STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL021-013	A. BUILDING: _____ B. WING _____	R 01/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUKE STREET FACILITY-EDENTON	200 LUKE STREET EDENTON, NC 27932

(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 An annual & follow up survey was completed on January 3, 2020. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability	V 000		
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. (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.	V 109		

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	MHL021-013	A. BUILDING: _____ B. WING _____	R 01/03/2020

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LUKE STREET FACILITY-EDENTON	200 LUKE STREET EDENTON, NC 27932

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V 109	Continued From page 1 (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 observation, record review and interview the facility failed to ensure one of one Qualified Professional (QP) demonstrated the knowledge & skills required by the population served. The findings are: Review on 12/31/19 of the QP's position description revealed: - signed 6/22/18 - ensure consumers receive the needed services and interventions from appropriate program staff necessary for active treatment - monitor all data for all assigned consumers on at least a weekly basis to ensure appropriate frequency and accuracy - ensure completion of monthly home inspection reports and to take appropriate action to ensure that all Life, Inc. property and equipment is well maintained and proper working order Review on 12/30/19 of an initial evaluation for client #5 revealed: - "7/12/18...staff report he has had several falls recently and requesting physical therapy evaluation..." - "7/16/18...referred to physical therapy to assess him for need or use of walker or cane...has fallen several times in the last few months... falls often toppling over when he leans	V 109		

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	MHL021-013	A. BUILDING: _____ B. WING _____	R 01/03/2020

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LUKE STREET FACILITY-EDENTON	200 LUKE STREET EDENTON, NC 27932

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V 109	Continued From page 2	V 109		

forward to pick up objects off floor...has a shuffling gait pattern also contributed into gait instability..."

Review on 12/30/19 of incident reports requested for the last six months for client #5 revealed:
- "11/11/19...in room going through his trash. Felt down when bending over to pick trash off floor and received carpet burn on forehead..."
- "12/9/19...returned home from [psychosocial rehabilitation] and brought his lunch box into his bedroom...a short while later staff heard [client #5] yelling from his bedroom...was found laying on the floor trying to get trash from under his bed...no injuries
- "12/13/19 ...fell down in his bedroom due to messing with his trash bag putting more trash in...staff heard [client #5] yelling very loud when staff got to his bedroom he was lying on floor on top of trash bag...no injuries"
- "12/22/19 - fell in his bedroom. staff did not see him fall but heard him yelling for help. When staff arrived he was lying on the floor. When assessed for injury [client #5] stated his arm hurt. Bruising was noted on his buttocks, left eye and left shoulder. [Client #5] was taken to the emergency room and diagnosed with nondisplaced fracture of left clavicle..."
- "12/24/19...was laying in bed but he got up out of bed to get his trash bag consumer called for staff where found [client #5] on his knees by his bed...no injuries"

During interview on 12/31/19 the QP reported:
- she visited the facility once or twice a week, more if needed
- she assisted with direct care; reviewed incident reports; completed treatment plans, however if the clients had a care coordinator, she only completed the short range goals

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	MHL021-013	A. BUILDING: _____ B. WING _____	R 01/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUKE STREET FACILITY-EDENTON	200 LUKE STREET EDENTON, NC 27932

(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 109	Continued From page 3 - client #5 had a history of falls - she developed a fall log for client #5 this month (December 19) but had not implemented it yet - client #5's treatment plan was a team effort to determine goals This deficiency is cress referenced into 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (V112) 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 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.	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL021-013	A. BUILDING: _____ B. WING _____	R 01/03/2020

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LUKE STREET FACILITY-EDENTON	200 LUKE STREET EDENTON, NC 27932

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V 112	Continued From page 4	V 112		

This Rule is not met as evidenced by:
Based on observation, record review and interview the facility failed to develop and implement strategies for 1 of 3 audited clients (#5). The findings are:

A. Cross-reference tag (V109). 10A NCAC 27G .0203 COMPETENCIES OF QUALIFIED PROFESSIONALS AND ASSOCIATE PROFESSIONAL. Based on record review and interview the facility failed to ensure one of one Qualified Professional (QP) demonstrated the knowledge & skills required by the population served.

