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KELLY'S CARE II	521 OSCAR JUSTICE ROAD RUTHERFORDTON, NC 28139

(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
V 000	INITIAL COMMENTS A complaint and follow up survey was completed on July 22, 2019. The complaint was substantiated (intake #NC00153357). 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,	V 108		

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V 108	Continued From page 1 reporting, investigating and controlling infectious and communicable diseases of personnel and clients. This Rule is not met as evidenced by: Based on record review, observation and interview, 1 of 3 current staff (Staff #1) failed to be trained to meet the mh/dd/sa needs of 2 of 3 audited clients (Clients #1 and #4). The findings are: Review on 7/19/19 of Client #1's record revealed: -She was admitted on 7/24/09, was 63 years old and diagnosed with Mild Intellectual Developmental Disability (IDD), Schizoaffective Disorder, Generalized Anxiety, Diabetes Mellitus, Hypertension, Osteoarthritis and Vitamin B-12 deficiency. Review on 7/19/19 of Client #4's record revealed: -He was admitted on 6/4/10, was 76 years old and diagnosed with Mild IDD, Antisocial Personality Disorder, Hypertension, Osteoarthritis, Ambulatory Dysfunction, Recurrent falls, Chronic Obstructive Pulmonary Disease (COPD), Chronic Renal Disease, Nicotine Addiction and Hyperlipidemia. Review on 7/22/19 of Staff #1's personnel record revealed: -Date of Rehire: 7/15/19 -Position: House Staff -Training: Week of 7/10/19, her training included Mental Health/Developmental Disabilities competencies, Client Rights, job description duties, company policies, medication training and	V 108		

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V 108	Continued From page 2 client-specific competencies; -Job description duties included: -Providing instruction, training and direct care to clients in their activities of daily living and personal care; -Client medication administration and monitoring; -Knowledge of client-specific information to help clients meet their goals and objectives; -Notifying the Director of Operations/Clinical Director/Qualified Professional (QP) of any changes, incidents or other client information of significance; -Providing clients with instruction and counseling to guide them in problem-solving and/or decision-making; -The Director of Operations/Clinical Director/QP was identified as the staff supervisor. Interview on 7/18/19 with Staff #1 revealed: -She started work as house staff on the previous night of 7/17/19; -She received her job orientation and training during the previous week and from management staff that included the Registered Nurse (RN); -She was mentored by current staff # 2 and former house staff (FS #4) at the facility on 7/15/19 before she started her shift last night; -She worked at the facility before and left her job for 3 years before she returned on 7/17/19; -She was familiar with 5 of the 6 residents in the facility through her previous job at the facility; -She re-oriented herself to the clients and learned about Client #3 by reviewing each of the client records and discussed each client with staff; -The Registered Nurse (RN) had not been at the facility to work with her on medications or client care; -She did not know the diagnoses of Clients #1, #3 and #4 and made no attempt to access the client	V 108		

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V 108	Continued From page 3 records for this information; -She did not know the client-specific goals of Clients #1, #3 and #4 and guessed their goals were all similar and included completing their personal hygiene, taking their medications, and exercising; -She prepared the breakfast meal which included biscuits, gravy, sausage, peaches and pancakes; -Clients #1 and #4 were on "regular diabetic diets" which meant they ate regular foods if their blood sugar level was not high; -She was uncertain what number constituted high blood sugar level for each of these clients; -She asked Client #1 what her blood sugar level was the morning of 7/18/19 and Client #1 told her it was 89; -She thought Client #4's blood sugar level was 68 which was "fine for him to have a big breakfast;" -She was aware Client #4 was at risk for falls and stated she was to supervise him when he used his walker; -Client #4 liked to stay in his bedroom most of the time where he watched his television and had to be prompted by staff to come out of his room for his meals and go to his doctor appointments. Observation and interview on 7/19/19 at approximately 10:20 am of Staff #1's attempt to access client MAR information revealed: -She could not access the electronic MAR (E-MAR) to produce a client MAR; -She initially stated a paper MAR was used when the electronic MAR (E-MAR) system was not working; -She could not produce a paper MAR at the facility for review; -The Director of Operations/Clinical Director/QP called the facility and Staff #1 asked for instructions about how to administer client medications when the E-MAR was not working;	V 108		

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V 108	Continued From page 4 -She later stated that the client medications were able to be recorded when the E-MAR was not working. Interview on 7/22/19 with the RN revealed: -She provided medication administration training to new staff which included Staff #1; -Staff #1 was placed at a facility with experienced staff (Staff #4) to be mentored for 1 day; -She relied on the experienced staff to tell her the "weak spots" of a new staff; -After the 1 day of mentoring, new staff started their assigned shift; -She did not know when she last visited the facility; -She stated she knew she was there but "it was just a blur;" -She did not deal with the E-MAR system if the system went down; that was an issue for staff to let Information Technology (IT) know about; -She had no idea Staff #1 did not know where paper MARs and additional client medication packs were kept in the facility. 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 108		
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.	V 109		

