mgr(FGH Mgr) and an incident report was completed; -the FGH Mgr stated she and the staff missed the order and the BP checks were not completed as ordered; -the FGH Mgr was demoted to a paraprofessional and transferred to another non-residential program where she will not be responsible for medication administration. Interview on 9/12/18 with the QP revealed: -was working direct care, was looking for another physician's order on 7/28/18(Saturday) and ran across the "Physician Appointment Record" form regarding DC#3 dated 7/20/18; -the form was still in a stack on the FGH Mgr's desk, not filed; -read over the form and saw the order to monitor DC#3's BP for a week; -checked DC#3's July 2018 MAR and saw it was not done; -asked staff #2 who was on shift about DC#3's BP monitoring and she stated she did not know anything about it; -tried to call FGH Mgr on Saturday and Sunday to find out about order but was not able to get a response; -when FGH Mgr came into work on Monday (7/30/18), asked the FGH Mgr about the order and she said she had not seen it; -the QP reported it was obvious by the way the FGH Mgr looked at the form she had never seen it; -the QP instructed the FGH Mgr to immediately contact DC#3's primary care physician (pcp) and inform her of the order to monitor DC#3's BP and it was not done, then ask for recommendations; -DC#3's pcp asked staff to monitor DC#3's BP for 3 days and then send the results to her; -the QP reported she was not even aware DC#3	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-082	A. BUILDING: _____ B. WING _____	09/26/2018

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V 291	Continued From page 4 went to the urgent care, FGH Mgr never notified her, the FGH Mgr stated she forgot to let the QP know; -the QP reported she was not aware of the orders for the BP monitoring until she discovered the form when looking through paperwork; -the FGH Mgr did not follow protocol of agency for medical appointments; -the FGH Mgr was supposed to take DC#3 to the medical appointment, not staff #3; -if an emergency and staff have to take a client for a medical appointment, staff contact the FGH Mgr with the results of the appointment, and put the "Physician Appointment Record" form in the FGH Mgr's bin on the desk and the FGH Mgr has to follow up; -FGH Mgr is responsible for getting information from the "Physician Appointment Record" form, placing new orders on the MARs, transcribing any new medications on the MARs, posting any new orders/medications on the "communicators" (a form to be posted on the staff board for all staff to see); -FGH Mgr should not have let staff #1 take DC#3 to appointment; -it was discovered FGH Mgr had been allowing staff to do a lot of her own responsibilities; -the FGH Mgr had not checked her stack of papers in her bin nor had she followed up with the form; -felt situation was FGH Mgr's responsibility, felt staff did what they were supposed to do; -did not re-train remaining staff after incident on coordination of care.; -in the process of looking for another GH Mgr. Review on 9/12/18 of a fax sheet from DC#3's pcp dated 8/3/18 revealed the following: -"BP Readings: 7/30/18 108/56, 8/1/18 97/54, 8/2/18 121/68, 8/3/18 92/61;"	V 291		

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	MHL036-082	A. BUILDING: _____ B. WING _____	09/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWELL	2250 BALTIC STREET GASTONIA, NC 28054

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V 291	Continued From page 5 -"Per [DC#3's pcp] Her readings are fine." Interview on 9/14/18 with staff #2 revealed: -worked 7 days on, 7 days off at the facility; -usually the FGH Mgr or the Lead Staff take clients to all medical appointments; -the FGH Mgr or Lead Staff let her know about any new orders, any new medications; -not familiar with a "Physician Appointment Record" form have to complete or what to do with it; -was not aware of any order to monitor DC#3's BP for a week; -if staff have to take a client for emergency medical care afterhours or on weekends, need to notify the FGH Mgr immediately. Interview on 9/13/18 with staff #1 revealed: -works at the facility 7 days on, 7 days off; -DC#3 had a low grade fever, took to the local urgent care on 7/20/18; -urgent care physician ordered an oral medication for the thrush in her mouth, was not able to get a urine sample, gave order for medication(Tylenol) for fever as needed; -had the urgent care physician complete the "Physician Appointment Record" form; -she wrote the medication Nystatin ordered by urgent care physician on DC#3's MAR; -DC#3 already had some Tylenol at the facility as needed and was already listed on DC#3's MAR; -does not know why the BP monitoring was not transcribed on the MAR; -after got back from the appointments with clients, put original "Physician Appointment Record" form in client's confidential book; -put copy of "Physician Appointment Record" form in client's MAR book; -relayed information to the FGH Mgr; -BP check was "overlooked, print was small."	V 291		

