STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-932	A. BUILDING: ______ B. WING ______	C 12/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALBERTA CARE	3107 SOUTH ELM-EUGENE STREET GREENSBORO, NC 27406

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V 000	INITIAL COMMENTS A complaint survey was completed on 12-18-20. The complaint was substantiated (intake #NC00172175). A deficiency was cited. This facility is licensed for the following service category: - 10A NCAC 27G .2300: Adult Developmental and Vocational Programs for Individuals with Developmental Disabilities	V 000		
V 106	27G .0201 (A) (8-18) (B) GOVERNING BODY POLICIES 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (8) use of medications by clients in accordance with the rules in this Section; (9) reporting of any incident, unusual occurrence or medication error; (10) voluntary non-compensated work performed by a client; (11) client fee assessment and collection practices; (12) medical preparedness plan to be utilized in a medical emergency; (13) authorization for and follow up of lab tests; (14) transportation, including the accessibility of emergency information for a client; (15) services of volunteers, including supervision and requirements for maintaining client confidentiality; (16) areas in which staff, including nonprofessional staff, receive training and continuing education;	V 106		

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V 106	Continued From page 1	V 106		

(17) safety precautions and requirements for facility areas including special client activity areas; and
(18) client grievance policy, including procedures for review and disposition of client grievances.
(b) Minutes of the governing body shall be permanently maintained.

This Rule is not met as evidenced by:
Based on observation, interview and record review, the facility staff failed to develop and implement a written medical preparedness policy, to be utilized in a medical emergency.
The findings are:

Review on 12-11-20 of client #1 ' s facility record revealed she was:
- admitted 9-10-16
- 64 years old
- diagnosed with:
  - Mild Mental Retardation
  - Impulse Control Disorder
  - Personality Disorder
  - Medication Induced Parkinson ' s Disease

Interview on 12-15-20 with client #1 revealed:
- she did not remember falling at Alberta Care on 11-25-20
- she ' s doing okay now, and feels good

Observation on 12-15-20 at client #1 ' s residence at approximately 4:30 pm revealed:
- client #1 ' s gait consists of shuffling her feet after putting them down hard on the floor, similar

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V 106	Continued From page 2	V 106		

to a stomp-slide-stomp-slide sequence when she walks
- entrance/exit to her residential facility consist of 2 steps with top step being unlevel due to raised threshold for the doorway

Review on 12-14-20 of an incident report dated 11-26-20 revealed an event at Alberta Care day program facility on 11-25-20:
- client #1 was at the facility
- about 12:50 pm she was leaving the facility
- staff #4 was walking next to client #1, to the side and slightly behind her, next to her right elbow
- client #1 stepped off the curb from the sidewalk to the parking surface
- client #1, "lost her footing"
- "She fell on her left side and injured her head on the concrete sidewalk"

Observation on 12-10-20 at approximately 4:30 pm revealed:
- a large brick facility with multiple levels of parking
- the lowest level had a relatively flat parking surface
- an entrance/exit door had a sidewalk approximately 15-20 feet straight to the parking area
- where the sidewalk reached the parking area, the sidewalk gently sloped downward to create no step down at the transition from sidewalk to parking surface
- the sloped area was approximately 4 feet wide
- on either side of the sloped area, the sidewalk was raised approximately 6 inches

Interview on 12-10-20 with the Clinical Director

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V 106	Continued From page 3	V 106		