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V 109	Continued From page 5 (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 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 and interview, the Director of Operations/Clinical Director/Qualified Professional (QP) and the Registered Nurse failed to demonstrate the knowledge, skills and abilities required by the population served. The findings are: Review on 7/18/19 of the Director of	V 109		

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V 109	Continued From page 6 Operations/Clinical Director/QP's qualifications revealed: -Date of Hire: 1/5/07 -Education: 1998, Bachelor of Science in Business Administration -Work experience in the field with populations diagnosed with Intellectual Developmental Disabilities and mental health since 2007; -Met the requirements of a QP. Review on 7/22/19 of a written job description for the position of Clinical Director which was signed on 6/3/08 by the Director of Operations/Clinical Director/QP revealed: -His essential job functions as a Clinical Director included: -Client care coordination with the clients served, their guardians, case managers, doctors and other service providers involved with each client's system of care; -Writing client goals and ensuring the goals were appropriate to the client needs; -Evaluating each client progress toward their goal achievement; -Evaluating incident reports per incident and on a quarterly basis; -Ensuring no abuse or neglect of the clients served was occurring; -Reviewing documentation related to client care and services; -Directing group home supervisors in their job duties and evaluating the supervisors' performances. Review on 7/22/19 of a written job description for the position of Qualified Professional (QP) and which was signed on 8/14/12 by the Director of Operations/Clinical Director/QP revealed: -His QP job responsibilities included: -Verbal and written communications with the	V 109		

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V 109	Continued From page 7 clients served, their families, the local Management Care Organizations (MCOs) and staff; -Assessing client strengths and needs and assisting in program planning; -Performing quality assurance and documentation checks to assure medical guidelines were followed; -Supervising service provision to assure all services and programs were delivered as specified in the plan; -Supervision of staff and operations; -Providing orientation and ongoing training to staff. Review on 7/22/19 of the Registered Nurse (RN)'s personnel record revealed: -Date of Hire: 4/25/18 -Licensed as a Registered Nurse with the NC Board of Nursing; -Work experience of 2 years with adults with mental health diagnoses; -A Privileging form dated 4/25/18 indicated the RN met the qualifications of an Associate Professional (AP). Interview on 7/22/19 with the RN revealed: -She had been employed for the licensee as a RN since 5/2018; -She did not know her specific position or job title; -Her job duties included: -matching doctor orders with client medications in the facility and on client MARs; -providing education and training to staff on client medical diagnoses and client medications; -serving as a liaison between each client's Primary Care Provider (PCP), home health agencies, pharmacy, and the staff to ensure everyone had the same client information; -She tried to make facility visits at least once a	V 109		

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month to check on client medications and to check on staff to identify further staff training needs;
-Client #4's frequent falls at the facility began in 1/2019;
-She did not know what caused his falls and guessed the falls were from increased physical weakness;
-His last fall was on or about 7/2/19 and she did not consider it a fall because he slid out of his wheelchair and onto the floor without having been injured;
-Staff called her and/or Director of Operations/Clinical Director/QP every time Client #4 fell, and they arranged for the facility transporter to take him onto the hospital;
-The transporter or a staff on duty at the facility at the time of Client #4's hospital discharge usually turned in his hospital discharge paperwork to her for review of his medications and any additional discharge instructions;
-Client #4 received home health services which included skilled nursing, physical therapy and occupational therapy;
-She did not have Client #4's home health care plan but could request a copy of the plan to be faxed to the office;
-She advocated for Client #4 to have a wheelchair the last time he fell and for him to have a medical social work evaluation to determine if he needed a higher level of care;
-She saw the Director of Operations/Clinical Director/QP daily in the office and discussed changes in clients' conditions which included Client #4's falls and hospital visits.

Interview on 7/19/19 with a medical social worker from a local home health agency revealed:
-5/12/19, home health services were physician-ordered and initially started with skilled

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nursing and physical therapy services due to multiple concerns about Client #4 that included:
-frequent falls, blood sugar and oxygen saturation levels, blood pressure, and treatment to a decubitus ulcer located on his buttock;
-6/17/19, medical social work services were physician-ordered to evaluate Client #4's need for a higher level of care and to assist him with an alternative placement if needed;
-Client #4 continued to receive skilled home health nursing services once weekly to monitor his vital signs in addition to his blood sugar and oxygen saturation levels;
-Physical therapy was provided to Client #4 from 5/13/19 until this service was discontinued on 7/10/19 because Client #4 had reached his maximum potential for the service;
-No occupational therapy had been physician-ordered or provided to Client #4 by the home health agency;
-There was not enough staffing at the facility to meet Client #4's daily and individualized care needs;
-Client #4 was his own guardian and he had agreed to move to a higher level of care facility;
-A medical form, a FL-2, was completed and signed by Client #4's physician on 7/10/19 for skilled nursing facility (SNF) level of care;
-She had contacted local SNFs for Client #4 to be moved but she had not yet found a bed opening;
-She stated she did not know she could ask the facility where Client #4 was placed to assist her with locating SNF care for Client #4;
-She stated she did not know who she would ask from the facility for help with Client #4's care coordination.

