Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-468	A. BUILDING: _____ B. WING _____	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TAYLOR HOME	5026 LANSING DRIVE CHARLOTTE, NC 28270

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 6-23-21. The complaint was unsubstantiated (#NC00176087). Defeciencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 5600C Supervised Living for Adults Whose Primary Diagnosis is a Developmental Disability.	V 000	DHSR - Mental Health JUL 2 2021 Lic. & Cert. Section	
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to conduct fire and disaster drills on at lease a quarterly basis and repeated on each shift. The findings are: Review on 5-25-21 of the facility's fire drills revealed: -No third shift drill the first quarter of 2021.	V 114	V 114 The Taylor Home will show evidence that quarterly fire and disaster drills were conducted for each shift of personnel as evidenced through drill reports. The Program Coordinator will ensure that evacuation drills are being held at least quarterly for each shift of personnel. Program Coordinator and/or QIDP will in-service staff on the guidelines pertaining to fire/disaster drills and adhering to the schedule by 7/23/21. Program Coordinator and/or QIDP will review monthly/ quarterly reports to ensure drills are completed each shift within the quarter.	

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V 114	Continued From page 1 -No first shift drill the fourth quarter of 2020. -No third shift drill the second quarter of 2020. Review on 5-25-21 of the facility's disaster drills revealed: -No third shift drill the first quarter of 2021. -No first shift drill the fourth quarter of 2020. -No third shift drill the second quarter of 2020. Interview on 5-25-21 with the facility manager revealed: -First shift was 7am- 2 pm. -Second shift was 2pm-10pm. -Third shift was 10pm-7am. -She had been the facility manager for six months. -Since she had been the manager the fire and disaster drills were being completed. -She didn't know why some of the documentation was not in the book. Interview on 5-25-21 with Client #1 revealed: -They do fire drills but she didn't say how often. -The staff helps everyone get out of the facility. Interview on 5-25-21 with Client #2 revealed: -They do have fire and disaster drills but she could not remember that last time they had one. Interview on 5-25-21 with Client #3 revealed: -The facility did have fire and disaster drills. -She could not remember how often the facility had the drills. Interview on 6-23-21 with the Residential Director revealed:	V 114		

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V 114	Continued From page 2 -That facility had gotten a new manager and the Qualified Professional had also recently left so some of the documentation may have been misplaced.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118	V 118 Nursing will in-service/retrain staff on medication administration, specifically in preventing documentation errors on eMAR/ paper MAR by 7/23/21. The Program Coordinator will review eMAR/paper MAR and medications weekly to ensure accuracy. The Program Coordinator will observe full medication administration at the group home weekly, QIDP will observe monthly. Nursing will review paper MAR monthly.	

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V 118	Continued From page 3 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to maintain an accurate MAR effecting three of three audited clients (Client #1, #2, and #3). The findings are: Review on 5-25-21 of Client #1's MAR's from March 2021-May 25, 2021 revealed: -3-34-21 missing 8pm signature for Levetiracetam 1,000mg (milligrams). -5-9-21 missing 8pm signature for antifungal powder 2%, Baby wash, Calcium/D3 600-400 tab (tablet), Galantamine 8mg tab, Levetiracetam 1,000 mg tab Oxybutynin ER 5mg tab, Vimpat 100mg tab. -5-21-21 8 pm missing signature for baby wash, Fiberlax 625 mg tab Galantamine 8 mg, Review on 5-25-21 of Client #2's MAR's from March 2021-May 25, 2021 revealed: -3-5-21 missing signature for Benzotropine Mesylate .5 mg 8pm. -Missing signatures for soft collar 3 times a day for one hour at mealtimes: 3-1-21 1200pm, 3-2-21 12 pm, 3-4-21 12pm and 5:00pm, 3-8-21 12pm, 39-21 12:00pm, 3-10-21 12pm, 3-11-21 12pm, 3-25-21 12pm, 3-29-21 12pm, 3-30-21 12pm. -4-16-21 missing signature for Loratadine tab 10mg 8pm, Melatonin 5mg 8pm. -Missing signature for soft collar three times a day for one hour at mealtimes missing signature 4-1-21 12pm, 4-14-21 2pm, 4-15-21 12pm. -5-9-21 missing signature 5-9-21 for Nyamyc 100,000 unit gm (gram) powder 8pm, Restasis	V 118		

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V 118	Continued From page 4 .05% opth emulsion 8pm, home exercise program stretches 8pm. -Missing signatures for soft collar three times a day for one hour at mealtimes 5-9-21 5pm, 5-19 -21 12 pm. Review on 5-25-21 of Client #3's MAR's from March 2021-May 25, 2021 revealed: -4-15-21 signature missing for Nyamyc 1000,000 unit gm powder 4 pm. -4-18-21 signature missing for Nyamyc 1000,000 unit gm powder 4 pm. Interview on 5025021 with Client #1 revealed: -She always hade her medications daily and there were no problems with them. Interview on 5-25-21 with Client #2 revealed: -She was able to list some of her medications and said that there was no problem with them. Interview on 5-25-21 with Client #3 revealed: -There were no issues with her medications. Interview on 5-25-21 with the Facility Manager revealed: -Sometimes the electronic MAR's are not working so staff has to use a paper copy. -They don't keep the paper copies very long so she couldn't show the surveyor some of the months in question. -She had no explanation for why the cited missing signatures had no correlating paper signature for the paper MAR's that were available for review.. -Client #2 would put her own soft collar on, so staff would sometimes forget to sign the MAR for it.	V 118		

