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	MHL011-359	A. BUILDING: _____ B. WING _____	C 03/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEWART HOME	**35 EILEEN WAY LEICESTER, NC 28748**

(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 A complaint survey was completed on March 22, 2021. The complaint was unsubstantiated (Intake #NC00174806). A deficiency was cited. This facility is licensed for the following service category: - 10A NCAC 27G .5600F: Supervised Living for Alternative Family Living	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.	V 291		

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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 interview, observation and record review, the facility staff failed to maintain coordination between the facility and qualified professionals responsible for treatment, for one (client #1) of one client surveyed.
The findings are:

Review on 3-2-21 of client #1 ' s facility record revealed:
- she was admitted 9-20-05
- was 49 years old
- diagnosed with:
  - Moderate to Severe Intellectual Disability Disorder
  - Anxiety Disorder Secondary to Obsessive Compulsive Disorder
  - Speech Impediment
  - Scoliosis
  - Osteoporosis
  - Urinary Incontinence

Reviews on 3-2-21 and 3-11-21, of incident reports revealed:
- client #1 was in her downstairs basement apartment getting ready for the day (2-18-21)
- at approximately 9:39 am client #1 was walking up the steps to the main level, and fell
- client #1 ' s husband, who also resides in the basement apartment came upstairs and told the Alternative Family Living Provider (AFLP) that she had fallen
- when asked why she fell, client #1 stated

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she felt she was running late and was hurrying up the stairs
- client #1 may have been attempting to dress herself as she went up the steps, as she was not fully dressed when the AFLP got to her
- AFLP noticed a bruise/scrape on her chin, and applied ointment
- AFLP contacted the Qualified Professional (QP) and informed her of the fall, and that client #1 said she was okay and further medical attention was not needed
- QP instructed AFLP to monitor client #1 more closely, and if she expresses that she is hurting; or swelling or limping is noticed, that he " ...is to take her to the doctor immediately"

A second incident report for an event on February 24, 2021 revealed:
- client #1 had been out of the facility with her Day Support (DS) services staff person for their daily 4 hour community time
- they returned to the facility around 1:00 pm
- client #1 was downstairs and DS and AFLP were on the main level of the facility
- at approximately 1:20 pm they heard client #1 yell and went downstairs to find her on the floor in her bedroom
- client #1 stated, "I hurt" and she was unable to get up independently
- 911 was called, and she was transported to the local hospital
- initial CAT (computerized axial tomography) scan revealed a small fracture on her clavicle
- client #1 was admitted to the hospital from the Emergency Department

Addendum February 26, 2021:
- the Local Management Entity (LME) upgraded the incident to a level III

Addendum March 2, 2021:
- additional information added to the incident report

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- hospital reported client #1 ' s injuries were more consistent with abuse, than fall
- Sheriff ' s Department investigating possible sexual or physical abuse
- hospital tests ruled out sexual abuse
- Health Care Personnel Registry notified about allegations of possible abuse

Observation at approximately 9:15 am on 3-2-21 at the facility revealed:
- multi-level facility with a basement below the main floor
- basement had been renovated, and contained a finished area
- finished area had two rooms and a bathroom
- entire floor in the basement is ceramic tile
- one long straight flight of stairs between basement and main level
- steps between basement and main level are bare wood

Interview and observation at approximately 12:30 pm on 3-1-21 with client #1 revealed:
- client #1 was in a hospital room
- has an expressive language impairment
- she patiently allowed surveyor to re-ask questions two and three times
- acknowledged that she lived at the Stewart Home AFL
- a small red abrasion was observed on client ' s chin, slightly to the right of center, about the size of a nickel
- the Stewart Home was, "a good place to live"
- acknowledged she fell downstairs at the facility
- clarified she fell on the basement steps, could not remember when
- reported she remembered the day she fell,

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when the ambulance brought her to the hospital
- stated "[AFL Provider] and her Day Worker (DS) were at her home upstairs"
- she was alone in her room when she fell