A confidential interview on 7/18/19 revealed:
-There was a lack of onsite supervision in place at the facility for staff to receive guidance about

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V 109	Continued From page 10 changes in client medical conditions such as elevated blood pressures, blood sugar levels, and their medications; -Staff were to call into the office and talk with the RN if they had questions about a client's medical condition or change in symptoms; -A nurse had not been seen at the facility during May 2019, June 2019 and through the week of July 8, 2019. -Staff prepared foods Clients #1 and #4 wanted instead of foods on their diabetic diet. Interview on 7/19/19 with the Director of Operations/Clinical Director/QP revealed: -The RN position was responsible for overseeing the medical care management of client care in the facility; -This responsibility included medical consultation with the clients' medical providers, scheduling client medical appointments and ensuring staff were trained in medication administration; -The RN position did not have a specified job description; -He was responsible for the client behavioral management of client care that included writing and updating client treatment plans and coordinating client care with the clients, their guardians and other provider agencies; -He acknowledged he was responsible for the overall care of each client in the facility but had to rely on the RN on the medical parts of client care because he did not have the medical knowledge or expertise; -Client #4 did not have any family or a legal guardian for him to coordinate his care needs; -He felt Client #4 needed a higher level of care because of his frequent falls that led to hospital visits; -Client #4 had not had any further falls since he received his wheelchair in 6/2019;	V 109		

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V 109	Continued From page 11 -The RN had not made him aware Client #4 fell in the facility on or about 7/2/19; -Client #4's physician ordered a home health services to assess his care needs; -He "pulled back" from decisions regarding Client #4's care when the home health agency became involved; -He allowed home health and Client #4 to make decisions about his care; -The RN talked weekly with the home health agency about Client #4 and relayed information to him that he needed to know; -He was not aware that Client #4 had a completed and signed FL-2 that medically recommended him for SNF care; -He had not spoken with the medical social worker about a higher level of care placement for Client #4; -7/19/19, he requested the local home health agency to fax their service information into his office; -He could place a one-on-one direct care staff with Client #4 immediately to ensure his daily care needs were sufficiently met while waiting on SNF placement. 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 109		
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	V 112		

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V 112	Continued From page 12 legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the 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 implement treatment goals and strategies to meet the presenting problems of 1 of 3 audited clients (Client #4). The findings are: Review on 7/19/19 of Client #4's record revealed: Date of admission: 6/4/10 Diagnoses: Mild Intellectual Developmental Disability, Antisocial Personality Disorder, Hypertension, Osteoarthritis, Ambulatory Dysfunction, Recurrent falls, Chronic Obstructive Pulmonary Disease (COPD), Chronic Renal Disease, Nicotine Addiction and Hyperlipidemia	V 112		

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V 112	Continued From page 13 -2/26/19, his treatment plan had Client #4: -responsible for self-monitoring his daily routine which included daily physical activities such as bathing, dressing, walking, and cleaning his bedroom; -responsible with staff assistance for maintaining his overall mental health and medical conditions with medication compliance, communication of changes in his health symptoms, and decision-making when he was faced with an unfamiliar or challenging issue; -with a crisis prevention strategy that his diet was the "most important step" to maintaining his health in the facility; -There was no updated treatment goals or strategies in Client #4's plan that addressed his presenting problems with ambulation, recurrent falls, urinary incontinence, or medical recommendations for a higher level of care; -10/3/15, original physician order for staff to check Client #4's vital signs (blood pressure, pulse, temperature and weight) once monthly and record; -His vital signs were documented on his 5/2019, 6/2019 and 7/2019 MARS on the first day of these months; -Except for weight gains of 3 pounds (lbs.) daily or 5 lbs. weekly, there was no written clarification in Client #4's record of his benchmark vital sign numbers to be used by staff to measure and report significant changes in his health conditions; -There was no documentation in Client #4's record of whether he received past or current home health services and what progress he made with this service provider. Review on 7/19/19 of Client #4's written hospital discharge notes from 2/8/19 to 6/3/19 revealed: -2/5/19-2/8/19, a local hospital admission and diagnosed with Ambulatory Dysfunction and	V 112		

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V 112	Continued From page 14 Recurrent Falls with discharged physician orders for a knee immobilizer when ambulatory and skilled nursing and physical therapy to be resumed for treatment of impaired ambulation; -5/11/19, a visit to a local emergency department (ED) and diagnosed with a fractured Pubic Rami (bottom of the pelvis comprised of the sitting bones) which resulted from a fall he had at the facility; -5/28/19 and 5/29/19, visits to a local ED due to falls at the facility diagnosed with a head injury and contusion; -His discharge instructions on both these ED visit dates indicated education was provided to Client #4 by hospital staff on fall prevention and home safety; -6/2/19, a local ED visit due to "multiple trauma" from a fall onto his walker in which he struck his head and diagnosed with a right-sided headache, left hand pain, and right hip pain with no medical findings of fractures to the head, hand or hip; -6/3/19, a return visit to a local ED and diagnosed with kidney failure, head injury, contusion, post-concussion syndrome with written discharge instructions that indicated education was provided to Client #4 by hospital staff on fall prevention and home safety; -His discharge instructions on this ED visit date included a recommendation for a follow up evaluation by Client #4's Primary Care Provider (PCP) for physical therapy and occupational therapy services. Review on 7/19/19 of a facility staff communication notebook revealed: -5/26/19 to 6/24/19, written communication staff notes about Clients #1, #3, and #4 that were written by various current and former staff; -A written note by Staff #3 and dated 5/26/19 had Client #4 on his bedroom floor from a fall during	V 112		

