

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL093-031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/15/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WARREN COUNTY GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 109 MUSTIAN ROAD NORLINA, NC 27563
---	--

(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 complaint desk survey was completed on May 15, 2020. The complaint was substantiated (NC#00164429). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or	V 291		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL093-031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/15/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WARREN COUNTY GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 109 MUSTIAN ROAD NORLINA, NC 27563
---	--

(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 291	<p>Continued From page 1</p> <p>safety issues become a primary concern.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to coordinate care between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. The findings are:</p> <p>This survey was done as a "Desk Review" as on-site observations, reviews and interviews were not possible during the state ordered shutdown due to the Coronavirus situation.</p> <p>A. Review on 4/28/20 of client #1's faxed information revealed: - admission date 7/19/12 - diagnoses of Profound Intellectual and Developmental Disability, Aortic Sclerosis, Psychotic Disorder (DO), Mixed Personality DO with tantrums, Hyperlipidemia and a history of Schizoaffective DO, Intermittent Explosive DO, Borderline Personality DO and Parkinsonism. - documentation of visits to her primary care physician on 12/12/19, 9/25/19 and 7/30/19 which was her annual physical. Documentation on the 12/12/19 visit noted "no distress" in chest area and for her to return in 3 months.</p> <p>Review on 3/26/20 and 4/27/20 of an IRIS report dated 2/23/20 submitted by the Executive Director (ED) of the agency revealed: - "When staff (#1) went to [client #1]'s bedroom at 6:42am she was face down on the floor between her bed and the wall, apparently deceased. She (staff #1) called management staff and 911 and completed chest compressions until EMS (Emergency Medical Services) arrived.</p>	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL093-031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/15/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WARREN COUNTY GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 109 MUSTIAN ROAD NORLINA, NC 27563
---	--

(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 291	<p>Continued From page 2</p> <p>EMS pronounced her Dead on Arrival (DOA)...It is unknown the cause of death...The only way this could have been prevented is if staff knew she was in distress."</p> <p>Review on 4/30/20 of an Incident Findings report dated 2/23/20 submitted by the ED revealed: - "...Previous Illness: Over the past week [client #1] has had a drippy nose and has been taking a PRN (as needed) over the counter medication for a cold which was prescribed by her physician. Staff report that she had a BM (bowel movement) accident on Friday evening (2/21/20), which was unusual and on Saturday (2/22/20) she had another BM accident which is unusual. She had juice for breakfast on Saturday (refusing food) a lunch of Chicken Noodle Soup on, but refused dinner. She was awake and walking throughout the home Saturday afternoon, and then decided to go to bed. Because she refused dinner, she was given some orange lance peanut butter crackers, juice and water which were found in her room. She has a history of aortic stenosis, but has had no complications to the knowledge of the agency...The EMS driver...indicated...they hooked up machine and it was flat lined. Due to her appearance and coolness of her skin he felt that she had been deceased for some time...He called the on-call physician...who pronounced her deceased based on the EMS findings...There were no signs of choking or vomiting...after reading her chart and history of aortic sclerosis, it is perhaps a possibility that this was a cardiac event-but he (EMS Worker) was quick to say he was not a doctor and not allowed to determine a cause of death-that would have to be ascertained by an autopsy if the mother/guardian wished for that to occur."</p>	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL093-031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/15/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WARREN COUNTY GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 109 MUSTIAN ROAD NORLINA, NC 27563
---	--

(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 291	<p>Continued From page 3</p> <p>During interviews on 3/26/20 and 4/27/20, client #1's guardian/mom reported:</p> <ul style="list-style-type: none"> - her daughter passed away on 2/23/20 at the group home - staff from her daughter's day program reported they had sent the daughter home on Tuesday (2/18/20) because she was not feeling well - the group home sent her back to work on Wednesday and on Thursday. The day program took a picture of her on Thursday to show how sick she appeared. - she wondered why she (mom/guardian) had not been contacted beforehand if her daughter wasn't feeling well - her death certificate documented she died of a Myocardial Infarction - the group home would not give her a copy of the IRIS (Incident Response Improvement Systems) or any internal reports about the incident. <p>During an interview on 4/27/20, the ED of the group home agency reported:</p> <ul style="list-style-type: none"> - all the clients in the group home had had the "sniffles" the week prior to 2/23/20 - no-one had temperatures but all had been given a PRN medication for the cold like symptoms - client #1 was the youngest and healthiest of the clients at the home - client#1 had come home from the day program one day during the week for not feeling well - she had not reported any symptoms the day before her death - client #1 did not have a cardiologist and her primary physician had never recommended one. - she (ED) went to the group home immediately after being informed on the day of 	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL093-031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/15/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WARREN COUNTY GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 109 MUSTIAN ROAD NORLINA, NC 27563
---	--

