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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 6-26-20. Complaints #NC 00159750, and #NC 00161688 were substantiated, and complaints #NC 00161287, #NC 00164586, #NC 00161431 were unsubstantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 5600 Supervised Living for Adults Whose Primary Diagnosis is a Developmental Disability.	V 000		
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		

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V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on interviews and record reviews the facility failed to ensure that treatment goals were implemented, effecting one of three clients (client #1). The findings are:

Treatment plan dated 9-1-19 had goals stating " staff will help Laura chose healthy food "
Menu plan dated 8-17-18 and signed by the physicians assistant revealed: most breads were not allowed

Interview on 3-10-20 with client #1 revealed:
-She had gotten a hamburger and staff had thrown it away.
-"They didn't give me my money back."
-"They didn't say why.
-Client #1 then stated that "her diabetes isn't that bad."

Interview on 2-17-20 with client #1's guardian/sister revealed:
-Client #1 had bought a hamburger and the facility took it away saying that she couldn't have it because of her diet.
-She knew her sister was diabetic and she had lost weight since she had been at the facility.

Interview on 2-20-20 with staff #1 revealed:
-Client #1 weighed 300 pounds when she moved into the facility (August 2018) and the

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V 112	Continued From page 2 doctor said she had been doing very well and she was losing weight. Interview in 2-20 and 3-13-20 with the facility manager revealed: -Client #1 had bought a hamburger and it was supposed to be a plant based burger but it wasn't. -Staff did take the hamburger away. -They had reimbursed the client for the burger. "I'm sure we did." -The facility had planned on eating pizza that evening and client #1 stated that she would rather have that to eat. -Client #1 is a diabetic and they do have to be careful about what she eats. A hamburger from that fast food restaurant was very high in sugar and carbohydrates. -One hamburger could make a big difference in her blood sugar levels. -Clients used debit cards to pay for anything they got. -She did not have copies of the debit card records but the licensee did. -Surveyor was shown copies of debit card transaction on the 3-13-20 interview. -They had written a check to client #1 to make sure there was documentation but client #1's guardian/sister had refused to take it. Review on 2-20-20 of client #1's financial record revealed: -Receipts for various items, including several fast food receipts. -No documentation of client #1 being reimbursed for her hamburger. Review on 3-10-20 of client #1's financial record revealed: -Written check for client #1 (who had been discharged).	V 112		

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V 112	Continued From page 3 Review on 3-10-20 of clients list of allowed food signed by the Physicians Assistant revealed: -High glycemic food was not allowed.	V 112		
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 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	V 290		

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V 290	Continued From page 4 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 interviews and record reviews the facility failed to ensure minimum staffing requirements effecting one of three clients (client #1). The findings are: Review on 2-19-20 of client #1's record revealed: -Admitted 8-17-18. -Diagnoses of Mild Intellectual Developmental Disability, Unspecified mental Disorder, Unspecified Psychosis, Cortical Blindness, Type II Diabetes, Post Traumatic Stress Disorder, Constipation, Unspecified Urinary Incontinence, hypercholesterolemia, Schizoaffective Disorder, Manic Episode, Traumatic Brain Injury. -Assessment dated 3-22-19 revealed: Requires assistance when making food and drink choices...behaviors of physical aggression, Self-injurious behavior, cursing, suicide ideation, homicide ideation, frequently paranoid, abused as a child. -Person Centered Plan dated 9-1-19 revealed: Goals include increase bathroom and self care skills, will choose healthy foods, will	V 290		

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complete household chores, will follow laundry schedule.

Review on 6-12-20 of emergency room records from a local hospital dated 2-26-20 for client #1 revealed:
-"Social Worker met with patient (client #1) states is unsure why she is here; states 'They dropped me off.' Patient states her back hurts."

Interview on 3-10-20 with client #1 revealed:
-"They left me (at the hospital) with a piece of paper, that was it."
-"I stayed awhile, a week, I mean a day. I got dropped in the afternoon."

Interview on 3-18-20 with client #1's sister/legal guardian revealed:
-"After they dumped her at the hospital they kept yelling at me she had been dismissed. "
-"On the 25th (of February) she (staff #1) said 'I'm taking [client #1] to behavioral health' then said 'no.'"
-"The next day, [Owner/CEO] (Chief Executive Officer) did take her to behavioral health."
-They had left client #1 at the hospital with just a piece or paper that had her address and an old phone number on it.