B. Cross-reference tag (V291). 10A NCAC 27G .5603 OPERATIONS. Based on record review and interview the facility failed to maintain coordination between the facility operator & the QP who was responsible for the treatment for 1 of 3 audited clients (#5).

C. Review on 12/30/19 of client #5's record revealed:
- admitted on 2/8/05
- diagnoses of Moderate Intellectual Development Disorder; Obsessive Compulsive Disorder; Hypocalcemia & Epilepsy
- a physician's order dated 9/18/19 "mobic 7.5 milligrams every morning" (can treat osteoarthritis and rheumatoid arthritis)

Review on 12/30/19 of a treatment plan dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL021-013	A. BUILDING: _____ B. WING _____	R 01/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUKE STREET FACILITY-EDENTON	200 LUKE STREET EDENTON, NC 27932

(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 112	Continued From page 5 11/1/19 with meetings on 9/17/19 & 9/19/19 for client #5 revealed: - "...requires staff to monitor him to make sure that he is not placing himself in dangerous situations to collect trash..." - "I like to collect unique things, considered trash to others, but to me they are treasures..." - "...obsession with collecting trash...will go to extreme measures to get trash..hitting or pushing someone, or even risking his own safety and health..." - "...go into roommates room and take their belongings..." - "...it is important I do not have any more falls...I have a history of falls and I fractured my ribs and broke my hip on separate occasions a few years ago...bumps into walls and stumbles a lot..." - "...emergency room 2/8/19 due to laceration of his scalp-sutures removed on 2/15/19..." (due to fall) - "residential home has installed a sensor system to ensure that I am safe in my room at night...alarms are on all the doors in my home...2 alarms were added (to client #5's bedroom door) because [client #5] will keep his bedroom door opened so staff does not hear him coming in/out of his room at night...he will also shut the alarm off so we felt we needed to have an alarm that he could not turn off..." - no goals or strategies to address client #5's falls Review on 12/30/19 & 1/3/20 of hospital discharge summaries for client #5 revealed the following: - admitted & discharged 12/22/19 "...fell in his room..caregiver said falls frequently...complains of arm pain...diagnosis: small bruise on left temple of eye; left buttock blue; closed	V 112		

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	MHL021-013	A. BUILDING: _____ B. WING _____	R 01/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUKE STREET FACILITY-EDENTON	200 LUKE STREET EDENTON, NC 27932

(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 112	Continued From page 6	V 112		

nondisplaced fracture of left clavicle...high fall risk: more than one fall in 6 months before admitted"
- admitted & discharged on 12/31/19...fell out of bed...the impact was heard by staff...has an abrasion and hematoma above the left eye with some ecchymosis developing on the medial aspect of the left eye...no other apparent injuries...patient head CT(computerized tomography) scan was negative..."

Observations on 12/30/19 & 12/31/19 revealed the following:
- at 11:17am client #5 in a wheelchair with a sling on his left arm
- between 11:20am - 11:24am alarms did not work on client #1 - #3 & #5's bedroom doors...client #5 also had a sensor above the entrance of his bedroom that didn't work
- at 11:26am a baby monitor located in the staff's bedroom & in the laundry near client #5's bedroom
- at 12:43pm the QP went to client #5's bedroom as surveyor stayed in staff's bedroom...surveyor could hear QP speak to client #5 through the baby monitor but was unable to determine the conversation
- on 12/31/19 at 2:38pm client #5 in living room sitting in wheelchair, sling on left arm, abrasion with redness & swelling on the forehead