(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 291	<p>Continued From page 4</p> <p>2/23/20. She arrived before 8:00am</p> <ul style="list-style-type: none"> - EMS had already pronounced her DOA - she contacted all necessary individuals and completed the IRIS (Incident Response Improvement System) form as required - she would fax any requested information to DHSR <p>During an interview on 5/4/20, staff #1 reported:</p> <ul style="list-style-type: none"> - she was the staff on duty from Saturday 6:00am (2/22/20) through mid morning Sunday (2/23/20) - all the clients in the home had colds and were coughing. Client #1's seemed worse than anyone else's and all were being given a prescribed cough syrup. - client #1 did not want any breakfast on Saturday but did eat some chicken noodle soup for lunch - client #1 did not make any specific complaints about not feeling well - client #1 did not want dinner and went to bed at approximately 8:30pm. She left some peanut butter crackers with her. - she checked on client #1 at 11:00pm before she retired for the night and she was okay. - she then went to check her at approximately 6:45am and found her face down on the floor between her bed and the wall - she immediately called 911 and agency management and started CPR (Cardio Pulmonary Resuscitation) until EMS arrived. <p>During an interview on 5/4/20, staff #2 reported:</p> <ul style="list-style-type: none"> - she was the Lead Staff and had worked at the facility for 2 years - she worked the Wednesday - Saturday (2/19/20 - 2/22/20) prior to client #1's death - all the clients went to a day program Monday - Thursday each week 	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL093-031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/15/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WARREN COUNTY GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 109 MUSTIAN ROAD NORLINA, NC 27563
---	--

(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 291	<p>Continued From page 5</p> <ul style="list-style-type: none"> - on weekdays she was scheduled to be off between 10:00am - 2:00pm. But if someone needed to be picked up from the day program they were expected to go back on duty. They only picked up clients if they had a fever or were seriously ill. She had only picked up clients if they had a fever - everyone in the house had cold symptoms the week of 2/18/20 and had been given cough syrup. No-one had a fever. - on Tuesday (2/18/20) the day program called and asked for client #1 to be picked up and she was picked up.. Client was sent back to the day program on Wednesday and Thursday and did not appear to be seriously ill - clients did not stay home or get picked up from the day program unless they had a temperature or had thrown up more than once. <p>During an interview on 5/4/20, the House Manager (HM) reported:</p> <ul style="list-style-type: none"> - client #1 and all the other clients had the sniffles and were be given cough syrup from a standing order they all had - no-one was taken to the doctor as it seemed like a mild cold for everyone - family members are not contacted every time a client does not feel well. If client needs to be seen by a doctor, they will contact parent/guardian - if clients go to the day program and say they are sick, the group home will only pick them up if they have a fever - the day program had copies of the standing orders and could give the clients cough syrup as needed. She understood they also have an area where clients can lay down if needed. She herself has not seen this area. - she has told the day program that they (group home) do not have staff available to pick 	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL093-031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/15/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WARREN COUNTY GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 109 MUSTIAN ROAD NORLINA, NC 27563
---	--

(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 291	<p>Continued From page 6</p> <p>up clients between 10:00am - 3:00pm</p> <ul style="list-style-type: none"> - she knows the ED of her agency and the Director of the day program have gone "back and forth" about clients being picked up - the day program now has rules about when a client needs to be picked up <p>During an interview on 4/28/20, a staff person at client #1's day program reported:</p> <ul style="list-style-type: none"> - client #1 came into program on Monday, 2/17/20. She did not look well, had dark circles around her eyes and said she had a headache and the sniffles - she called the group home to pick up client #1 and was told they would not pick up a client unless she had a fever (she did not). Staff said there was no-one on duty between 10:00am - 2:00pm. - client #1 came back to the day program on Tuesday 2/18/20 with same symptoms. She called the group home again and this time they did come and pick her up that day - client #1 came in again on Wednesday 2/19/20 and Thursday 2/20/20. Client #1 said she felt better but she did not look better. She kept her head down on Thursday until they were picked up. - she took a picture of client #1 on Thursday because she looked so bad and she wanted to show it to her Director. - the staff at client #1's group home have told the day program that they don't pick someone up unless they have a fever or are "very sick" (vomiting more than once, bowel accident). They reported they did not have staff on duty between 10:00am and 2:00pm. <p>B. Review on 5/1/20 of documents submitted by the day program revealed:</p> <ul style="list-style-type: none"> - "10/24/18. Left message for [group home 	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL093-031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/15/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WARREN COUNTY GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 109 MUSTIAN ROAD NORLINA, NC 27563
---	--