Interview on 3-11-20 with the local hospital social worker revealed:
-She was shocked at the facility, they left the client alone in the emergency department.
-"They didn't talk to anyone, they left her with a little piece of paper with her basic demographics."

Interview on 2-26-20 with the Director of a local Behavioral Health unit that client #1 was initially

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V 290	Continued From page 6 taken to on 2-26-20 revealed: -The facility staff (staff #2) had brought client #1 to the emergency department of behavioral health unit. -"Staff (staff #2) said he was instructed to leave her." -When she called the Owner/CEO of the facility he told her that DHSR (Department of Health Service Regulation) told him that he could take client #1 to the emergency behavioral health and leave her. -"I said 'no, she was not in crisis.'" -The Owner/CEO stated that he would take her to another hospital. Interview on 3-17-20 with staff #2 revealed: -He had first taken client #1 to a Behavioral Health Hospital that would not accept her, he then took her to another hospital close by. -"I was instructed by [facility manager] to take her." -"I took her to the front desk...they checked her in a put a band on her wrist." -Staff #2 went to move the van to a parking place and when he came back, client #1 was not in the waiting room. He assumed she had been admitted and left. This deficiency is cross referenced into 10A NCAC 27G 27G .5603 Operations (V291) for a Type B rule violation and must be corrected within 45 days.	V 290		
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	V 291		

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V 291	Continued From page 7 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. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure coordination of care effecting one of three clients (client #1). The findings are: Cross Reference: 10A NCAC 27G .5602 Staff (V290) Based on interviews and record reviews the facility failed to ensure staffing requirements effecting one of three clients (client #1). The findings are:	V 291		

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V 291	Continued From page 8 Review on 6-12-20 of a local hospital medical records from 2-26-20 to 2-27-20 for client #1 revealed: -Arrival date/time 2/26/20 11:24 am, admit date/time 2-26-20 1:13 pm. -Discharge date/time 2-27-20 6:46 pm -Final diagnosis: Suicidal ideation -Ancillary note 2/26/20 2:55 pm "She is agitated...Her affect is angry and blunt...She expresses impulsivity. She exhibits a depressed mood. She expresses suicidal ideation. She expresses no homicidal ideation. She expresses suicidal plans." -Ancillary note 2/26/20 2:55 pm "Number of Diagnoses or Management Options: Suicidal ideation; new and requires workup." -"Clinical impressions: final diagnoses; suicidal ideation." -Behavioral Health Access Screening dated 2-26-20: Triage Screen: " The patient is experiencing Suicidal/Homicidal ideations with an identifiable plan intent, means, or recent gesture/attempt....PT will be seen by psychiatry for final disposition." -Nursing orders 2-26-20: "no metal on tray-Plastic only...no plastic knives....15 minute safety check." -2-26-20 6:40 pm: Patient has been evaluated and determined to be medically stable by ED (Emergency Department) provider...does not meet criteria for a psychiatric admission. Sister/legal guardian has stated she can no longer return to current facility. She is able to pick up patient tomorrow. Pt also has care coordinator with [LME]. She will remain in the ED overnight with plan for discharge in the morning. -2-26-20 6:40 pm History of present illness: "Per access; Pt is a 48 y/o (year old) Caucasian female who endorses passive SI (suicide	V 291		

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ideation) with no plan. patient reports her sister is ruining her life due to a car accident in 1988. Patient reports she has been hospitalized 2x times the past for depression at [hospital] and [hospital] for depression...on exam, patient is alert and oriented x3, keeping eyes closed. Came to ED with suicidal ideation contextual to her sister/legal guardian stating patient will come live with her. Patient notes that she has been staying at a group home for the past two years and would hate to leave her friends. She does not want to go stay with her sister because she is controlling. Patient currently denies any suicidal ideation, intent, or plan. 'I was mad earlier'...Collateral per ACCESS: clinician spoke with patient's sister/LG (Legal guardian)...for collateral. She reports yesterday the group home Kerr home threatened to bring the patient to the ED if she didn't pick her up because they wanted to discharge the patient from their facility. [Sister/legal guardian] reports the patient's behaviors at this group home have been fine, 'they just didn't want her anymore...'".