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V 291	Continued From page 5	V 291		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure coordination between facility operator and the qualified professionals who are responsible for treatment/habilitation,	V 291	V 291 The Taylor Home will ensure coordination of care for all clients is occurring with the clinical team members. This will ensure that the clinical team is cooperatively involved, resulting in timely and appropriate intervention/ treatment not only for client #1 but for all the clients. The Lead Nurse/QIDP will in-service staff on communication relating to coordination of care and the group home on-call checklist for notifications by 7/23/21. The Program Coordinator and QIDP will discuss client care during monthly staff meetings. The facility and the clinical team members will continue to document all communications through our electronic system, Therap.	

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V 291	Continued From page 6 effecting one of four clients (Client #1) The findings are: Review on 5-25-21 of Client #1's Person Centered Plan dated 2-1-2021 revealed: -Diagnoses include: Moderate Intellectual Disabilites, Major Neurocognitive disorder due to possible Alzheimer's disease, without behavioral disturbance, Major Depressive Disorder recurrent episode unspecified, Autistic Disorder, Conversion Disorder with Seizures or Convulsions, Hypertension, Hypothyroidism, Unspecified Dementia without Behavioral Disturbance, Corns and Callosities, Difficulty walking, not elsewhere classified, Unspecified Urinary Incontinence, Unspecified Convulsions, Unspecified psychosis not due to substance abuse or known physiological condition, Arthopathy. "I need extensive support for mobility concerns...If I must walk a long distance, I will need my walker or even my wheelchair...I will shuffle my feet." -"Has a history of displaying self-injurious behaviors where she will intentionally scratch, pick skin, or other behaviors with the purpose of harming herself. -Risk/Needs Assessment dated 2-1-2021 revealed: -"Fractured her left wrist in October 2019. The radiologist determined that the bones are osteopenia." Review on 5-17-21 of IRIS report dated 2-10-21 and completed by the Qualified Professional revealed: -"2-8-21...approximately 8:30 am Lead Nurse reported the QP (Qualified professional) that they have been notified ...[Client #1] was stating she had arm pain and was not wanting to move her arm or begin her daily routine. ...an unwitnessed	V 291		

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V 291	Continued From page 7 fall had been reported earlier the evening prior with no observed injuries...Staff arriving for moring shift reported discovered brusing to nursing on left arm and a front tooth missing...discovered brusing while preparing for transport...results of CT (Computed Tomography) scans and XR (X-ray) findings...left shoulder was dislocated with fracture. A rib fracture was also discovered..." Review on 5-17-21 of 5-Working Day report for the Health Care Registry dated 2-9-21 and completed by the Social Work Coordinator revealed: -" discovered on the floor of her bedroom by staff...stated that she fell, staff did not witness this fall...stated her arm was sore, when asked which one she pointed to one, then the other, according to staff . Staff contacted the nurse and at that time the next staff arrived and they both assisted [Client #1] into bed. The next morning [Client #1] was complaining that her arm hurt more and that she had lost two teeth when she fell....was taken to urgent care the the ER (Emergency Room) bruises of an unknown origin were also discovered which could have come from the fall or staff lifting her off the floor. X-ray showed fractured shoulder and three broken ribs. Staff located teeth on the floor in bedroom..." Review on 5-17-21 of the General Incident Reports dated 2-7-21 and competed by Staff #1 revealed: -"[Client #1] used the restroom and went into her bedroom. The phone rang and DSP (Direct Support Professional) went to answer the phone. Once the DSP hung up the phone [Client #1] yell. When the DSP came back into the bedroom [Client #1] was on the and stated that she had fallen."	V 291		

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V 291	Continued From page 8 -Nurses added note dated 2-8-21 7:01 am (entered 2-8-21 but from call the night before); "No observable signs or symptoms of pain or injury noted. Staff instructed to monitor and report any pain, swelling, brusing, limitation of movement and/or other signs of injury." Review on 6-23-21 of nurses report dated 2-7-21/2-8-21 revealed: - On call nurse: "No observable signs or symptoms of pain or injury noted. Staff instructed to monitor and report any pain, swelling, brusing, limitation of movement and/or other signs of injury." -Lead nurse: 7:01am Lead Nurse notified by staff [Client #1] had an unwitnessed fall 2-7-21 before 9pm. [Client #1] was assisted up and into bed and was believed to to have no injuries. At 7am [Client #1] complained of arm pain and blood around mouth, [Client #1] reported to staff she lost two teeth during fall. Staff confirms one tooth missing. QP notified. [Client #1] taken to urgent care of x-ray of arm and evaluation of mouth." Review on 5-25-21 of undated and unsigned Neglect Investigation revealed: -"9:15 pm-DSP [Staff #2] arrives at the home and finds [Client #1] on the floor and [Staff #1] on the phone with [Licensee] nurse. [Staff #1] and [Staff #2] do a two person assist lift to help [Client #1] off the floor by grabbing under the arm. While lifting, [Client #1] collapses as to fall again and staff was forced to grab under her legs to keep her from falling. Staff is able to get [Client #1] into her bed. They ask [Client #1] is she is hurt, she states her arm is a little hurt. Staff asks [Client #1] which one, she points to her left, then says no, it's this one and points to the right. Neither staff notice any other injuries per staff statements."	V 291		