(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 291	<p>Continued From page 7</p> <p>manager (HM)) to call in reference to [client #1] not feeling well"</p> <p>- "10/24/18. follow up call received from [HM]...stated that everyone in the home has allergies and it is her allergies that are acting up at the moment. [HM] stated the [ED] stated that the only way that she would come to pick up [client #1] or bring her medicine would be if she had a fever over 101. QP (Qualified Professional) stated that [client #1] does not have a fever and we would like to give her some medicine for her symptoms, however we do not have an order. We are not requesting that anyone pick her up. [Group home manager said she will work on getting us an updated order for cough and cold medicine as well as allergy medicine."</p> <p>- "2/17/20. The PM (program manager of the day program) call the HM to pick up [client #1]. [Client #1] came to work with a runny nose, coughing and complaining of a sore throat. She later complained about having a headache. [Client #1] told PM she wasn't feeling good and wanted to go home and lay down. The GH Manager came to pick [client #1] up about 30 minutes after the call."</p> <p>- "2/17/20. I (PM) stand at the entrance door every morning and greet the clients and I notice [client #1] looked like she didn't feel well...the first thing she said to me was 'I don't feel well or would say my throat hurts'. A phone call was made to group home to inform them that [client #1] wasn't feeling well. This continued a little over a week."</p> <p>- "2/18/20. [Client #1] returned to work...today...The group home staff reported she was fine. [client #1] however did not appear to be feeling any better. She seemed to drag throughout the day. She did not have any get up and go in her as usual. She was offered a mask due to the constant coughing. She refused to</p>	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL093-031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/15/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WARREN COUNTY GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 109 MUSTIAN ROAD NORLINA, NC 27563
---	--

(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 291	<p>Continued From page 8</p> <p>wear the mask."</p> <p>- "2/19/20. I informed my Supervisor that [client #1] was looking really bad with mucous running from her...I spoke with [HM] (she was bringing another consumer in) about [client #1] She said if she had a fever she could take her home...[HM] checked ...and she did not have a fever. [HM] told me if we needed her later to call. [Client #1] stated to me "call my Mom, I don't feel well."</p> <p>- "2/19/20. I (day program director) spoke with [ED (of group home agency)] on the phone and by email. [ED] stated in reference to client #1 being sent home on 2/17/20 that her staff at the home reported that [client #1] looked fine and was not sick the remainder of the day. [ED] questioned why she was sent home and stated that [day program staff] are not nurses. I responded that I saw [client #1] on 2/17/20 and that she did look ill, was congested and her nose was running quite a bit.</p> <p>- 2/19/20. (This was written by the day program Director). "[Innovations Coordinator (IC)] called me to report that [client #3] had been throwing up this morning and was weak. She said he was asleep in the wheelchair and she had called [HM] for him to be picked up but was told she was not able to pick up client if he did not have a fever. I called [ED]...regarding [client #3]'s throwing up...[ED] stated she believed he had only thrown up one time and did not have a fever so she was not going to have staff pick him up. I stated that our policy states that if someone has thrown up they need to be picked up for the remainder of the day. She stated she did not have [day program]'s policy stating that information. Further she stated she did not have staffing to pick up people when they did not have fevers and that she felt [day program]'s staff overreacts when participants appear sick. I</p>	V 291		
-------	--	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL093-031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/15/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WARREN COUNTY GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 109 MUSTIAN ROAD NORLINA, NC 27563
---	--

(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 291	<p>Continued From page 9</p> <p>responded that I have sent letters and the policy previously but would send it again. She said if she was provided with [day program]'s policy stating this information then she would have a staff person pick him up. I sent the policy via email at 11:30am. [Client #3] was not picked up until 2:00pm. [IC] said [client #3] slept from the time he threw up until 1:45pm in the wheelchair and when he woke up he wanted to eat his lunch. Shortly after he started eating a house staff arrived to pick him up."</p> <p>- 2/19/20. (Written by Innovations Coordinator). "Innovations Coordinator informed [HM] that [client #3] was throwing up and appeared to be feeling bad. Coordinator described [client #3] as presenting as sluggish & tired and refused to walk. [HM] informed IC that per her director's (ED) orders that the group home managers are not to send anyone to pick up participants if they did not have a fever or were throwing up more than once. [HM] said to call if [client #3] throws up again and she will have someone come to [day program] to pick [client #3] up.</p> <p>- "2/20/20...staff asked her (client #1) if she was ok as she appeared very tired and pale. [Client #1] stated 'I do not feel well, I do not want to go in the back (work area)...staff...told her if she needed to put her head down and rest until they (group home staff) arrived that would be okay..." (Group home staff were coming to pick up all clients early as day program was closing due to weather conditions).</p> <p>During an interview on 4/28/20, the Director of the Day Program reported:</p> <p>- she has had several conversations with staff and the ED from D.D.Residential and has been told that unless a client has a fever or is very sick (vomiting/diarrhea) it is their policy not to pick up</p>	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL093-031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/15/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WARREN COUNTY GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 109 MUSTIAN ROAD NORLINA, NC 27563
---	--