-Ancillary note 2/26/20 3:00 pm: "....presents to the ED, receive consult from ED team member nursing staff states Patient is here but unclear why she is here in the ED...states 'they dropped me off'. Patient states her back hurts...Social worker called [LME] states that [care coordinator] is the care coordinator assigned to patients case....States that Kerr home was intending on discharging Patient as of 2-24-20...[LME] explains that since Kerr home is the preferred provider, Patient will need to remain at their group home...Social worker learned from nursing team that patient has verbalized suicidal statements and behavioral health is evaluating."

-Ancillary note 2/26/20 3:00 pm "Potential Risk to Self: Suicidal threats/behaviors in the past 6 months?:Yes, suicidal ideation or Suicide Threats: Yes, Recent attempt to Harm Self?: No,

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V 291	Continued From page 10 Intent for above: No, Currently engaging in self-injurious behavior?: No, History of Suicidal/Self-injuring behaviors?: Yes (per chart review pt has hx (history) of head banging, History of Suicidal/Self Injurious behavior Last 6 months?: Yes, History of Suicidal/Self Injurious behaviors Greater than the past 6 months?: Yes (pt reports she attempted suicide x 2 in the past)" -ED provider note 2-26-20: "Chief complaint; patient presents with back pain. Pt is blind and lives with sister. Stated that her sister brought her here because she was having lower back pain. Family is not here at this time and pt is not giving out much info (information) about complaint. Initially triaged as coming to ER (Emergency Room) for having low back pain. On my initial assessment the patient denies having any low back pain but spontaneously without questioning from me admits to me that she is suicidal with plans of harming herself by striking her head against the wall until she dies. She does have a history of depression, bipolar disorder she currently resides in a group home" -Ancillary note by hospital social worker dated 2-27-20 time 6:54 pm revealed: "Access spoke with pt's (patient) (client #1)) sister and guardian [sister/guardian] who was present at the ED re (regarding) dc (discharge) plan to either go home with her or back to Kerr home. [Sister/Guardian] states that pt is not able to return to the group home, she has been discharged. Access relayed information from ED social worker that [Local Management Entity (LME)] did not authorize DC (discharge) and that pt is authorized to return. Sister states she had to get a police escort to get pt's meds, that she is not allowed back on the property. States she is not able to care for pt, who requires 24 hour care. Sister asked whether pt can stay in the ed until the 4th (of March) as she is able to get to another placement on the 6th and	V 291		

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she could care for pt for 2 nights. Access relayed that ed psychiatrist has documented that pt has no further need for emergency room care and is not appropriate to keep pt in the emergency room. Sister reluctantly agreed to take pt home."

-Ancillary note by hospital social worker dated 2-27-20 time 9:42 am revealed: "Anticipatory Discharge: Social worker received phone call from Patients sister [sister/guardian]...is planning to pick up patient from ED however is having a barrier, states group home is not picking up the phone to help facilitate picking up Patients's medications...Social worker received call from [LME] states that group home has authorization for Patient to stay at [facility], states that the group home attempted health and safety discharge, that was denied therefore, patient would still remain at Kerr home or can be picked up by Patients's sister. [LME] states that unfortunately patient's sister and owner of the group home have a difficult relationship."

-Progress note dated 2-27-20: "presented to ED complaining of back pain and suicidal ideation. On examination she has no symptoms of depression or psychosis and is stable for discharge. ...Her main issue is not liking her current living situation and her sister who is guardian is working with her to find an alternative."

Review on 3-9-20 of police records of facility visits revealed;

-2-19-20 at 18:45 (6:45 PM) welfare check

-2-22-20 at 20:13.05 (8:13 pm) welfare check.

-2-27-20 at 15:38.11 (3:38 pm) escort.