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which he hit his head and non-emergency medical service (Non-emergency EMS) was called to the facility;
-Staff #3 stated Client #4 "would not try to lift himself up at all" and non-emergency EMS personnel assisted her with his lift from the floor;
-6/2/19, a note by Former Staff (FS #6) had Client #4's return from the ED at about 12:00 pm and she placed a table at Client #4's bed "to limit some of his walking" as he was "very weak;"
-6/19/19, two notes signed by FS #6 with:
-The 1st note had Client #4's bed needed to be sprayed with bleach if he wet his mattress and for his window to be kept opened to "keep the urine smell down;"
-The 2nd note was not to allow Client #4 to remain seated in his chair because a therapist said he was to be up and walking to the restroom and to his meals;
-6/20/19 during the "morning," Client #4 fell in an unknown location and was checked by an unidentified staff who stated he had no injuries or complaints.

Review on 7/22/19 of a written physician's note for Client #4 revealed:
-5/7/19, his 3-month follow up medical visit for recurrent falls and difficulty walking;
-This note stated he " ...tends to sit all day. Not moving much. Sitting with feet dangling-does not elevate them ..." and "noticed wound on bottom. Does not move or rotate position much. Tends to stay in one spot;"
-The wound on Client #4's buttock was "skin breakdown;"
-She was concerned he was having weakness that was secondary to his immobility;
-Her medical treatment plan was for a local home health service involvement with facility staff for skilled nursing services and physical therapy to

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address with Client #4's balance and mobility problems and for medical treatment of his buttock wound.

Review on 7/19/19 of faxed home health service notes for Client #4 that were dated from 5/10/19 to 7/10/19 revealed:
-5/10/19, physician-orders for a skilled nursing (SN) assessment and a physical therapy (PT) evaluation;
-5/12/19, a written home health plan of care (POC) that contained:
  -physician-ordered SN visits twice weekly for 2 weeks and then once a week for 7 weeks with PRN (as needed) visits, and PT visits once a week for 1 week;
  -no physician orders for occupational therapy services;
  -goals for Client #4 that pertained to:
    -fall risk reduction;
    -ambulation of functional distances to complete his daily living activities;
    -safe transfers between varied surface heights and types;
    -increased knowledge of disease management for diabetes;
    -prevention of skin breakdown;
  -strategies had Client #4 and facility staff to:
    -identify and address home safety hazards such as lighting and allowing for Client #4's vision to adjust to lighting changes;
    -allow him time for his blood pressure to stabilize during position and transfer changes;
    -maintain a diabetic diet and use moisture barriers with proper hygiene to maintain skin integrity;
    -recognize/report signs and symptoms of changes in his health conditions.

Observations on 7/18/19 between 10:20 am and

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V 112	Continued From page 17 12:33 pm of the facility revealed: -10:20 am, a strong odor of urine in the facility hallways between the side door and Client #4's bedroom; -10:30 am, the urine odor was significant in smell in Client #4's bedroom which he shared with Client #2. Observations on 7/18/19 at 12:33 pm and 12:52 pm of Client #4 revealed: -12:33 pm, he was seated in a wheelchair in his bedroom and was watching television; -He wore a long sleeve shirt, pajama pants and had no shoes on his feet; -Both his feet appeared to be swollen with fluid; -12:52 pm, he entered the dining room using his rolling walker and as he sat down in a dining room chair, he physically struggled to move himself to the table to eat his lunch until he was assisted by staff; -His lunch consisted of a bologna sandwich on white bread with potato chips and slices of a halved banana, and an orange-flavored beverage. Interview on 7/18/19 with Client #4 revealed: -He had lived at the facility for 4-5 years; -He was okay if he moved somewhere else; -He used his wheelchair and a rolling walker to get around in the facility; -He had problems getting to the toilet in time; -He had falls at the home at times which caused him to be sent to the hospital; -He had gravy, bread and sausage for breakfast; -Staff prepared all his meals; -He was not on any special diet; -Staff gave him his medicine, helped with his shower and assisted him with changing his clothes.	V 112		

