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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 12/18/19. The complaint was substantiated (Intake #NC00158460). 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 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on record review and interview one of one	V 512		

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former facility staff [FS#1] failed to protect 1of 5 clients (#1) from harm and neglect. The findings are:

Review on 12/6/19 of Former Staff #1's (FS#1) record revealed:
- Hire date of 8/14/17 as a Paraprofessional
- Termination date is 11/3/19
-Review of documentation of all required training is current.

Review on 12/6/19 of client #1's record revealed:
- He was admitted into the facility on 6/13/05
- He is diagnosed with Intellectual or Developmental Disability, Cerebral Palsy, and Anxiety Disorder.

Record review on 6/18/19 of a facility incident report dated 10/23/19 revealed:
"Provider was informed by Day Support staff that consumer was behaving strangely; Group Home provider went to pick him up and at the time she noticed a scar on the right side of his face and on his right elbow. Provide question him as to what happen to obtain information about his injury. Consumer stated that no one had injured him and he didn't know what had happen. Provider then transported/accompanied him to Wake Med. The consumer was examined by medical staff and provider was informed that he possibly had a UTI (Urinary Tract Infection), several attempts were made to conduct other scans but was unsuccessful due to his refusal to cooperate and him moving around. Consumer was released from hospital with close monitoring, provider notice that he was not his normal self and decided to call the paramedic for further evaluation and follow up. It was at the time that provider was informed of a possible skull fracture. For further monitoring it was decided to keep

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consumer over night for further monitoring and testing".

Record review on 6/18/19 a local hospital report dated 11/3/19 revealed
" [Client #1] is a 40 year old male with PMHx (Past Medical History) of developmental delay, cerebral palsy, Reye's syndrome chronic LUE(Left Upper Extremity) contracture and right ete blindness and recent admission for skull fracture and epidural hematoma who presented to the ED today with increased agitation

Of note, the patient was admitted from 10/23/19-11/1/19 following a reported fall on 10/21/19 with resultant altered mental status. He was initially seen at Wake Med but a CT (Computed Topography) scan was unable to be obtained due to the patient being uncooperative. He continued to be lethargic with additional falls and ultimately presented to DRH ED (Durham Regional Hospital Emergency Department) where on the CT he was found to have a left frontal epidural hematoma with bifrontal contusions and skull fracture. His labs also demonstrated rhabdomyolysis. Throughout that admission his neuro exam improved slightly and he was ultimately discharged to a local nursing home for further care with plans for follow up CT scan on 11/21/19

There is a question of whether or not patient's initial injury was due to a fall or deliberate trauma. An APS report has been initiated for this".

Record review on 12/18/19 of a written statement from FS #1 dated 10/28/19 revealed:
"I woke up [client #1] was laying on the living room floor. The table and the lamp had been moved. So I called [owner] and she told me to try

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to get him up. I tried to get him up, but I couldn't do it by myself. So someone tried to help me get him up. So we couldn't get him up. I called [owner] she told me she was sending [owner's husband] over. It took a minute before [owner's husband] came. So he was trying to help [client #1] up. [Client #1] had used the restroom on himself. I then tried to remove his clothes so I could give him a bath. [Owner's husband] helped me get his stuff off. He then called [owner] and told her that [client #1] needed to go to the hospital, so [owner] came over. She proceeded to check on [client #1]. She told me to call EMS after I got him cleaned up. Then I called EMS to come over to the Group Home. So when they got there they proceeded to take [client #1's] vital signs. He had a fever his temperature was 101.5. I explained to what was going on with him. The EMS worker told me that it sounded like he had a UTI. So they got the medical chair in to help him get to the ambulance. So they stood [client #1] up and put him in the chair. The EMS had called the fire department to come assist them with putting him on a stretcher. They did proceed to put him up there. Afterwards the EMS took him to the hospital. I drove behind them. When I got to the hospital. I told the nurse who I was and that I needed to go back there with him. So then the doctor came in and I explained to him what had happened. So he said he was going to do a CT scan and take some blood work. So at this time his parents came in. I was explaining to them on what had happened. So after I told them the transporter came to take [client #1] to get a CT scan done. So I asked his parents if they wanted to go back with him to take the CT scan. So then the nurses came back to take his blood work. So they stuck him two times and didn't get anything. So they went to get another nurse to do it. So the other nurse came in and was able to get his blood