Review on 3-10-20 of an email sent 2-14-20 from the Owner/CEO (Chief Executive Officer) to the LME (Local Management Entity) Care

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V 291	Continued From page 12 Coordinator revealed: -"Good morning, I would like to request a meeting with you and your supervisor to discuss [client #1]. I would like to get clear understanding of what is going on and to report some things that are not healthy for her. ...[Sister/legal guardian] is changing doctor's appointment without letting us know and my staff was not allowed to go back to share any information with the doctor. My staff drove to the doctor for our scheduled appointment at 10:20 am but it had been changed to 12pm without our knowledge. This should be addressed because we are the clinical home and are held legally responsible for her healthcare. If we can not control this part of her treatment that is unhealthy and is not safe for her. We are with her 24 hours a day and take care of her. We need to be able to speak with the doctor. [Sister/legal guardian] also requested a TB (tuberculosis) test while there but didn't tell us and we were not in the room. She also took the appointment discharge summary that we have to show the state and other audit organization such as [accrediting agency]. She would not give it to us. Then she called two days later and told my staff to meet her at the doctor's office without warning. Of course we didn't go because that's not how this works. [Sister/legal guardian] is being very unprofessional and sneaky. I do not want this to be a negative refection on my organization. We have done a great job with her and she is stable and happy. I know [client #1] told you that she likes her placement and works well with everyone. ...My goal is for us to discuss ways to communicate to [sister/legal guardian] that these things are not healthy and are causing unnecessary stress in staff and [client #1]." Review on 2-25-20 of an email sent to the LME's Care Coordinator from Owner/CEO on 2-20-20,	V 291		

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KERR HOMES, INC	5518 STONE BLUFF COURT CHARLOTTE, NC 28214

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V 291	Continued From page 13 at 3:50 pm revealed: -"Good Afternoon, I called you earlier to speak with you at 2:37 pm. I spoke with DHHR (Department of Health and Human Resources) today regarding our shared member. I was advised to do immediate discharge because I can no longer safely care for her. The DHHR stated that I can discharge her into [Sister/legal guardian]'s care because she is the LRP (Legally Responsible Person). [Sister/legal guardian] has blocked my company from attaining any medical information from the doctor's office. This afternoon she changed appointment times and took medical information that we needed after the appointment. This puts my company at immediate risk and we can no longer keep her in our facility. This is effective immediately. We will have her things packed and ready to go for [sister/legal guardian] in the morning. Let's set a time for pick up. [Sister/legal guardian] also called and put in complaints with DHHR and [local police department] this week. Of course, nothing was wrong or out of place. [Provider] cannot be provide the required care that our member needs without access to her medical information." Review on 3-10-20 of series of emails dated 2-24-20 between Owner/CEO and LME's Care Coordinator revealed: -11:01 am from Owner/CEO to LME: "My staff reported police coming Saturday and Sunday: yes 3 came out Sunday..she said when she answered the door one was standing back on one side one was on the other side with hands on the holster and one at the door was to the side...smh (shake my head). This is unacceptable. I feeling like I'm being taken advantage of. This needs to be resolved today." -11:12 am from the LME: "...I am attempting to gain some insight from CCD (Care	V 291		

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Coordination Department) on status for this members move and will reach out to you later today to discuss."

-11:16 am from the Owner/CEO: "Also look into alternate placements for her today. And I would like to know how to report this behavior to the arch or a guardianship agency to investigate her ability to remain guardian."

-12:38 pm from the LME: "I wanted to make sure I updated everyone at once. Residential placement for this member has been located and I have verified a start date with the new provider of 3/6/20. I sent out an update Friday evening for the team to sign reflecting this change. ...The start date is not changing. This update is to reflect residential services ending with [provider] on 3-5-20 and starting with [new provider] on 3-6-20."

-1:22 pm from the Owner/CEO to the LME: This date does not work for Kerr Homes, Inc.. we still do not have access to medical information and [sister/legal guardian] continues's to call the police everyday for health and safety checks. [Sister/legal guardian] needs to come pick up [client #1] until new placement opens up. What you propose does not fix any of my health and safety concerns."