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V 291	Continued From page 9 Interview on 5-25-21 with Client #1 revealed: -She lost her balance when she fell on 2-7-21, she did not get dizzy. -She did not tell staff that she had lost her teeth. "I was half asleep." -She had gone to the bathroom, but fell in her bedroom. -"I didn't have a rail (bedrail) then." -Client #1 did state that she didn't think staff knew she was hurt. -Client #1 didn't know if she told staff she was hurt or not. Interview on 6-7-21 with Staff #1 revealed: -She was not in the room at the time of the fall but heard Client #1 make a noise. She went into the bedroom and Client #1 had fallen. -"I asked her what happened. I asked her what hurt and she said she wasn't." -"She had her left hand pointing to her right hand, then said the left hand. She was moving both. "The nurse told me to see if she could get up on her own." -"The other staff (Staff #2) came in, I told her what happened." -"I asked the nurse what to do, I asked the nurse if they (Staff #1 and #2) should call an ambulance. The nurse said she couldn't authorize that." -The staff thought that the fall might have been related to Client #1"s behaviors. -The staff got on each side of Client #1 and helped her sit up. -"There was no blood, no brusing, no nothing." -They got Client #1 to stand up and Staff #2 checked her for bruising. -Staff #1 and #2 had to then lift Client #1 into	V 291		

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V 291	Continued From page 10	V 291		

the bed, as Client #1 either could not or would not support herself on her legs.

-"I got a call (the next morning) saying her teeth were out. Her teeth were not out then (when she fell), there was no blood."

-"She did complain about her arm, but we saw no blood."

-Staff #1 insisted that Client #1 still had her teeth when she left. She said she would have noticed when she talked to her, and there was no blood.

-"I told the nurse she was complaining about arm pain."

Interview on 5-24-21 with Staff #2 revealed:

-She had called Staff #1 to let her know she was running a few minutes late. When she got to the facility, Client #1 was on the floor, face down.

-Staff #1 was on the phone, she believes with the nurse.

-"She (Client #1) said her arm was hurting."

-"I did not see blood on her face or nowhere. I did not see that her teeth were out."

-Staff #1 was the one that talked to the nurse and did the paperwork.

-Staff #2 checked on Client #1 throughout the night.

-Client #1 slept through the night.

-When staff went into Client #s' room the next morning, that was when she saw Client #1 had a small amount of dried blood around her lips, and staff found her teeth on the floor.

-She has not been back to the facility since the incident.

Interview on 6-7-21 with Staff #3 revealed:

-She came in the morning of 2-8-21 and went in to check on Client #1.

-She noticed that Client #1 had a tooth missing and that she had multiple bruises on her.

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V 291	Continued From page 11 -She called the nurse and reported it. -Client #1 could only tell her that she had fallen. -There was only a small amount of blood on Client #1's face and no blood on the bedding. Interview on 6-14-21 with the on call nurse revealed: -Staff will call her anytime there is a change in client condition, and that includes a fall. -She did question the staff about Client #1 and if she was injured. -The nurse was "flabbergasted" when she found out the next day the extent of Client #1's injuries. -"They didn't say she was injured." -"I can authorize them (staff) calling the ambulance." -The on call nurse stated that she has to go by what the staff report to her. It would not be unusual for her to tell staff to transport to an Urgent Care or the Hospital for a fall. -She called back the next moring to check on Client #1 and was told she was injured. -She rechecked her notes and reiterated that "no one told me she was hurt." -The agency takes falls very seriously. -"It was a three minute phone call, they (Staff #1) said there were no injuries noted." -When she called the next morning, staff told her that Client #1 was having knee pain and arm pain. -She gave permission for a PRN medication and let the Lead Nurse know. -"So until 6:25 am, they didn't know she was injured." -"From what they told me she had no complaint of pain. They said she was moving her arm when they were not looking." -She couldn't remember if Client #1 had been	V 291		

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V 291	Continued From page 12 in bed when staff called. -"But I do know all injury was denied, I know that for sure." Interview on 6-23-21 with the Lead Nurse revealed: -After any fall staff will continue to monitor and notify the on call nurse of her self of any changes. -The nursing staff will give facility staff specific changes to look for. -Client #1 was on medications that will increase bruising. -She was sure that the on call nurse went over what needed to be done with the facility staff. -Client #1 can have a broken bone and not be aware of it. -When they realized she was injured, they took her to Urgent Care immediately.	V 291		