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MEADOW HOUSE	1407 EAST MEADOW ROAD EDEN, NC 27288

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on August 10, 2021. The complaint (#NC00179910) was substantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court	V 291		

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V 291	Continued From page 1 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 observations, record reviews and interviews, the facility failed to coordinate services with those responsible for 1 of 3 clients (#1). The findings are: Review on 8/6/21 of the Program Director (PD)'s record revealed: -A hire date of 11/4/2004 -A job description of PD Review on 8/5/21 of client #1's record revealed: -An admission date of 12/1/2009 -Diagnoses of Paranoid Schizophrenia; Major Depressive Disorder; Mild Intellectual Disabilities; Type 2 Diabetes; Seasonal Allergies; Hypogamic: Asthma; Gastro-Intestinal Disorder, Distress; and COPD (Chronic Obstructive Pulmonary Disease). -An updated assessment dated 7/6/21 noted "requires supervised living services, has limited contact with his family, he must sleep with oxygen and use oxygen as needed throughout the day. He is on a smoking schedule (1 cigarette per day at 4pm). Has a diagnosis of COPD and a DNR (Do Not Resuscitate) order, has a lack of engagement during the day, his medical needs often impact his ability to participate in some activities. He often gets tired and out of breath due to his COPD. He can't walk too long, and his oxygen levels stay between 71 and 81. He is not able to complete his ADLs (Activities of Daily Living) most of the time. He has an oxygen machine and may be in need of an updated psychological evaluation for the possibility of seeking an ICF (Intermediate Care Facility)	V 291		

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facility in the future, staff will assist with medication management and ensure his safety at all times."
-A treatment plan dated 7/6/21 noted "will received residential supports to maintain his maximum functional level while improving and maintaining daily living skills, socialization skills and adaptive skills to live as independently as possible, will increase his self-help skills, and will have the opportunities to socialize."

Review on 8/6/21 of client #1's medical consultation appointments, provided by the facility, from 7/1/21 to 8/3/21, revealed:
-On 7/1/21, client #1 was seen by his Primary Care Physician (PCP) for an updated FL-2 and a higher level of care was recommended due to his severe COPD diagnosis
-From 7/5/21 to 7/7/21, client #1 was hospitalized for COPD Exacerbation and a chest x-ray revealed a 2 centimeters lung mass. The hospital staff scheduled an appointment with a local oncologist for 7/9/21
-On 7/8/21, client #1 was seen by his PCP
-On 7/9/21, client #1 saw a local oncologist who noted "57-year-old male with long smoking history. Found to have a 2cm mass on lung. Will order a PET/CT (Positron Emission Tomography) and blood work. Refer to [a state university's medical department] for surgery ... spoke to patient regarding the abnormal CT finding with a mass in his lung ...further evaluation with PET-CT is recommended as it was believed the mass on his lung was cancer."
-On 7/22/21, a state university's medical department called the facility with an appointment on 7/23/21 for client #1's PET CT and spoke with the Team lead (TL).
-8/3/21, client #1 had a follow-up appointment with the local oncologist.

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V 291	Continued From page 3 -No documentation as to why client #1's medical appointment was canceled on 7/23/21 -No documentation of attempts to reschedule client #1's medical appointment with a state university's medical department after the cancellation on 7/23/21 Observation and interview on 8/5/21, at approximately 1:15pm, with client #1 revealed: -Was wearing his oxygen tube in his bedroom and was sitting in his recliner -"They (facility staff) check my oxygen levels twice a day. If it gets below 90, they have to call the ambulance to check on me." -Was diagnosed with COPD -When asked about his medical appointments, client #1 stated "as far as I know, I have been to all of my appointments. Staff takes me." -Relied on the facility staff to keep up with his medical appointments -While admitted to a local hospital, from 7/5/21 to 7/7/21, client #1 had a chest x-ray. -"I know the doctor wanted me to get a special scan. He said they found a small speck in my lung. The doctor talked to me about it possibly being cancer. He scheduled the appointment at [a state university's medical department]. That appointment was canceled because I did not think I could travel all that way. My back and legs hurt." -When asked if his PET CT was rescheduled, client #1 stated "you will have to ask [PD]." Interview on 8/10/21 with the Registered Nurse, from the local oncologist's office, revealed: -On 7/12/21 at 11:21am, a telephone call was made to the facility and a message was left with the contact person and the office number -On 7/14/21 at 12:44pm, a telephone call was made to the facility.	V 291		