-4:32 pm from the LME to the Owner/CEO: "At this time we are still awaiting input from our Clinical team regarding the Health and Safety Discharge Request submitted by you on Friday (2-21-20). Clinical is working to round this request with our Medical Team tomorrow afternoon. Per my discussions with CCD today...alternate placement has been located and the member is set to be transitioned on 3/6/20. In light of alternate placement being quickly secured with a transition date of 3/6, we ask that your agency maintain placement of this member until the date of transition in an effort to diminish the amount of moves. As you are aware, and we have

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discussed, there is a 60 day discharge notice requirement within your agency's General Conditions to Contract. I do understand your frustration with the current situation regarding your agency's interaction with the LRP and the issue of the police coming out for safety checks. We do ask that in the interest of the member, that the member is able to remain in the current authorized home until the transition date of 3/6/20..."

-5:00 pm from the Owner/CEO to the LME: "I would like for you to stop stating the 60 day contract rule!!!!!!!!! The contract has been violated by the LRP and [LME]!! If I can not access medical information or medication orders I am in violation of with DHHR! So the 60 days are not applicable in this situation. [LME] can not hold me liable for not dealing with a LRP that is out of control and has made this placement unsafe for her sister and my staff!! Cops showing up with their hands on their guns isn't safe. It isn't safe for the other two residents living there. They are [different LME] consumers and deserve to live in peace. [LME] needs to address the real issue in this situation! You are accountable for her health and safety just as much as I am. I know that if something medical happens to her [LME] will not support me. I will not keep her in my group home after tomorrow. Until I get in writing from [LME] that I will not be held liable for anything that happens to [client #1] until she moves and I have access to hr medical information. If I do not receive this in writing by 10am. I will be forced to take her to her sisters home or behavioral health but out of my facility. Please have all this in writing. I will be giving a copy to my attorney."

Review on 3-10-20 of facility discharge policy last revised March 2013 revealed:

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V 291	Continued From page 16 -"Kerr Homes, Inc. may discharge a client on an emergency basis if: 1. After the parent or guardian...has agreed to the rules of the facility and provision of the Person-Centered-Plan upon the client's admission to the residential facility and...refuses to carry out the rules of the facility...and this creates immediate jeopardy to the client, other clients, then general public or staff." Review on 3-10-20 of a document titled Request for Emergency Health and Safety Discharge dated and completed by the Owner/CEO on 2-20-20 revealed: -The sister/legal guardian picked up client #1 around Christmas time and took her to the hospital to have her checked. Client #1 spent Christmas in the hospital. -The sister/legal guardian was not communicating with neither him nor the LME. He was trying to keep the LME "up to speed." -"The member (client #1) was finally released back to the group home (no date noted). The LRP kept her medications from the hospital at discharge. During this time [Care Coordinator] and I discussed [sister/legal guardian] and her actions being unstable. ...From there her (sister/legal guardian) outburst and interference with [client #1] medical care increased into changing medical appointment times without notifying group home, would not allow staff from group home to speak with physician and nurse in spite of being clinical home, ordering tests without groups knowledge, then finally telling doctors not to communicate at all with my group home regarding her medical care." -" I know [client #1] loves it at Kerr Homes, Inc. and we love her but the risk is too great if no one addresses the LRP and her behaviors." -"My attorney and DHHR advised me to do an	V 291		

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emergency discharge immediately because this puts my company at too great of health and safety risk. I am exercising my right to terminate this placement based on the LRP violating my company policies and the policies of the MCO contract. Without access to any medical information to include medication orders and refills, Kerr Homes, Inc. will no longer keep [client #1] in it's facility. I am waiving my requirements of a 60-day notice because of the severity of the violation and the risk it has put my company in..."

Review on 3-10-20 of a document titled Request for Emergency Health and Safety Discharge (response section) revealed:

-"Date form received by [LME]: illegible."

-"Emergency H & S Discharge Accepted : No"

-"Has member been transitioned to a new provider: No"

-"Identify new provider: The plan is to move [client #1] to a different provider [new provider] 3/6/20."

Review on 3-9-20 of an incident report dated 2-26-20 and signed by staff #2 revealed:

-"[Client #1] was distraught, not wanting to move due to sisters request. [Client #1] kept repeating she 'doesn't like her sister', she wants her sister to 'go to h**l', she 'wants to kill herself', 'her sister ruined her life.' Since the start of staff's shift [client #1] was threatening to fight her sister. [Client #1] said her sister didn't love or care about her. She states that she is going to hurt herself. Staff (staff #2) then dropped her off at [local hospital] ER (Emergency Room). They heard her speech of wanting to hurt herself and admitted her."