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V 112	Continued From page 18 A confidential collateral interview on 7/18/19 about Client #4 revealed: -He "always smelled of urine" because of his incontinence; -Staff kept his bed stripped of sheets in the daytime so he would not lay down and urinate on his bed; -He was placed in his wheelchair to watch television every day; -He tended to "wet" himself which caused him to have a sore place on his buttock; -He had frequent falls at the facility because there was not enough staff to supervise him and help him with his transfers in and out of bed and toileting while there were 5 other residents that needed their care needs met; -Client #4 needed to be in assisted living care instead of his current placement. Interview on 7/19/19 with Client #4's primary medical care provider revealed: -Confirmation of Client #4's falls which led to his local emergency room visits on 5/11/19, 5/26/19, 5/28/19, 5/29/19, 6/2/19, and 6/3/19; -The causes of his falls may have been related to his improper posture when sitting and standing and an imbalanced gait; -Client #4 was incontinent of urine and had a rash on his buttocks a couple of months ago; -The rash appeared to be the beginning of skin breakdown and could have resulted from him sitting in his urine most days; -Staff who worked at the facility were instructed by the PCP to change and turn Client #4 every 2 hours to prevent further skin breakdown; -He was last seen at the medical office on 7/2/19 and was found to be in need of "total care" and a local home health agency was seeking a skilled nursing facility (SNF) placement for Client #4.	V 112		

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V 112	Continued From page 19 Interview on 7/19/19 with the Director of Operations/Clinical Director/Qualified Professional revealed: -He was responsible for updating client treatment plans; -Client #4 needed a higher level of care because of his frequent falls since the beginning of this year that led to his hospital visits; -He stated Client #4 had not had a fall since he got his wheelchair in 6/2019; -Client #4's physician ordered home health agency to assess his care needs; -He had not updated Client #4's treatment plan with his presenting problems and needs; -He had not updated Client #4's treatment plan with new goals or strategies regarding his care which included his goals and strategies from his home health plan of care. 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 112		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by	V 118		

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V 118	Continued From page 20 unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to administer physician-ordered medications as prescribed and failed to keep current the client MARs affecting 2 of 3 audited clients (Clients #1 and #4). The findings are: I. Review on 7/19/19 of Client #1's record revealed: -Date of admission: 7/24/09 -Diagnoses: Mild Intellectual Developmental Disability (IDD), Schizoaffective Disorder, Major Depressive Disorder, Generalized Anxiety, Hyperlipidemia, Hypertension, Diabetes Mellitus, Osteoarthritis, Vitamin B-12 Deficiency, Alcohol Abuse-in remission;	V 118		

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-3/7/19, physician order for Atenolol-Chlorthalidone 50-25 milligram (mg), once daily to treat hypertension;
-No written order for self-administration of a blue-colored, over the counter pain relief gel.

Reviews on 7/18/19 and 7/19/19 of Client #1's MARs for May 2019, June 2019 and July 2019 revealed:
-7/18/19, Atenolol-Chlorthalidone had staff initials and was circled with an exception code that indicated the facility was out of the medication;
-7/1/19-7/22/19, Atenolol-Chlorthalidone was initialed by staff as administered to Client #1 on these dates with exception on 7/18/19.

Observations on 7/18/19 and 7/19/19 of Client #1's medications at the facility revealed:
-7/18/19 at 11:02 AM, the Atenolol-Chlorthalidone 50-25 mg was not present in the facility;
-At 1:12 PM, a container of the blue-colored, over-the-counter (OTC) pain relief gel was in Client #1's bedroom she shared with Client #6;
-This pain relief gel sat on top of Client #1's chest of drawers next to her television;
-7/19/19 at 9:30 AM, the Atenolol-Chlorthalidone was not present in the facility.

Observations and interviews on 7/18/19 at 10:46 am with Client #1 revealed:
-At 10:46 AM, Client #1's right knee appeared swollen in comparison to her left knee;
-She stated her knee was swollen and painful;
-She had to rest her knee about every 15 minutes when she did her chores such as sweeping and cleaning her bedroom;
-Her doctor talked with her about knee replacement surgery, but she was scared to have this surgery and decided against it;
-At 11:30 AM, she held a container of an OTC

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blue-colored pain relief gel in her hands;
-She asked if she was supposed to have a doctor's order for this gel;
-She applied the gel herself to her knees, back and shoulder when she felt pain;
-She kept the gel in her bedroom and staff knew she had the gel which she bought with her money.

Interview on 7/18/19 with Staff #1 about Client #1's medication revealed:
-She wondered about the Atenolol-Chlorthalidone medication not being at the facility this morning when she gave Client #1 her 8:00 AM medications;
-Client #1 was given the 1 tablet left in her pill pack the previous morning;
-She wrote this medication down to let the staff transporter know as he was supposed to be at the facility on this date;
-The transporter checked the medication carts when he came to the facility for client medications needed and he picked up discontinued medication packs for disposal;
-She would let the staff registered nurse (RN) call the pharmacy for a refill on the Atenolol-Chlorthalidone;
-She did not know Client #1 kept pain-relief gel in her bedroom; she must have bought it when she went shopping and did not tell staff she had it.

Interview on 7/22/19 with Staff #3 about Client #1's Atenolol-Chlorthalidone medication revealed:
-This medication was delivered to the facility on 7/20/19 which was the date she started her shift at the facility;
-She did not know why she initialed the medication pill pack as having arrived on 7/19/19.