(CD)
- Despite the facility being officially closed, they were distributing a Thanksgiving meal to clients and staff. Some were eating at the facility but most were taking their meal away
- client #1 ' s AFL (Alternative Family Living) operates under the umbrella of services provided by the day program ' s licensee
- client #1 was at the facility helping with a Thanksgiving meal for clients and staff
- the CD reported client #1 walked from the exit door, towards the parking area
- the automobile in which she was riding was parked towards the left
- client #1 and staff #4 walked towards the automobile and instead of walking down the sloped area where there was no step down, she walked to a spot where she had to step off the sidewalk onto the parking surface
- it was in that area where client #1 lost her footing and fell, striking her head on the sidewalk
- before helping her stand up, client #1 was assessed to determine the extent of her injuries, of which it appeared was only her head
- she had a red spot on the left side of her forehead, and an abrasion on her left cheek below her eye
- a wheelchair was brought out, and client #1 was assisted into the wheelchair and rolled back into the facility
- first aid was administered to client #1, including ice for the abrasion on her head
- CD reported client #1 is her own legal guardian
- telephone calls were placed to client #1 ' s brother who is her Power of Attorney, her AFL residential provider, (staff #1) and her Local Management Entity (LME) Care Coordinator
- when she spoke with her AFL provider- staff #1, she agreed to come pick up client #1 and

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V 106	Continued From page 4	V 106		

take her to an Urgent Care facility to be checked for injuries
- within an hour, client #1 was seen by a Medical Doctor at an Urgent Care Facility
- the Medical Doctor refused to treat her, and suggested staff #1 take her to a local hospital emergency department
- when client #1 and staff #1 reached the local hospital emergency department, that hospital referred her to another hospital in their network, and client #1 was transported by ambulance to a larger hospital emergency department
- "Looking back on it, whether we should have called EMT (Emergency Medical Technician; ambulance staff) or not, yes, I would have absolutely"

Interview on 12-16-20 with staff #4 revealed:
- "We were leaving the day program to pick up some more items for the Thanksgiving Dinner"
- "I was escorting her as I always do"
- "When she stepped off the curb, her left foot gave out and she went down on the ground and her head hit the sidewalk"
- when asked if looking back on it, would she have preferred an ambulance been called, staff #4 stated, "definitely"

Interview on 12-18-20 with client #1 ' s brother and Power of Attorney (B/PoA) revealed:
- "she (client #1) has spells where her brain gets so excited and when she starts walking, she sometimes gets ahead of herself and puts herself at risk"
- he remembered the day she fell at Alberta Care, the staff called him immediately
- she was first taken to Urgent Care, then to

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V 106	Continued From page 5 the hospital - he talked to his sister by telephone while she was at the hospital, and she couldn ' t remember what happened - he was called by the doctor at the first hospital and told client #1, "had a bleeder on the brain" - he was told it could be serious enough to warrant surgery, and they asked his permission, if it worsened - he didn ' t know why, but client #1 was transported to a larger second hospital, where more tests were conducted - then a second doctor contacted him and reported client #1 had a "dot-bleeder, and it would stop on it ' s own ..." - "I couldn ' t believe they (Alberta Care) didn ' t call an ambulance -I was shocked" - "I asked [CD] if it had been your child, would she have called someone to give her a ride, or would she have called 911 - and she couldn ' t answer" Review on 12-16-20 of the second hospital ' s Emergency Department (ED) admission and treatment record revealed: - client #1 was triaged at 4:50 pm on 11-25-20 - "CT (computerized tomography) head with 7mm (millimeter) hemorrhagic parenchymal contusion within the left front lobe. CT cervical negative. Will consult with neurosurgery for treatment recommendations. Caregiver does not feel comfortable taking patient home with concerns for neurologic decompensation. Plain films negative." - "CONSULT with Dr. [Neuro-Surgeon] with Neurosurgery who recommends Obs (observation) overnight given caregiver uncomfortable with taking patient home. He will	V 106		

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V 106	Continued From page 6	V 106		

admit the patient. Labs orders and COVID testing placed. VS (vital signs) stable at this time."