Interview on 2-20-20 with client #1's sister/legal guardian revealed:

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V 291	Continued From page 18 -She was told by the Owner/CEO that she had to pick up client #1 because they no longer had any consents to take her to the doctor. -She stated that she did withdraw all consents for the facility to take client #1 to the doctor or to speak to doctors about client #1 because "I had to protect my sister." -She would not elaborate as to how that would protect her sister. -She stated that the facility had previously taken client #1 to the doctor and didn't tell her. -She had called the police to have a welfare check done because staff had hung up the phone when she called. Interview on 2-25-20 with client #1's sister/legal guardian revealed: -"[Staff #1] threatened to take [client #1] to Behavioral Health. [Staff #1] was saying I broke the contract." -"I had a welfare check over the weekend because I had not heard from [client #1] in several days." -"[Staff #1] said, 'If you don't think we are taking care of her, come get her or we will take her to Behavioral Health." -"[LME Care Coordinator] told them to file the proper forms." Interview on 2-26-20 with client #1's sister/legal guardian revealed: -The hospital called her and informed her that client #1 was there and she needed to pick her up. -The facility had taken client #1 to a local hospital and left her. -She had gone to the facility to get client #1's medications and she had gotten the police to go with her.	V 291		

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V 291	Continued From page 19 Interview on 3-18-20 with client #1's sister/legal guardian revealed: -Client #1 had not been admitted to the hospital on 2-26-20. -She was told where client #1 was by the hospital and was also told to come and get client #1. -Prior to receiving a call from the hospital she received a call from client #1's LME Care Coordinator to inform her that the facility had attempted to drop client #1 of at local Behavioral Health Hospital. -"Finally, late in the night, they (Hospital) said 'come get her.'" -"When I got there on the 27th, they wanted me to take her back to Kerr Homes, Inc.. I said, 'do you want me to be arrested for trespassing?'" -"They (facility) kept yelling at me she had been dismissed." -"[Client #1] was in scrubs. They wouldn't keep her because she wasn't suicidal." Interview on 3-10-20 with client #1 revealed: -"They (facility) left me with a piece of paper, that was it." -"I stayed awhile, a week, I mean a day." -"They (hospital) took my watch, my clothes, everything. I didn't get my watch back." -"I told them (hospital) I was going to kill my self." -"[Staff #2] told me my sister told him to take me to the hospital." -"[Staff #2] told me that my sister was coming to get me." -The police had been called to the facility by her sister. -"They (police) woke me up." -She told the police that she was fine and they left.	V 291		

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V 291	Continued From page 20 Interview on 3-11-20 with the local hospital social worker revealed: -She was shocked at the facility, they left the client alone in the emergency department. -"They didn't talk to anyone, they left her with a little piece of paper with her basic demographics." Interview on 2-26-20 with the Director of a local Behavioral Health unit that client #1 was initially taken to on 2-26-20 revealed: -The facility staff #2 had brought client #1 to the emergency department. -"Staff said he was instructed to leave her." -When she called the Owner/CEO (Chief Executive Officer) of the facility he told her that DHSR (Department of Health Service Regulation) told him that he could take client #1 there and leave her. -"I said 'no, she was not in crisis.'" -The Owner/CEO stated that he would take her to another hospital. Interview on 2-20-20 and 3-10-20 with the facility manager revealed: -Client #1's sister/guardian had revoked all the consents so the facility couldn't take her to the doctor or get medical information. -This had been done the first part of February, 2020. -The police had come to the facility because the sister/guardian couldn't get client #1 on the phone, but she had been in the shower. -The second time the police were called, client #1 had been asleep. -The police came out and talked to client #1 and she told them she was fine. -The Monitoring Specialist from the LME also came out and had no concerns. -The day of February 26th staff #2 had	V 291		

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reported client #1 had been upset.
-Staff #2 had completed an incident report and took client #1 to the hospital.

Interview on 3-17-20 with staff #2 revealed:
-On February 26th, he had taken client #1 to a local Behavioral Health Hospital that would not accept her, he took her to another local hospital that was close by.
-"I took her to the front desk...they checked her in a put a band on her wrist."
-Staff #2 went to move the van to a parking place and when he came back, client #1 was not in the waiting room. He assumed she had been admitted and left.