Interviews on 7/19/19 and 7/22/19 with the RN

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V 118	Continued From page 23 revealed: -7/19/19, the RN stated that Client #1 had her Atenolol-Chlorthalidone medication dose administered to her this morning by staff; -Staff #1 called and told her Client #1 was administered this medication this morning and a refill on this medication was needed; -She called the pharmacy this morning and requested refill of the Atenolol-Chlorthalidone; -7/22/19, she relied on staff to let her know when client medication needed to be reordered; -Staff had been advised by her multiple times to call her or the pharmacy when client medications needed to be reordered; -Client #1 had standing physician orders for pain relievers like an over-the-counter (OTC) acetaminophen and this order likely included the pain-relief gel; -Client #1 did not have a physician order to self-administer her medications; -She did not have any written medication error reports because she "fixed any errors" by calling staff and making sure they gave the medication. Interview on 7/19/19 with the facility's contracted pharmacy revealed: -Client #1's Atenolol-Chlorthalidone was called into the pharmacy as a refill by the facility on this date, 7/19/19; -7/10/19 was the last dispense date on the Atenolol-Chlorthalidone with 30 pills; -7/12/19 was the medication delivery date to the facility; -The pharmacy technician understood this medication was not listed on the delivery sheet and the facility stated they did not receive the medication; -The pharmacist stated that 2-3 days without this medication was not life-threatening, but symptoms of edema and increased blood	V 118		

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V 118	Continued From page 24 pressure could result. II. Review on 7/19/19 of Client #4's record revealed: Date of admission: 6/4/10 Diagnoses: Mild Intellectual Developmental Disability, Antisocial Personality Disorder, Hypertension, Osteoarthritis, Ambulatory Dysfunction, Recurrent falls, Chronic Obstructive Pulmonary Disease (COPD), Chronic Renal Disease, Nicotine Addiction and Hyperlipidemia; -2/12/19, physician-prescribed: -Nicotine Transdermal Patch 14 mg/24-hour, apply one patch topically once daily in the morning (AM) and remove at bedtime (HS) to treat nicotine addiction; -Symbicort 80-4.5 micrograms (mcg), inhale 1 puff twice daily to treat COPD. Reviews on 7/18/19 and 7/19/19 of Client #4's MARs for May 2019, June 2019 and July 2019 revealed: -The written instruction for the Nicotine Transdermal Patch was to be applied topically once daily in the morning (AM) and removed at bedtime (HS); -The Nicotine Transdermal Patch and Symbicort medications were initialed on the MARs administered as prescribed; -7/1/19 at 7:54 AM had his glucose monitoring check initialed and circled by Staff #2 with an exception code reason that indicated the check was "withheld per DR/RN orders." Observation on 7/18/19 at approximately 11:00 AM of Client #4's medications revealed: -A date was marked on the Symbicort medication box that the medication was opened on 6/16/19 and had an expiration date of 7/16/19.	V 118		

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V 118	Continued From page 25 Observation and interview on 7/18/19 with Client #4 revealed: -During the interview that began at 12:33 pm, Client #4 had a congested cough; -He used to smoke cigarettes and had stopped smoking one year ago; -He wore a nicotine patch that helped him quit smoking; -He slept with his nicotine patch on every night and staff removed it every morning and put a new patch on; -He did not know the names of his medications; -He used an inhaler to help him breathe better. Interview on 7/18/19 with Staff #1 revealed: -She administered clients their medications as instructed on each of the client's MAR; -Client #4's Nicotine Patch was removed every morning and new patch applied on his body; -She had not noticed Client #4's Symbicort had expired but it had just expired. Interview on 7/22/19 with the RN revealed: -Client #4's doctor order for his Nicotine Patch, his MAR and the label on his Nicotine Patch box matched for placement on him in the mornings and removal in the evenings; -She thought staff understood these instructions; -House staff were trained on medications and MARs documentation before they entered a facility to work directly with clients and administer client medications. 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 118		

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V 289	Continued From page 26	V 289		
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 serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or	V 289		

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V 289	Continued From page 27 (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 record review, observation and interview, the facility failed to serve clients within the scope of its license, affecting 2 of 3 audited clients (Client #1 and Client #4). The findings are: CROSS-REFERENCE: 10A NCAC 27G .0203 Personnel Requirements (V108) Based on record review, observation and interview, 1 of 3 current staff (Staff #1) failed to be trained to meet the mh/dd/sa needs of 2 of 3 audited clients (Clients #1 and #4). CROSS-REFERENCE: 10A NCAC 27G .0203	V 289		