Review on 12/30/19 of an email for client #5 revealed:
- email dated 12/18/19
- from the QP to the Program Manager (PM)
- "...House Manager (HM) & I (QP) were talking after the last couple of weeks of falls, [client #5] seems to be falling more frequently...facility registered nurse (RN) suggested we help him in the afternoon with

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	MHL021-013	A. BUILDING: _____ B. WING _____	R 01/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUKE STREET FACILITY-EDENTON	200 LUKE STREET EDENTON, NC 27932

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V 112	Continued From page 7	V 112		

unloading his treasures but [HM] explained he gets more irritated by us being there and then when we leave he goes back through everything and that causes falls. It seems like we need to have a behavior plan put in place. At this point we feel like we should really have something in place and hopefully it will help out with reducing the falls. We discussed who he's seen locally... [psychiatry services]..."

During interview on 12/30/19 client #2 reported:
- client #5 will come in his room for trash
- "I say stay out of my room"
- client #5 fell and hurt his collar bone
- "I heard him holler"
- client #3, staff and him helped client #5 up and put him in the wheelchair
- staff took him to the doctor

During interview on 12/30/19 client #3 reported:
- the alarm on his bedroom door was not working...the battery was dead
- nothing was missing from his bedroom
- client #5 fell off his bed and hurt his shoulder
- he & client #2 helped him up
- client #5 said "it hurt"

During interview on 12/30/19 client #5 reported:
- "fall...in room"
- repeated several times...

During interview on 12/30/19 staff #2 reported:
- she had worked at the facility for 2 weeks
- she was hired to work with client #1 from 9am - 12pm
- client #5 was usually at the day program during her work hours
- since the 12/22/19 fall he has been at the facility
- she worked with client #5 on 12/27/19 &

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	MHL021-013	A. BUILDING: _____ B. WING _____	R 01/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUKE STREET FACILITY-EDENTON	200 LUKE STREET EDENTON, NC 27932

(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 112	Continued From page 8 12/30/19 - she assisted him to the bathroom and getting him in and out of bed - client #5 has not fallen during her shifts - she monitored him every 15 - 30 minutes - she does not document her checks - she was not informed to document her checks...she does the monitoring checks on her own - she was not told to do anything different since client #5's fall on 12/22/19 - she was not sure why the clients had alarms on their bedroom doors - she does not work night shift During interview on 12/30/19 staff #3 reported: - she had worked at the facility for 14 years - client #5's gait was off balance - prior to the fall on 12/22/19, he used a walker - he liked to collect trash and had to be reminded to slow down when he saw trash - she would offer to get him what he needed to prevent the falls - client #5 has not fallen during her shift - there were alarms on the clients' bedroom doors that alerted staff when clients went in and out of their bedrooms - client #5 went in other clients' rooms for trash - the alarms has been on the bedroom doors for over 2 years - she was not aware the alarms on the bedroom doors were not operable - she was not told to do anything different for client #5 to prevent falls During interview on 12/30/19 staff #4 reported: - he had worked at the facility for 7 years - he worked a week on and a week off - he was considered sleep staff from 10pm - 6am	V 112		

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	MHL021-013	A. BUILDING: _____ B. WING _____	R 01/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUKE STREET FACILITY-EDENTON	200 LUKE STREET EDENTON, NC 27932

(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 112	Continued From page 9	V 112		