- "Labs at baseline. COVID pending however no concern for COVID infection. The patient appears reasonably stabilized for admission considering the current resources, flow, and capabilities available in the ED at this time, and I doubt any other EMC (emergency medical condition) requiring further screening and/or treatment in the ED prior to admission."
- "Final Clinical Impressions(s) / ED Diagnoses
Final diagnoses:
Fall, initial encounter - Contusion of brain without loss of consciousness, initial encounter
ED Discharge Orders: None"

Review on 12-14-20 of the facility ' s Service Manual related to medical emergencies revealed:

- Section 4.1, Page 1 of 3; Accident/Incident Reporting and Critical Incident Analysis Procedure
  - "(a) The Agency shall respond to level I, II or III incidents by:
    (1) attending to the health and safety needs of individuals involved in the incident; ..."
- "Section 4.8.10, Page 1 of 2; Outing medical Emergencies/Workplace Violence"
  "1. If an ambulance is needed:
    A. Administer appropriate emergency first aid immediately;
    B. Summon an emergency vehicle;"

Further review of the Service Manual failed to reveal what type of medical emergency might warrant when, " ...an ambulance is needed ..."

Interview on 12-14-20 with client #1 ' s AFL Provider, staff #1 revealed:

- When she was first called by Alberta Care staff, they thought her fall wasn ' t that serious

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V 106	Continued From page 7	V 106		

- she picked her up and immediately took her to an urgent care facility, "we got there about 1:30 or 1:45pm"
- the urgent care wouldn ' t treat her, and told her to take client #1 to an emergency room
- "I took her to [first smaller hospital], and they transferred her to [second, larger hospital]."
- "she ' s doing a lot better. She has trouble with balance anyway. Her appetite is back, she ' s made good improvement. She was complaining about her head hurting, but not now."
- this was the most serious fall she has ever had. As far as staff #1 knew, client #1 had never fallen at the day program.
- Staff #1 stated she would have preferred Alberta Care called an ambulance when client #1 fell

Review on 12-17-20 of a Plan of Protection written on 12-16-20 by the CD revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care?

As of 12/16/2020, if any client on the premises suffers an injury to their head or a serious injury to any other part of the body due to accidental falls or otherwise, 911 will be called, first aid will be provided, and the client will be transported to the hospital by ambulance immediately. All pertinent people in relation to the client will be contacted, and an incident report will be completed. All staff will be trained on this procedure.

Describe your plans to make sure the above happens.

Effective 12/16/2020, if there are any accidents that occur on the program premise, [Chief Compliance Officer] will be notified after 911 is

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V 106	Continued From page 8 called. All accidents will be documented on an incident report form and turned into the QM (Quality Management) department. Follow-up and on-going debriefing will occur between the Alberta Care Day Program Director and the Chief Compliance Officer to ensure that this procedure is being followed. Additionally, the Chief Compliance Officer will revise APS ' (Alberta Professional Services, Inc.) current policy to give clear instructions about calling 911 and informing leadership in the case of accidents. This facility, which serves adults with Intellectual Disability Disorders was officially closed due to the Co-Vid 19 pandemic. On November 25 a Thanksgiving meal was distributed to clients and staff from the facility, with client #1 attending to assist with the meal. Client #1 has diagnoses of Mild Mental Retardation, Impulse Control Disorder, Personality Disorder and Medication Induced Parkinson ' s Disease. Upon exiting the facility, client #1 fell while walking to the parking lot, and hit her head on a concrete sidewalk. Obvious impact from the fall revealed a bruise on her forehead and an abrasion to her cheek, but medical diagnosis later exposed bleeding on her brain. When client #1 ' s AFL provider was contacted, she agreed to drive to the facility and take client #1 to an urgent care medical office. Facility staff did not know the full extent of client #1's head injury, and by not contacting emergency medical personnel immediately, a delay of nearly 4 hours occurred before she was seen and diagnosed by trained medical personnel. Therefore, this deficiency constitutes a Type A2 rule violation for substantial risk of serious harm, and must be corrected	V 106		

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V 106	Continued From page 9 within 23 days. An administrative penalty of $1,000.00 has been assessed. If the violation is not corrected within 23 days, an administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 106		