Interview on 2-24-20 with the LME's Care Coordinator revealed:
-"It was hard for client #1 to tell the difference between the truth from the past."
-She had noticed inconsistencies with the sister/legal guardian and thought there were issues on both sides.
-"I am concerned for [client #1] because of the relationship between LRP and the QP (Qualified Professional) (QP is also Owner/CEO)."

Interview on 3-9-20 with a Quality Management staff from the LME revealed:
-"It looks like he (Owner/CEO) sent in the documentation for emergency discharge due to the conflict with the guardian."
-"I'm not sure of the date. This note (that she was reviewing) was entered on 2-27-20."
-"Typically, they (emergency discharges) have to be reviewed."
-Another member of the LME "reached out (to the Owner/CEO), he was very unsympathetic."
-We were clear we did not agree with the

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discharge and he was in violation."
-"[Owner/CEO] would not budge."
-"The decision was made not to accept the request."
-"I think [Owner/CEO] told us that DHHS (Department of Health and Human Services) had approved the request."

Interview on 6-16-20 with the LME's Care Coordinator revealed:
-As far as she knew, there had been no changes in the decision to deny the emergency discharge.

Interview on 2-25-20 with the Owner/CEO revealed:
-The sister/legal guardian's behaviors was "out of control."
-He had called DHHR (Department of Health and Human Resources) complaint line and gotten advice on what to do about client #1.
-He was told by DHHR and his lawyer that he could leave her at a hospital because he had no access to clients #1's medical information.
-Client #1 did not want to leave the facility.

Review on 6-23-20 of the first Plan of Protection dated 6-23-20 and signed by Owner/CEO revealed:
What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm?
" The service recipient in question has been discharged."

Describe your plans to make sure the above happens.
"The facility qualified professional will maintain coordination of care between the facility and other professionals who are responsible for

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V 291	Continued From page 23 treatment/habilitation or case management. The QP (Qualified Professional) (QP is also the Owner/CEO) will coordinate discharges with the prevailing LME/MCO Care Coordination Department and the legally responsible party of the service recipient." Review on 6-26-20 of the second Plan of Protection dated 6-23-20 and signed by the Owner/CEO revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? "With regard to staffing: In accordance with NCAC 27G .5602 the facility will ensure that a minimum of one staff shall be present with all service recipients except when allowed by .5602(b) i.e. when service recipients plan documents that service recipient is capable of remaining in the home or community without supervision. Specifically the facility will ensure the presence of staff should a service recipient require hospitalization until such time as the hospital assumes custody of the service recipient. With regard to service coordination: In accordance with NCAC 27G .5603 the facility will ensure the Qualified Professional will maintain coordination of care between the facility and other professionals who are responsible for treatment/habilitation or case management. Specifically, the QP (QP is also the Owner/CEO) will ensure that any discharge from the facility is coordinated with the LME/MCO Care Coordination Department in a timely manner and	V 291		

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V 291	Continued From page 24 in conformance with applicable standards around discharge." Describe your plans to make sure the above happens. "Regarding staffing: In the event a service recipient has a medical emergency and requires medical care at a hospital, the facility QP will assign staff to stay with the service recipient until the hospital assumes custody of the service recipient. Assuming custody means the hospital admits the service recipient or does not admit the service recipient but refuses to allow staff to accompany the service recipient. An example of this would be 23 hour bed placement and the hospital does not allow staff in the unit. Regarding coordination of care: The facility QP (QP is also the Owner/CEO) will maintain documented coordination of care between the facility and other professionals who are responsible for treatment/habilitation or case management including legally responsible persons, medical professionals and care coordinators. Specifically the QP will coordinate discharges with the prevailing LME/MCO Care Coordination Department and the legally responsible party of the service recipient." -Client #1 had diagnoses that included Mild Intellectual Developmental Disability, Unspecified mental Disorder, Unspecified Psychosis, Cortical Blindness, Type II Diabetes, Post Traumatic Stress Disorder, Constipation, Unspecified Urinary Incontinence, hypercholesterolemia, Schizoaffective Disorder, Manic Episode, and Traumatic Brain Injury. Assessment dated 3-22-19 revealed: behaviors of physical aggression, Self-injurious behavior, cursing, suicide ideation, homicide ideation, frequently	V 291		