(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 291	<p>Continued From page 10</p> <p>clients from the day program because they do not have any staff on duty between 10:00am - 2:00pm.</p> <ul style="list-style-type: none"> - when the day program has called they get questioned and want to know "graphic details" such as how many times has person thrown up, what does it look like and ask why client would have to be picked up if they don't have a fever or only threw up once. - they sent out a letter on 2/26/20 to all family members, guardians and residential providers re-iterating the illness policy which is signed yearly (policy noted below) <p>Review of paperwork submitted by the ED on 5/13/20 revealed:</p> <ul style="list-style-type: none"> - email dated 2/13/2019 from the Director of the day program to the ED (of group home) with: "I got your message about looking for information about sickness...It is listed in our Participant Handbook that they all receive when they begin the program..Each person/guardian signs that the received the hand book...I copied the section from the Health and Safety heading of the Handbook. "If you develop an illness such as the flu, TB (tuberculosis), ringworm, head lice, measles, or other illnesses which can be given to other people through the air or by touch, you must report this to [Day Program] staff immediately. For you and others to be protected from illness it is very important that you do not come to the Agency or any other work site, if you think you have such an illness. You will be required to leave if it seems you do have such an illness, and we may require a doctor's note before you are able to return. We will follow the advice of medical authorities if you, staff or others have a communicable disease." - an email dated 2/19/20 at 11:31am from the Director of the day program to the ED (of group 	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL093-031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/15/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WARREN COUNTY GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 109 MUSTIAN ROAD NORLINA, NC 27563
---	--

(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 291	<p>Continued From page 11</p> <p>home) with: Hi [ED] Attached is the illness policy from the participant handbook that is resigned each year. The part you are looking for is the second paragraph from the bottom. I just checked in with IC about [client #3]; she stated he's asleep in the wheelchair and quite weak. Let me know with any questions but we appreciate staff picking him up.</p> <p>- an email dated 3/20/20 from the ED of the group home to the Director of the Day Progam with: " Hi [Director of day program], Not to beat a dead horse but I wanted to give you an update on [client #3] from yesterday. When [staff] arrived to pick him up they (day program) had fed him his sandwich for lunch. Not sure if he was so sick and weak why they gave him food..... He had no fever. He never threw up again (I believe he had only thrown up once at [day program] and was fine the rest of the day. Day program staff did not administer any PRN medication for upset stomach and he walked out of the building with no problem. He showed no signs of illness the rest of the day. It appears as if perhaps [day program] staff overplayed his "illness". I appreciate not wanting to spread germs but none of your staff are nurses and this was another case of an unnecessary pickup. Since I have not seen the illness policy that is in your handbook until yesterday, and haven't signed it - I am wondering if it can be revised to be more specific about pick-ups. Certainly we aren't going to send anyone who we believe is coughing excessively, has a fever, or the flu (to our knowledge) but if we have gone to the trouble of getting PRN orders for folks, why can't that be administered and a temperature taken before we are called for a pick-up."</p> <p>- an email dated 3/20/20 from the ED of the group home to the Executive Director of the Day Progam's agency with: "Thank you for your open</p>	V 291		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL093-031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/15/2020
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WARREN COUNTY GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 109 MUSTIAN ROAD NORLINA, NC 27563
---	--

(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 291	<p>Continued From page 12</p> <p>invitation to air concerns regarding the Henderson location of [day program]. Please know that I have nothing but the highest regard for [Director of day program] and truly feel she is doing her best to professionally deliver services to the 30 (plus) residents that we take to the program Monday - Thursday...For the past 2 years that I have been with this agency, [Director of day program] and I have tried to work together to overcome obstacles and barriers. Here is a list of issues that we have complained about and continue to seek resolution for...</p> <ul style="list-style-type: none"> - There has been a longstanding problem with [day program] calling our managers during the day and asking for residents to be picked up when they have soiled themselves...Often we will take them home, shower them and bring them back, only to get attitude that they should stay home all day and not return. - there has been issues with [day program] calling for a pickup for a resident who seem ill, but we have provided a PRN medication for them, and they haven't been fever checked before required to leave. - Recently we had a resident pass away (from what most likely was a heart attack), some staff made comments to the manager that she was sent home from work the week before for a runny nose - as if to imply that we are neglecting her health and responsible...." <p>During an interview on 5/15/20, the ED reported they were hard pressed to work out a solution when the day program's senior management had not communicated with them since her memo on 3/20/20 and the fact that the program is currently closed due to the Coronavirus pandemic.</p>	V 291		