STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL055-025	A. BUILDING: _____ B. WING _____	R 05/31/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLN COUNTY	2466 CARRIAGE LANE LINCOLNTON, NC 28092

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V 000	INITIAL COMMENTS An annual and follow up survey was completed on May 31, 2019. 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 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and	V 108		

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V 108	Continued From page 1 clients. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure continuous training of a staff (Staff #1) to meet the mh/dd/sa needs of a client (Client #3) according to her treatment plan. The findings are: Review on 5/29/19 of Client #3's record revealed: Date of admission: 10/4/10 Diagnoses: Down Syndrome, Moderate IDD, History of Petit Mal Seizure Disorder, Depressive Disorder with psychotic features rule out Bipolar Disorder, Sleep Apnea -Her 7/1/18 treatment plan included: -medical and behavioral information of her seizure diagnosis; -information about her use of a seizure helmet for face and head protection and a gait belt to be used by staff to support Client #3 when she walked; -a statement that while not all of Client #3's falls came from seizures, she could go into a seizure; -5/16/19, local hospital emergency room (ER) medical information which contained Client #3's diagnoses of seizure and facial laceration due to a fall; -Her ER discharge instructions had her with a scheduled neurology appointment on 5/24/19; -5/16/19, a written plan of protection by the Qualified Professional (QP) with safety measures for Client #3 that had an implementation date of 5/16/19 and included: -Client #3's gait belt would be used by staff when Client #3 was assisted with walking;	V 108		

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V 108	Continued From page 2 -Her hands would be free of objects (eating utensils, plates and cup); -She would be alerted by staff of possible obstacles to walk around; -She would have shatter-proof plates and cups; -5/23/19, a medical note that Client #3 had her sutures removed. Review on 5/28/19 of a written Level II report in the NC Incident Response Improvement System (IRIS) for Client #3 revealed: -Her fall occurred at approximately 7:20 am while she (Client #3) was assisted by staff (Staff #1) with walking; -Staff (Staff #1) held her by her gait belt; -Client #3's coffee cup was still in her hand at the time of the fall and the cup hit her over the eye which caused a gash and bruise to her face; -Staff #1 was unable to tell if Client #3 had a seizure or just fell; -The incident prevention measures were that staff would take Client #3's plate and cup to the sink so she would not have the items in her hand in case of a fall, and her gait belt would be used by staff when Client #3 was assisted with ambulation. Review on 5/31/19 of a local emergency medical service (EMS) written report dated 5/16/19 for Client #3 revealed: -EMS arrived at the facility at 7:27 am and found Client #3 sitting on the floor; -Staff (Staff #1) reported to EMS that as Client #3 took her dishes to the sink, Client #3 "stopped, became stiff and fell to the floor;" -She dropped her coffee cup, which shattered, and Client #3 had a cut above her right eye and a small cut under the right side of her chin; -Client #3 was monitored and assessed by EMS and was transported to a local hospital for further	V 108		

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V 108	Continued From page 3	V 108		

medical treatment;
-Client #3 had head protection.

Interview on 5/28/19 with Client #3 revealed:
-She had a fall at the home and hurt her head but was not in pain;
-Her fall happened in the morning because she had her coffee cup in her hand;
-She had a cut near her eye from the fall and went to the hospital.

Interview on 5/29/19 with Staff #1 revealed:
-She began work in 8/2018 as a direct support staff at the facility;
-Her work schedule was 7 days on and 7 days off;
-Her work duties were assisting clients with their daily living tasks that included meal preparation, medication administration, personal hygiene and ambulation when needed;
-Client #3 had a history of seizures but had not had a seizure "in a long time;"
-She stated that Client #3's symptoms of a seizure were that she tensed up and got stiff;
-She stated she did not see these symptoms prior to Client #3's fall on 5/16/19;
-Client #3's last fall prior to 5/16/19 was about 1-2 months ago and resulted in no injuries;
-She had no training in seizure management, but knew Client #3 was to wear her helmet in case she fell;
-Client #3 had on her helmet on 5/16/19 but her helmet did not cover her head around her eyebrow area where either her eyeglasses cut her or from the shattered coffee cup Client #3 had in her hand when she assisted her in walking to the kitchen with her plate and coffee cup.
-She had no formal training on client gait belt use;

Interview on 5/31/19 with the Group Home Manager (GHM) revealed:

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V 108	Continued From page 4 -He provided client-specific training to staff during their orientation that included Client #3's seizure symptoms which were jerking motions and stiffening up; -Client-specific training about Client #3 was provided to Staff #1 and which covered how staff were expected to respond to her seizure symptoms and gait belt use; -There had not been refresher training to staff regarding seizure management. Interview on 5/31/19 with the Qualified Professional (QP) revealed: -Facility clients who had a history of seizures or had a current seizure diagnosis could benefit from staff training on seizure management; -She would follow up on this need to get the staff training implemented.	V 108		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to be maintained in a clean, attractive and orderly manner. The findings are: Observation on 5/29/19 between 3:00 pm-3:05 pm of the first client bathroom located in the hallway near Client #1's bedroom revealed:	V 736		

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V 736	Continued From page 5 -A walk-in shower with a folded shower chair at one side of the shower and a white chalky-like substance appeared on all 3 of the shower walls and bottom of the shower. Interview on 5/29/19 with the Group Home Manager (GHM) revealed: -The white chalky-like substance was soap scum and he agreed this substance was significant on the walls and bottom of the shower; -He would ensure the soap scum was removed from the shower walls and bottom and that the shower was maintained in a clean manner.	V 736		
V 750	27G .0304(b)(3) Maintenance of Elec., Mech., & Water Systems 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (3) Electrical, mechanical and water systems shall be maintained in operating condition. This Rule is not met as evidenced by: Based on observation and interview, the facility's water system was not maintained in an operating condition and there were client bedrooms that were not well-lit. The findings are: On 5/29/19, observation at 3:02 pm of Client #3's bedroom and observation of Client #4's bedroom at approximately 3:10 pm on the same date revealed that both these bedrooms had dim overhead lighting which was not adequate for	V 750		

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V 750	Continued From page 6 Clients #3 and #4 to engage in their daily personal activities. Observation at 3:05 pm of the second client bathroom located in the hallway across from Client #4's bedroom revealed a sink which had overflowed with water and was spilling onto the bathroom floor. Interview on 5/29/19 with the Group Home Manager (GHM) revealed: -A work order would be placed by him to maintenance staff to correct the client bedroom lighting; -Clients #3 and #4 liked to spend time in their bedrooms; -The sink in the 2nd client bathroom had a clogged drain which resulted in the water overflow; -A work order would be placed by him into maintenance to correct the clogged drain. Further interview on 5/31/19 with the GHM revealed: -The 2nd client bathroom clogged drain had not been corrected; -He had placed a maintenance order for the sink drain to be unclogged and he was waiting on response from maintenance staff; -Clients who used the 2nd bathroom were temporarily using the first hallway bathroom to wash their hands and brush their teeth until the sink drain was fixed.	V 750		