Interview on 2-26-21 with the Department of Social Services Adult Protective Services (APS) staff investigating the incident revealed:
- client #1 was having surgery on her back this date, to fuse two vertebrae
- in client ' s first fall on 2-18-21 she was walking up stairs
- did not know how far up the staircase client was, before she fell
- struck her chin and cheek
- later reported she was sore
- on second fall on 2-24-21 both the DS and AFLP were in the facility and heard client #1 yell for help
- there have been no issues with this facility in the past
- no significant changes with this facility in past 3 months
- both client #1 and her husband have lived in this facility since 2009

Interview on 3-2-21 with client #1 ' s Legal Guardian Representative (LG) revealed:
- she had been client #1 ' s LG for 17 years
- had a, "very good relationship with her"
- "[client #1] is happy to be at the Stewart Home"
- the facility had lots of activities client #1 liked
- she participated in client #1 ' s treatment team meetings
- there was a fall in June of 2020, where she broke her right leg just above the ankle
- "after [client #1] fell last June (2020) ...her falls were few and far between" There was no

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increase in the frequency of falls, so no need to create a specific goal related to falling
- "the surgeon who did her surgery back in June (2020), said her bones, ' were as brittle as a 90 year old ' s ' ."
- client #1 has braces she is supposed to wear on her ankles because of her Osteoporosis, but frequently does not wear them
- "we should have (already) addressed her living in the basement and having to go up and down those stairs."

Interview on 3-2-21 and 3-16-21 with the AFLP revealed:
- client #1 fell in June of 2020
- the doctor said she had brittle bones
- she fell down the steps on 2-18-21
- client #1 ' s husband came upstairs and told me she was in pain and that she had broken something
- I went down and found her in her recliner
- she had fallen down the steps, but didn't know how many steps or how far she had fallen
- she said she fell on the steps, "but couldn ' t tell me how, whether she was coming up or how high she had gotten"
- she had a red mark below her left eye and a scrape on her chin
- she was sore and moving slow, but wanted to go with her DS person into the community, and did
- several things were considered in his decision to not seek medical help for client #1 ' s fall on 2-18-21:
  - she was able to move her arms and legs
  - he asked her to stand up and she stood right up
  - she came up the stairs and ate her breakfast like normal

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V 291	Continued From page 6 - he knew she would be sore - he called her guardian, who gave him permission to give her aspirin - he didn ' t have any indication that anything was seriously wrong - he called the QP, "she didn ' t tell me to take her to the doctor either. She said to keep her posted and let her know how she ' s doing, keep an eye on her. All (the following) weekend we were doing good, going outside" - she fell again on 2-24-21 - the DS was talking with him when they both heard her yell - she went to the hospital because of that fall, due to her not being able to get up independently - "I ' ve been wracking my brains for what I could ' ve done to keep her from falling." Interviews with the QP on 3-2-21 and 3-12-21 revealed: - she talked to the AFLP every month on her visits to the facility as well as in between visits by telephone - prior to the fall on 2-18-21, she had thought about client #1 having, "a lot of stairs in the home" and wondered if a different AFL would suit her better - she had contacted the LG and client #1 ' s Care Coordinator prior to the fall on 2-18-21, to schedule a meeting for 3-3-21, to discuss relocating her - AFLP called her after the fall on 2-18-21. He said he checked on her and put ointment on her chin. There was no mention of any other marks or bruises - client #1, "went on and did her regular activities with her day staff" - "looking back on it, [client #1] should have been taken to a medical facility because she had Osteoporosis and Scoliosis, to be checked out"	V 291		

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- "even if she didn ' t have Scoliosis and Osteoporosis, I still think she should ' ve seen a medical person just because she ' s IDD (Intellectual Developmental Disability) and speech impediment and might not be able to answer questions you would ask, to assess someone else ' s cognitive or mental state after a possible fall involving her head"