- client #5 loved trash
- he would fall when he tried to pick up trash
- he was used to being independent and tried to do things for himself
- his balance has changed over the years
- staff encouraged client #5 to call them if he needed assistance
- client #5 fell at least once or twice a month
- the morning of 12/22/19 he was getting client #4 ready...he heard client #5 holler out...he went in his bedroom and client #5 was sitting on the side of his bed...client #5 was able to push himself up and sat on the side of the bed...he has a high tolerance for pain...he was not sure if he fell out of bed
- the morning of 12/31/19...he was in staff bedroom getting ready to get the clients up...client #5 hollered out...he found client #5 on the floor...he called the supervisor...he was transported to emergency room
- since client #5's fall 12/22/19, he monitored him every 1 - 2 hours
- he was not instructed to monitor client #5, he just does it
- if he was not able to hear client #5 fall or if he needed help during the night, the other clients would let him know
- there was also a baby monitor in staff's bedroom to hear clients when they got up during the night
- the baby monitor had been in use since client #5 was admitted to the facility
- alarms were on all clients' bedroom doors
- client #5 went in the other clients' bedrooms to get trash
- the alarms alerted staff when client #5 went in the other clients' bedrooms
- the alarms had been on the client doors for more than a year
- the alarms worked on each client's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL021-013	A. BUILDING: _____ B. WING _____	R 01/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUKE STREET FACILITY-EDENTON	200 LUKE STREET EDENTON, NC 27932

(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 112	Continued From page 10 door...especially client #1's alarm because he was just in there - shortly after the interview with surveyor, he checked the clients' bedroom door alarms and they were not operable with exception of client #4 - the batteries needed to be replaced During interview on 12/31/19 the RN reported: - she visited the facility once a week or every other week - client #5's falls average twice a month - staff will either call or document in computer system - his falls pertained to him looking for trash - client #5 may need an alternative placement due to him aging and falls increased - he saw a physical therapist in the past due to falls - client #5 may need to be reevaluated by a physical therapist - the physician had completed lab work & there were no flags for the increase in falls - the physician will visit with the clients on 1/9/20 - they will discuss the falls with the physician at this time During interview on 12/30/19 & 12/31/19 the QP reported: - she had been the QP for the last 5 years - in the last 6 months client #5 had fallen 1 - 3 times a month - staff documented level one incident reports in the facility's computer system - management including the RN were able to view the incidents in the computer system - she reviewed incidents in the computer system from July 2019 - December 2019 - staff had only documented a fall in September 2019 & October 2019 with no injuries	V 112		

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	MHL021-013	A. BUILDING: _____ B. WING _____	R 01/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUKE STREET FACILITY-EDENTON	200 LUKE STREET EDENTON, NC 27932

(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 112	Continued From page 11 - November 2019 & December 2019 incidents were given to surveyor - during meetings, staff are requested to be consistent with documentation for any incidents - client #5 falls had increased this month (December 2019) - she developed a fall log for client #5 this month but had not implemented it yet - a baby monitor was placed in staff's bedroom today (12/30/19) in case client #5 called for staff - each client had an alarm on their bedrooms doors - client #5 had a door alarm & a sensor on his bedroom door to alert staff of his movements - she was not aware the alarms were not operable on the clients' bedroom doors - staff were to monitor client #5 closer (face to face) since his falls had increased...she did not discuss how often - she reached out to client #5's care coordinator today (12/30/19) to discuss options due to the increase in falls - client #5 was last assessed for his falls by a physical therapist in 2018 - the physician prescribed medication (mobic) to see if that would help with the falls - on 12/31/19 client #5 fell out of his bed - she emailed her supervisor to inform her client #5's falls had increased - she wanted to discuss a behavior plan for client #5 or a higher level of care - he would have a 1:1 and awake staff with a higher level of care - goals and strategies to address client #5's falls were a miss on their part During interview on 1/3/20 the care coordinator for client #5 reported: - she visited client #5 every three months at the facility	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 112	Continued From page 12 - he had a history of falls - staff notified her when client #5 had falls - his falls had increased this month (December 2019) - staff should monitor him when he was mobile - client #5 had mobility issues - he was assessed last year by a physical therapist, a CT scan was done this year (2019) to make sure nothing was going on...alarms are set up at the facility to alert staff of client #5's movement - during her visits she visited client #5 in his bedroom...she was not aware the alarms were not operable...she last visited October 2019 - there were no goals or strategies clearly written out in client #5's treatment plan to address his falls - the facility's QP had reached out to her due to the increase in falls - she will contact the QP to schedule a time to update client #5's plan with interventions to address client #5's falls Review on 12/31/19 of the Plan of Protection dated 12/31/19 written by the QP revealed: "QP, Agency RN, Program Manager and Habilitation Coordinator for all individuals in my care will meet on 1/3/20 to review safety concerns. Protocols for all individuals will be implemented based upon their needs. For individuals having a Care Coordinator protocols will be provided to be included in their plans. For individuals without Care Coordinators, Program Manager will implement into the person center plan. Treatment team meetings will be scheduled with Care Coordinator, Program Manager will implement into the person center plan. Treatment team meetings will be scheduled with Care Coordinators and team members by 1/15/20. All follow up appointments will be scheduled with 48	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL021-013	A. BUILDING: _____ B. WING _____	R 01/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUKE STREET FACILITY-EDENTON	200 LUKE STREET EDENTON, NC 27932