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	MHL036-082	A. BUILDING: _____ B. WING _____	09/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 291	Continued From page 6 Interview on 9/20/18 with the FGH Mgr revealed: -happened on a weekend; -she did not work on the weekends; -DC#3 had a low grade fever, staff were monitoring the fever; -the fever continued despite giving DC#3 some Tylenol; -she had been at the facility earlier but had left with instructions from the QP to the staff that if the fever persisted, take DC#3 to the local urgent care; -later, talked to staff #1 and the decision was made to take DC#3 to the local urgent care for the continued low grade fever; -staff #1 took DC#3 to urgent care, also for the suspected thrush in her mouth and a possible UTI; -staff #1 called her(FGH Mgr) back the evening of 7/20/18(Friday) when staff #1 and DC#3 returned to the facility that pm; -staff #1 related to her(FGH Mgr) DC#3 got some medication for her mouth, needed to follow up with her pcp and also try to get an urine sample to take back to the urgent care the next day for testing for the UTI as urgent care staff were not able to get a sample at the urgent care as DC#3 wears diapers; -staff #1 never related any information regarding monitoring DC#3's BP for a week; -staff #1 should have transcribed the BP check on the MAR; -FGH Mgr checked the MARs on a weekly basis; -all "Physician Appointment Record" forms went in the DC#3's confidential record and copies were placed in DC#3's MAR book; -if the "Physician Appointment Record" form has new orders or new information all staff need to know, the form is placed on the clipboard in the staff office for all staff to see and sign off they	V 291		

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V 291	Continued From page 7	V 291		

have reviewed it;
-once all staff have initialed the form, the form is filed in the client's confidential book;
-she has gone over this procedure with staff in meetings, can't say exactly when;
-"I believe the QP says it was my responsibility;"
-don't remember if a copy of the "Physician Appointment Record" form with the BP monitor order for DC#3 was placed in her MAR book;
-the QP pulled her into the staff office and asked her why the BP monitoring did not happen;
-she told the QP she never saw the order;
-the QP instructed her to call DC#3's pcp and inform her what happened and get recommendations;
-she did as the QP said and the pcp asked the staff to monitor DC#3's BP for 3 days and send results to the pcp for review which she did;
-usually the Lead Staff who works first shift during the week takes all clients to their appointments;
-only time regular staff take clients to appointments would be in the pm or on weekends, very rare;
-staff #1 had not taken any clients to the doctor in a while;
-staff #1 was focused on the thrush and the possible UTI, not the BP order;
-the Lead Staff know what to do for coordination of care;
-staff leave the completed "Physician Appointment Record" forms for her or the Lead staff;
-FGH Mgr would do oversight of staff to ensure everything was done properly.

Review on 9/25/18 of a Plan of Protection dated 9/25/18 and completed by the QP documented the following:
-"What will you immediately do to correct the above rule violations in order to protect clients

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POWELL	2250 BALTIC STREET GASTONIA, NC 28054

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V 291	Continued From page 8	V 291		

from further risk or additional harm? To immediately correct the action the QP has assumed the role of manager for the Powell home and is responsible for handling doctors appointments, including all follow up paperwork related to the appointment and staff notification regarding medication/order changes. After a doctor's appointment the QP will ensure that the physicians appointments record is posted for staff review. All new orders, order changes or changes to protocol will be communicated to staff using the physician appointment record form (to be placed in the MAR) and the COMMUNICATOR (to be posted on the staff bulletin board). Staff will read and sign both forms singling understanding;"
-"Describe your plans to make sure the above happens. QP will retrain all staff on coordination of care protocol, i.e. Doctors appointments, Therapy appointments, Psychiatric appointments and medical equipment. Training will be completed by 9/27/18."

DC#3 had a diagnoses of Intellectual Developmental Disorder Severe, Cerebral Palsy and Seizure Disorder. On 7/20/18 staff took DC#3 to a local urgent care for thrush, possible urinary tract infection and a low grade fever. A physician's order to monitor DC#3's BP daily for one week was provided to staff and the physician's order also instructed staff if DC#3's BP was repeatedly less than 90 over 60, DC#3 should be taken to the local emergency room. The QP found the order for the BP monitoring a week later in the FGH Mgr's stack of unfiled papers in the staff office and determined the BP monitoring was never conducted. The FGH Mgr and staff stated they did not see the order. This lack of coordination of care was detrimental to the health, safety and welfare of DC#3 and constitutes a Type B rule violation. If the violation

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	MHL036-082	A. BUILDING: _____ B. WING _____	09/26/2018

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POWELL	2250 BALTIC STREET GASTONIA, NC 28054

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V 291	Continued From page 9 is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 291		