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V 291	Continued From page 25	V 291		

paranoid, abused as a child. Client #1 had no recent history of suicidal threats or ideation. The sister/legal guardian had removed all consents for medial treatment in the early part of February making it impossible for the facility to talk to her doctors or get medical treatment. Client #1's sister/legal guardian and the Owner/CEO had a difficult relationship and the Owner/CEO had requested an emergency discharge on 2-20-20 which was denied in part because client #1 was already scheduled to move on 3-6-20. Emails between the Owner/CEO and the local LME revealed that he wanted client #1 removed from his facility immediately and because the sister/legal guardian had revoked all the consents, he did not have to abide by the 60 discharge notice. The sister/legal guardian reported that the facility manager had told her that they would drop client #1 off at an emergency room if she did not come take client #1 out of the facility. Review of incident reports revealed that on February 26, 2020 client was distraught and expressing suicidal ideation and anger at her sister. On February 26th client #1 was first taken to a behavioral health hospital and was refused entry because she was not in crisis. The director of this hospital spoke with the Owner/CEO who told the director that he would take client #1 to another hospital. Staff #2 stated he had been given directions to leave client #1 at the hospital. Staff #2 then took her to a local emergency room, checked her in at the front desk and went to move his vehicle. When he returned client #1 was not in the waiting area, he assumed she had been admitted, and left. Hospital records indicate that client #1 initially stated that she was there for back pain and then expressed suicidal ideation. Client #1 was admitted and evaluated, without staff to help her. The client was left at the hospital with no staff and no coordination of care which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601142	A. BUILDING: _____ B. WING _____	06/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KERR HOMES, INC	5518 STONE BLUFF COURT CHARLOTTE, NC 28214

(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	Continued From page 26 was detrimental to the health, safety and welfare of the client. This deficiency constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of 200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 291		
V 542	27F .0105(a-c) Client Rights - Client's Personal Funds 10A NCAC 27F .0105 CLIENT'S PERSONAL FUNDS (a) This Rule applies to any 24-hour facility which typically provides residential services to individual clients for more than 30 days. (b) Each competent adult client and each minor above the age of 16 shall be assisted and encouraged to maintain or invest his money in a personal fund account other than at the facility. This shall include, but need not be limited to, investment of funds in interest-bearing accounts. (c) If funds are managed for a client by a facility employee, management of the funds shall occur in accordance with policy and procedures that: (1) assure to the client the right to deposit and withdraw money; (2) regulate the receipt and distribution of funds in a personal fund account; (3) provide for the receipt of deposits made by friends, relatives or others; (4) provide for the keeping of adequate financial records on all transactions affecting funds on deposit in personal fund account; (5) assure that a client's personal funds will be kept separate from any operating funds of the facility; (6) provide for the deduction from a personal fund account payment for treatment or habilitation services when authorized by the client	V 542		

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 542	Continued From page 27 or legally responsible person upon or subsequent to admission of the client; (7) provide for the issuance of receipts to persons depositing or withdrawing funds; and (8) provide the client with a quarterly accounting of his personal fund account. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to keep adequate financial records in the manner required effecting one of three clients (client #1). The findings are: Review on 2-20-20 of client #1's financial records revealed: -Receipts for various purchases. -No documentation of deposits for client #1. Interview on 2-17-20 with client #1's guardian revealed: -She had asked the facility for a record of client #1's finances but never received it. Interview on 2-18-20 with the facility manager revealed: -The guardian had only started asking for financial information in December 2019. -They offered to show her the receipts for client #1 but the guardian hadn't wanted to look at them. -All clients had a debit card that they made purchases from. -Each client received 100.00 per month for purchases. -She did not have access to the bank statements but the Executive Director did and The surveyor would have to get that information from him.	V 542		

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 542	Continued From page 28 Interview on 2-25-20 with the Executive Director revealed: -Client #1's guardian had not requested financial information until recently -"This is new, and a pattern." -The legal guardian was not the payee for client #1, the licensee was. -Client #1's receipts were at the facility and the guardian could look at those.	V 542		