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V 291	Continued From page 4 -The RN stated on 7/14/21 she spoke with the TL. -The TL told the RN to call the PD and provided her with the PD's cell phone number -"I actually spoke with [PD] (on 7/14/21) to schedule [client #1]'s PET CT. I was told [client #1] was in transition to another facility ...She further told me her leadership (upper management) would probably make her take [client #1] for his PET CT ...[PD] told me she would call me back to schedule [client #1]'s PET CT, but she never did." -Since the facility staff had not scheduled client #1's PET CT, the RN called the facility a third time. -On 7/22/21, the RN spoke with the TL and "I made her aware [the state university's medical department] had scheduled an appointment for [client #1]'s PET CT." -The appointment was scheduled for the following day, 7/23/21. -On 7/22/21, the PD canceled client #1's PET CT appointment and did not reschedule his appointment. -"Since no one from the facility called us back, a call was made on July 28th (2021). I left a message for [PD] to call me. She never did ..." -On 7/30/21, the oncologist's office left another message with the PD, trying to schedule the PET CT appointment for client #1 -"On July 31st (2021), I was finally able to speak with [PD]. Her main concern was transportation to [a state university's medical department] ...she further stated [client #1]'s care was getting too involved for the staff." -On 8/3/21, client #1 had an appointment with his local oncologist and the TL and the PD were both present. -"They agreed to reschedule the PET CT. So, it was rescheduled for August 13th (2021). We also made an appointment for his thoracic biopsy	V 291		

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surgery. They still were concerned about transporting [client #1] to the PET CT. We assessed him and since he had portable oxygen, he was cleared to make that appointment. They never gave a reason as to why there were issues with [client #1]'s transportation. We even offered to set up Medicaid transportation. [Client #1] verbalized at the appointment he wanted to go to the appointment for the PET CT."
-On 8/6/21 at 12:28pm, the RN spoke with the PD and client #1's thoracic surgery has been scheduled for 8/24/21.

Further interview on 8/10/21 with the RN revealed:
-There had been a long delay in client #1's treatment (35 days)
-" ...the delay could have resulted in [client #1]'s death. If it is cancer, we don't know if it has spread or not. We do not know what his prognosis is."

Interview on 8/6/21 with the Adult Protective Services Social Worker revealed:
-Client #1 was admitted to the hospital 7/5/21 to 7/7/21.
-An x-ray was taken on 7/5/21 and a lung mass was discovered
-Client #1 was referred to local oncologist on 7/9/21
-The facility's TL took client #1 for this appointment
-The oncologist reviewed client #1's x-rays
-The x-rays revealed a 2 cm (centimeter) lung mass
-The oncologist referred client #1 to a state university's medical department's oncologist for a PET CT
-The local oncologist would call the facility staff with an appointment for client #1 with the second

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oncologist
-According to the local oncologist's office professionals, they had called the TL with an appointment for 7/23/21.
-Client #1's appointment for 7/23/21 was canceled by the PD
-The medical office stated they had attempted to reschedule client #1's appointment on several occasions but their telephone calls were never returned.
-"There was no follow through by the facility staff for [client #1]. The facility staff did not have any documentation to prove what they did and did not do. They have no documentation about rescheduling [client #1]'s appointment. The medical office does have the documentation."
-The local oncologist was upset the facility staff had not made the appointment with the second oncologist.
-"There was no sense of urgency to get [client #1] seen. That is what [PD] told me. There should have been follow through by the facility staff. How they handled this situation is not acceptable. They delayed [client #1]'s treatment for an entire month. In my opinion, it was neglectful. They are a residential treatment facility, and they are making decisions on his behalf. [Client #1] relies on them to assist him with his medical treatment."
-Client #1's new appointment with the second oncologist was scheduled for 8/13/21.