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V 289	Continued From page 28 Competencies of Qualified Professionals and Associate Professionals (V109) Based on record review and interview, the Director of Operations/Clinical Director/Qualified Professional (QP) and the Registered Nurse failed to demonstrate the knowledge, skills and abilities required by the population served. CROSS-REFERENCE: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) Based on record review, observations and interview, the facility failed to implement treatment goals and strategies to meet the presenting problems of 1 of 3 audited clients (Client #4). CROSS-REFERENCE: 10A NCAC 27G .0209 Medication Requirements (V118) Based on record review, observation and interview, the facility failed to administer physician-ordered medications as prescribed and failed to keep current the client MARs affecting 2 of 3 audited clients (Clients #1 and #4). CROSS-REFERENCE: 10A NCAC 27G .5602 (V290) Based on record review, observation and interviews, the facility failed to be staffed to respond to the individualized client needs of 1 of 3 audited clients (Client #4). CROSS-REFERENCE: 10A NCAC 27E .0101 Least Restrictive Alternative (V513) Based on record review, observation and interview, the facility failed to provide client services in a manner that promoted a respectful environment for 1 of 3 audited clients (Client #4). Review on 7/19/19 of an initial Plan of Protection dated 7/19/19 and completed by the Director of Operations/Clinical Director/QP and a designated	V 289		

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V 289	Continued From page 29 QP to oversee the plan and signed by the designated QP on 7/19/19 revealed: What will you immediately do to correct the above violations in order to protect clients from further risk or additional harm? "Effective immediately (7/19/19): A second staff member shall be on site to support and monitor needs of clients. Staff will be advised to contact on call person if any emergencies arise. Staff will check client 4's blood pressure 4 times daily coinciding with pulse oxygen checks at 8 am, 12 pm, 4 pm, and 8 pm. Per [local home health provider], staff should seek medical attention for consumer if systolic blood pressure exceeds 160, if diastolic blood pressure exceeds 100, if blood ox levels drop below 87, if heart rate exceeds 110, or if heart rate goes below 50. Blood pressure and heart rate readings to be recorded on provided form. These guidelines have been provided to staff and will be incorporated into client's treatment plan as well. Staff has been advised not to refer to any client by any nicknames. Staff will report any incidences occurring to on call person as soon as the safety and well being of clients has been established and any required incident reports shall be filed within 24 hours. We have begun reaching out to other facilities and resources seeking a higher level of care for client #4. These efforts will continue until such time that appropriate level of care placement is obtained. Spoke with representatives from [local home health provider] on evening of 7/19, and they are seeking other placement as well." Describe your plan to make sure the above happens. "Overall implementation will be supervised by [the designated QP]. Residential supervisors will perform onsite visits at a minimum of 12 hour intervals to review documentation and the status of client and report	V 289		

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V 289	Continued From page 30 any concerns to [the designated QP] or on call staff. Staff that will be working on site between now and 7/23 are being trained on these protocols as of 7/19. Training for additional staff will be conducted beginning 7/22 and continued as necessary." Review on 7/22/19 of an amended Plan of Protection dated 7/22/19 and completed by the Director of Operations/Clinical Director/QP and the designated QP for an additional citation of 10A NCAC 27G .0209 Medication Requirements to the 7/19/19 Plan of Protection which was signed and dated by the Director of Operations/Clinical Director/QP revealed: What will you immediately do to correct the above violations in order to protect clients from further risk or additional harm? "Beginning 7/22 and continuing as needed, staff will receive refresher training on med. admin. (electronic MAR) usage, and company policies and procedures relating to these areas. Will review appropriate procedures for checking in medications, how and when to reorder medications, and appropriate action to take when a medication dose is missed or medication error is made. Staff will be observed doing a med pass, and instructed on proper methods in any areas they are lacking." Describe your plan to make sure the above happens. "Registered nurse will provide training. [The Director/QP] and [the designated QP] will supervise the implementation and make sure all staff are retrained. MARs, medication administration, and med cart to be quality checked at a minimum of weekly." Client #4, age 76 years old, was admitted on 6/4/10 with diagnoses of Mild IDD, Antisocial	V 289		

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Personality Disorder, Hypertension, Osteoarthritis, Chronic Renal Disease, Nicotine Addiction and Hyperlipidemia. He was diagnosed during a 2/5/19 hospitalization with Ambulatory Dysfunction. Client #4 fell 11 times in the facility between 4/17/19 and 7/2/19 (4/17/19, 4/18/19, 4/24/19, 4/28/19, 5/9/19, 5/11/19, 5/28/19, 5/29/19, 6/2/19, 6/3/19 and 7/2/19).Of those occurrences, 5 falls resulted in hospital visits (5/11/19, 5/28/19, 5/29/19, 6/2/19 to 6/3/19) with injuries that ranged from a diagnosed fractured pubic bone on 5/11/19 to head injury and a contusion on 6/3/19. Although a local home health service was ordered by Client #4's physician on 5/10/19, he continued to have recurrent falls. His treatment plan was not amended to include strategies for fall prevention, urinary incontinence or his need for additional staffing and a higher level of care until 7/19/19.