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work. So they came back and said he had a skull fracture and some bleeding around the skull. So we were shocked about the results and the situation. The doctor said he was going to get a neurosurgeon to come in to talk to us about what they had planned to do. As neurosurgeon was in the room with [client #1] his sister came in with an attitude. So the doctor explaining to us what was going on and showed us his CT scan results. So I texted [owner] and told her what was going on. She said she was on the way. The doctor said that they was going to put him in ICU so they can keep a eye on him".

Note: The DHSR surveyor was unable to interview client #1, due to his level of functioning.

Note: The DHSR surveyor attempted to contact FS #1 on 12/18/19 for an interview, however; she was not available.

During an interview on 12/18/19 the Licensee stated :
- "[FS#1's] story became inconsistent throughout the internal investigation".
- "[FS#1] initially reported that [client #1] was picked up by his assigned transportation service and transported to his Day Program. She also reported [client #1] had fallen getting onto the van".
- she received a phone call from the Day Program staff that [client #1's] head was swollen and he didn't seem like himself. They felt he needed to be assessed by a medical doctor.
- The Day Program confirmed FS #1 dropped client #1 off at the Day Program in her personal vehicle.
- "I immediately went to the Day Program and transported [client #1] to the hospital. He was evaluated and admitted into the hospital for UTI

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V 512	Continued From page 5 and a fractured skull". - "[Qualified Professional] and I met with staff #1 regarding the inconsistency of her story involving client #1. She was placed on administrative until the internal investigation was completed. After we completed the investigation we decided to terminate [FS#1]'s employment". - She acknowledged that FS #1's written statement was not true. In addition, the Licensee and the Qualified Professional called the Transportation Service and they confirmed they did not pick client #1 up from the facility the day of the incident. Review on 12/18/19 of a Plan of Protection dated 12/18/19 written by the Qualified Professional revealed: - "What immediate action will the facility take to ensure the safety of the consumer in your care? [Facility] is a residential facility that we believe provides the best care possible for residents with a developmental disability. [Facility] goal is to enhance the lives of residents by providing a strong support system that would strengthen their provision of hope to live as independently as possible. Our hope is to maintain and promote stability, self-confidence, self-esteem and motivation through encouragement and care. [Facility] helps residents from all ethical background to become independent in many settings such as habilitations, training, vocational and instructions as well as developing moral ethics, supporting the desire to positively engaging in a healthy lifestyle while in the home and in the community as a productive citizen. [Facility] services are carried out with quality, respect, commitment, and integrity for every resident.	V 512		

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V 512	Continued From page 6 The immediate action the facility is currently implementing to ensure the safety of each resident in our care is as follow: " [Inez House HC] will ensure that in the event of an injury or accident [Inez House HC] will immediately contact the authorities and will thoroughly document event and contact entities such as State reporting system, DSS, Health Care Registry and Alliance Behavioral Care. " [Inez House HC] will ensure that monthly supervisions are conducted more frequently with unexpected visits and schedule visits and will notate each visit. " [Inez House HC] will ensure that each resident is properly supervised appropriately with a daily check off supervision log (this log will document their morning to evening activities daily). " [Inez House HC] will interview each resident upon schedule and unscheduled visit (this is already done, however, the interview will be enhance with review of body such as any noticeable scares, bruises etc, asking open end questions and ensuring no negative verbal communication has occurred such as any form of verbal abuse). This will be conducted by administrator and QP only (please note it will be no invasion of privacy but external review only (looking upon them noting any review of marks etc). " [Inez House HC] will ensure that each employee is thoroughly trained before working with the resident with any/all additional training provided if needed. Each employee will sign documentation after training that they understands each process and they are able to perform the job expected (this process has been in place, however moving forward, we will ensure	V 512		

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that additional training is completed before employee is released to work with residents. Should administrated recommend that employee receives more training but the employee disagree, that employee will not be release to work within the group home until all requirement, acknowledgement has been completed with satisfaction of administrator.

" [Inez House HC] will ensure that all supporting documentation is available for review.