Review on 3-2-21 of the licensee ' s policies and procedures revealed:
- in the "Participant Section" under "When to Seek Medical Assistance," was written, "It is your responsibility to know when to seek medical assistance"
- "1. Experiencing deviations from normal breathing, skin color, movement and consciousness"
- "2. Orientation, affect/mood, speech and attitude is to be assessed individually ..."
- in the "Emergency Plans" section was written a list of procedures which included, "If the individual ' s condition indicates, Emergency Medical Services will be summoned for further evaluation and more intensive treatment"

Interview on 3-12-21 with the Physician ' s Assistant who treated client #1 at the local hospital revealed:
- she treated client #1 for the fall on 2-24-21
- client #1 had a previous thoracic vertebrae fusing (date not provided)
- client #1 also had broken ribs on 2-24-21
- reported most of the bruises likely came from the fall 6 days earlier
- the previous fall could have contributed to the injuries in the fall on 2-24-21
- When asked if the AFLP should have ensured client #1 was seen by a medical professional for the fall on 2-18-21 she answered,

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V 291	Continued From page 8 "Yes, I agree, he should have." Interviews on 3-12-21 and 3-16-21 with the Regional Services Manager (RSM) revealed: - there was no policy or procedural directive that said, "If this happens, do this ..." - in hind sight, the AFLP should have called 911 after the first fall - if it had been just a short fall, such as off a chair, with no bruising and no marks, then administer first aid - but since it involved stairs, "a hard surface and there was a visible injury like the thing on her chin, then yes" medical professionals should have assessed her - looking back, the QP, "should have told him (AFLP) to make sure she sees a doctor, if only the urgent care. I ' d rather over-react than under-react." - new procedures have been put in place to insure providers make better decisions regarding handling injuries and whether or not to seek care: - re-train all our QPs regarding responses to injuries - re-train all our AFL providers for responses to injuries - insure everyone is trained the exact same way - created a checklist that helps AFLPs to know if they should: - move someone or not - call 911 or not - administer first aid or not - we reviewed our policies to consider updates and revisions - "I talked to [QP] and she agreed too, ...we should have had him (AFLP) at least take her somewhere" - "I concur 100%, if that was my own family member, I would want them to be checked out.	V 291		

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V 291	Continued From page 9 Our primary focus is for our consumers to live a meaningful and safe life." Review on 3-18-21 of a Plan of Protection written by the RSM and submitted on 3-17-21 revealed: What immediate action will the facility take to ensure the safety of the consumers in your care? "February 26, 2021 the client/person served involved in the incident was removed from the home along with the other members residing in the Stewart Home to ensure their protection and safety." Describe your plans to make sure the above happens. "The client/individual involved in the incident will not return to the home, as the residential facility cannot meet her physical or medical needs. It has been determined that because of her physical and medical issues the home will be unsafe for her due to the construction design of the home. It involves lots of stairs to enter the home and additional stairs to access the bedroom the individual once occupied. The home will only be appropriate to accommodate individuals who do not have mobility issues and are able to ambulate safely up and down a flight of stairs." On February 18, 2021 a 49 year old client with diagnoses of Moderate to Severe Intellectual Developmental Disability, Anxiety Disorder secondary to Obsessive Compulsive Disorder, Speech Impediment, Osteoporosis and Scoliosis fell on a flight of stairs in her Alternative Family Living facility. She was known to have a history	V 291		

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V 291	Continued From page 10 of brittle bones, from a fall and broken leg 8 months earlier when her Orthopedic Surgeon reported she had the bones of a 90 year old woman. Regarding the fall on 2-18-21, there was no way to know if she had fallen from the top of the stairs, or somewhere below the top. It was known she struck her head, due to an abrasion on her chin and red mark on her cheek. Because of her Intellectual Development Disability and Speech Impediment, there was no way to accurately assess the client ' s orientation after the fall, which is required per policy; nor was she thoroughly physically assessed, despite being known to have brittle bones. When the client sustained another fall 6 days later, the attending Physician ' s Assistant reported the earlier fall could have contributed to her extensive injuries in the subsequent fall. Not having the client seen by a medical professional after the first fall, was detrimental to her health, safety and welfare. 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		