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V 112	Continued From page 13	V 112		

hours. Program Manager will document reviews with all staff on an inservice form. program will complete training with QP, RN and residential staff on goals implemented to ensure safety of individuals. Appointments will be documented when scheduled by Habilitation Coordinators in [facility computer system]"

Client #5 had a history of falls resulting in a fractured rib, a broke hip and a laceration of the scalp requiring sutures. The most recent falls occurred on 12/22/19 & 12/31/19 causing a hematoma and a nondisplaced fracture of the left clavicle. Client #5 was mobile with a walker prior to the 12/22/19 incident, however, was currently wheelchair bound. An alarm and sensor were placed on client #5's door more than a year ago to alert staff of his movement. The alarm nor the sensor were operable. Management and staff were unsure of how long both had been inoperable. In the last 6 months, client #5 had fallen between 1 -3 times a month, however there were no consistent documentation of the falls. Management requested staff monitor client #5 closer due to the increase of falls, however, didn't give any clear instructions or training to staff regarding the increased supervision . Client #5 was being monitored at different times throughout the day. One staff monitored client #5 every 15 to 30 minutes and another staff every 1 - 2 hours. The QP was aware client #5 had a history of falls, however failed to ensure goals and strategies were implemented into his treatment plan. Client #5 was supposed to follow up with an orthopedic physician within 1 week of his fall on 12/22/19, however this did not happened. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $1,000 is imposed. If the violation is not corrected within 23 days, an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL021-013	A. BUILDING: _____ B. WING _____	R 01/03/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUKE STREET FACILITY-EDENTON	200 LUKE STREET EDENTON, NC 27932

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V 112	Continued From page 14 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 112		
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 safety issues become a primary concern.	V 291		

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V 291	Continued From page 15 This Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain coordination between the facility operator & the qualified professional (QP) who was responsible for the treatment for 1 of 3 audited clients (#5). The findings are: Review on 12/30/19 of client #5's record revealed: - admitted on 2/8/05 - diagnoses of Moderate Intellectual Development Disorder; Obsessive Compulsive Disorder; Hypocalcemia & Epilepsy - a facility's physician's order form dated 12/30/19 "refer to orthopedics" (signed by the facility's Registered Nurse (RN) Review on 12/30/19 of a hospital discharge summary for client #5 revealed: - admitted & discharged 12/22/19 - diagnoses: closed nondisplaced fracture of left clavicle - follow up with orthopedic within 1 week During interview on 12/30/19 the Qualified Professional reported: - she had been on vacation since December 19, 2019 & this was her first day back (12/30/19) - the House Manager (HM) was responsible for coordinating services with the orthopedic - the HM was currently on vacation - she contacted the HM (12/30/19) & the HM attempted to schedule an orthopedic appointment today (12/30/19) - the orthopedic will not see client #5 without a referral - the facility's RN completed a referral today (12/30/19) This deficiency constitutes a re-cited deficiency.	V 291		

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V 291	Continued From page 16 This deficiency is cress referenced into 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (V112) for a Type A1 rule violation and must be corrected within 23 days.	V 291		