" [Inez House HC] will ensure a stronger documentation system by adding a daily ledger of daily activities. This ledger will be a check off ledger of each resident and will be mark (by their initial) by staff member working. This ledger will be completed throughout the shift and will end at the end of the shift daily by them signing that each item stated on the form was conducted and completed. The results of the form will be kept in a daily binder. Should there be any issues stated on forms, those issues will be address immediately by notification of the administrator and/or QP.

" Additional daily contact will be conducted.

" [Inez House HC] will conduct additional monthly meeting to decrease any opportunities of a safety risk. Please note that should a risk be discover/identified it will be address immediately.

" [Inez House HC] will provide each employee feedback (positive or negative) and will address any/all concerns.

" [Inez House HC] will ensure that each Personal Centered Plan is carried out to the best of ability and will ensure that all revisions of PCP will be completed or discontinued as needed.

" [Inez House HC] will update plans to revisions and will include any changes such as any/all medical care and instructions after discharges etc.

" [Inez House HC] will do everything possible to

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V 512	Continued From page 8 safe guard each resident. " [Inez House HC] will ensure the safety and security of each resident by any means necessary and will document any/all changes necessary with additional training to ensure knowledge of each employee. Describe your plans to make sure the above happens. " [Inez House HC] will conduct unscheduled visits and will provide feedback, dismiss or provide additional training should it is seen to be warranted immediately. " [Inez House HC] will ask open end questions to each resident to ensure safety is being provided and they are secure with the staff member engaging services (Not fearful of staff member etc). " [Inez House HC] will continue to provide training and will enhance any training necessary with the employee signing that they have completed training satisfactory. " [Inez House HC] will note and inquire immediately any changes to residents such as new marks/scares or behavior and will address change/issues immediately (this will be done by review of anything noticeable by eye view. No invasion of privacy will be conducted at anytime. " [Inez House HC] will provide continuing staff meeting addressing any/all concerns if found and will implement a procedure of how addressing the concerns will be carried out (such as time frame of completion of course is needed, additional training is conducted by a certain time frame, better time management in completing a task etc). " [Inez House HC] will ensure that each Personal Centered Plan is carried out to the best of ability and will ensure that all revisions of PCP	V 512		

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will be completed or discontinued as needed.
" [Inez House HC] will update plans to revisions and will include any changes such as any/all medical care and instructions after discharges etc.
" [Inez House HC] will report any/all finding to the property entity and will follow all recommendation / protocol and procedures to the maximum expectation to ensure safety of residents.
" House HC, LLC will provide each employee feedback (positive or negative) and will address any/all concerns. House HC, LLC will dismiss any employee that is not performing as needed.
" [Inez House HC] will ensure that each Personal Centered Plan is carried out to the best of ability and will ensure that all revisions of PCP will be completed or discontinued as needed. For best practice [Facility] will continue to utilize the PCP as the driving document and will update with strong details as needed and will follow all guidelines".

Client #1 is diagnosed with an Intellectual or Developmental Disability, Cerebral Palsy, and Anxiety Disorder. The day program staff where Client #1 attended contacted the Licensee regarding his concerns about unusual behavior exhibited by Client #1 and a slightly swollen area on the left side of Client #1's head. Client #1 was taken to the hospital and examined by a medical doctor and the results of the examination determined that client #1 had sustained a skull fracture and had a urinary tract infection. FS #1 reported to the Licensee and Qualified Professional regarding an incident involving client #1 on October 31, 2019. Staff #1 initially reported that client #1 had fallen while getting onto a transportation van. An internal investigation was conducted by the Licensee and Qualified

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V 512	Continued From page 10 Professional. During this investigation, it was discovered that staff #1 had reported false information about the incident and Client #1 being transported by the day program van. It was discovered that FS #1 had transported Client #1 to the day program. FS #1 was immediately placed on administrative leave during the internal investigation. FS #1 was terminated after the completion of the investigation because it was determined that she had reported false information regarding the incident and the physical injury to Client #1's head. This deficiency constitutes a Type A1 violation for serious harm and neglect 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 per day will be imposed each day the facility is out of compliance beyond the 23rd day.	V 512		