Client #1 had diagnoses which included Mild Intellectual Developmental Disability (IDD), Schizoaffective Disorder, Hyperlipidemia, Hypertension, and Osteoarthritis. Her physician-ordered medication, Atenolol-Chlorthalidone 50-25 milligram (mg)), was to be taken daily to treat her hypertension. The facility's system for refilling client medication was not followed by facility staff and the Registered Nurse (RN) to ensure the pharmacy had delivered her medications on 7/12/19. Due to discrepancies in verbal accounts by the RN, Staff #1 and Staff #3 it was not possible to determine how many doses of the antihypertensive medication were missed. There were no written medication reports that provided for clarification on Client #1's missed medication doses and no documentation by Staff #1 or the RN indicating notification of a physician or the pharmacy for the missed doses. The failure to administer Client

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V 289	Continued From page 32 #1's medication as ordered increased the risk of uncontrolled blood pressure and edema. This deficiency constitutes a Type A1 rule violation for serious neglect and harm and must be corrected within 23 days. An administrative penalty of $2,000.00 is imposed. If the violation is not corrected within 23 days, an additional 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 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by	V 290		

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V 290	Continued From page 33 the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review, observation and interviews, the facility failed to be staffed to respond to the individualized client needs of 1 of 3 audited clients (Client #4). The findings are: Review on 7/19/19 of the facility's written staff schedule for May 2019 through July 2019 revealed: -Staff schedules indicated one house staff was present each day at the facility per shift; -June 2019 had Staff #3 working as house staff. Review of written facility incident reports regarding Client #4's falls in April 2019 revealed: -He had recurrent falls on the following dates with Former Staff (FS #5) and Client #2 having	V 290		

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physically lifted Client #4 after each fall:
-4/17/19 in his bedroom which resulted in a bruise on his right side and a small bruise on his buttock from his fall, 4/18/19 in the bathroom, 4/24/19 in the dining room, and 4/28/19 in his bedroom which resulted in a "skinned up" right knee;
-His falls on 5/11/19, 5/28/19, 6/2/9 and 6/3/19 indicated one staff was on duty and there was non-emergency medical service involvement to assist staff (Former Staffs #4, #6, #9) and Current Staff #3 with Client #4's lifts and transports to a local hospital.

Interviews on 7/18/19 with Clients #1, #2 and #3 revealed:
-One staff was always present at the facility with them;
-If two staff were present at the facility, it was because one staff was new and being trained.
-The residential services supervisor visited the facility to check on all the residents and staff, but she did not stay long and did not assist with their daily care;
-Former Staff (FS #4) quit her job and Staff #1 returned to work as staff.

A confidential interview on 7/18/19 revealed:
-1 staff per 6 clients per shift worked at the facility unless there was a new person being trained as house staff;
-The staff work schedule varied in the number of days and depended on the number of staff available to work at the facility;
-Staff #3 was working a shift alone when Client #4 fell in May 2019 and in June 2019 with both of his falls having resulted in injuries and hospital visits;
-FS #5 depended on Client #2 to help her lift Client #4 off the floor when he fell in April 2019

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V 290	Continued From page 35 because there was no additional staff available to help her respond to Client #4's falls. Interview on 7/22/19 with the Director/Qualified Professional (QP) revealed: -Staff knew they could call emergency medical services or the non-emergency medical service for additional assistance with Client #4's falls; -He would increase facility staffing with an additional staff on to monitor and meet Client #4's individual and daily needs. 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 290		
V 513	27E .0101 Client Rights - Least Restictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include:	V 513		

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V 513	Continued From page 36 (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use. This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to provide client services in a manner that promoted a respectful environment for 1 of 3 audited clients (Client #4). The findings are: Observation on 7/18/19 at approximately 12:30 pm of Staff #1's verbal communication with Client #4 revealed: -She referred to Client #4 by his nickname; -Client #4 did not verbally acknowledge the nickname and made no eye contact with Staff #1. Observation and interview on 7/18/19 at 12:33 pm with Client #4 revealed: -He wanted to be called by his first name and not by his nickname "Pops;" -He made eye contact with a surveyor when he verbalized this want. Interview on 7/18/19 with Staff #1 revealed: -All staff called Client #4 by his nickname and she was not aware this bothered him. Interview on 7/22/19 with Staff #3 revealed: -She called him by both his name and nickname and did not know he did not like his nickname. A confidential collateral interview on 7/18/19 about Client #4 revealed: -He "always smelled of urine" because of his incontinence;	V 513		

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V 513	Continued From page 37 -Staff kept his bed stripped of sheets in the daytime so he would not lay down and urinate on his bed; -In May 2019 until 6/24/19, he had no blinds in his bedroom window next to his bed which resulted in Client #4 laying in bed with no protection from the sun and no privacy during this period of time; -There blind was removed because the blind had broken pieces and needed to be replaced; -The blind was hung in Client #4's window on 6/24/19. Interview on 7/22/19 with the Director/Qualified Professional (QP) revealed: -Client #4 had been a resident of his facility for about 10 years and never seemed to be bothered by his nickname "Pops;" -He would make it known to staff to respect Client #4's wish to be called by his first name and not use his nickname any longer; -He was not aware of Client #4 having been without a window blind from May until 6/24/19. 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 513		