Interview on 8/5/21 at 12:24pm with staff #1 revealed:
-He did not schedule medical appointments for client #1.
-Medical appointments were scheduled by either the TL or the PD.
-Was not aware client #1 had an appointment at a state university's medical department.
-Stated client #1's health has declined, in the last

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few weeks, and he had become confused.
-"It is getting harder and harder for him to move around. He is just not breathing well."

Interview on 8/5/21 with the TL revealed:
-Client #1's oxygen levels had been low, and he is on oxygen 24/7
-Either she or the PD were responsible for scheduling medical appointments.
-"We are taking him to all of his appointments."
-Client #1 had a medical appointment on July 9th (2021) with a local oncologist.
-"I did take [client #1] to his oncology appointments here in town. That was on July 9th (2021). [PD] was off that day. His local oncologist wanted him to be seen by another oncologist doctor [at a state university's medical department]."
-Received a call from a state university's medical department on 7/22/21
-"They called on a Thursday (7/22/21) afternoon and his appointment was scheduled for the following day (7/23/21). I let [PD] know. [PD] canceled the appointment since they did not give us a 24-hour notice and we already had stuff scheduled that day ...they were supposed to call back to reschedule but they did not."
-When asked who was responsible for rescheduling client #1's appointment with the state university's medical department for the PET CT, the TL stated she had no idea.

Further interview on 8/9/21 with the TL revealed:
-After client #1's appointment on 7/9/21 with the local oncologist, "his office told me they would be making a referral for him to [a state university's medical department]. They did not schedule that appointment on July 9th (2021). Because the appointment wasn't made, I did not dwell upon it. I did try to remember what all his oncologist said

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that day."
-When asked if the information with the local oncologist from client #1's 7/9/21 appointment was shared with the PD, the TL stated "It may have come up in the midst of a conversation. I did not document anything ..."

Interview on 8/5/21 with the PD revealed:
-Duties included ensuring the clients' medical needs were met
-Client #1 had been diagnosed with severe COPD, he was on oxygen 24/7 and his health had been declining in the last 2 months.
-"[Client #1] was hospitalized from July 5th to July 7th (2021). A chest x-ray revealed he had a lung mass and was to see a local oncologist on July 9th (2021). I did not take him to that appointment. [TL] took him for that appointment. Later, she told me he had an appointment at [a state university's medical department]. I did not think [client #1] would be able to travel that far and it would be better for him to go via ambulance, so I canceled his appointment ...I felt comfortable making that call."
-Stated the TL was supposed to call and reschedule the appointment from 7/23/21 but had not.
-"No one told us they suspected his lung mass was cancer. We have now scheduled 7 appointments for [client #1] in the next 2 weeks."
-Stated she felt the TL dropped the ball when the appointment was not rescheduled for client #1.
-Stated the facility was not given a 24-hour notice.
-Stated the drive to the state university's medical department would not be good for client #1's chronic back and leg pain
-Felt client #1 needed to be transported by ambulance "because he refused to wear his oxygen" and "what if something happens to him on the way to the appointment?"

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V 291	Continued From page 9 Further interview by telephone on 8/9/21 with the PD revealed: -When asked for specific information of dates and documentation of telephone calls and appointments, the PD stated "I am not at the group home. I keep all the appointments in my head. [TL] and I went to [client #1]'s follow-up appointment with [the local oncologist] on August 3rd (2021). I only had one call from [the second oncologist]'s office. They called me maybe a week later. I don't remember anything else. My head is not clear, and I can't remember." Interview on 8/6/21 with the Qualified Professional (QP) revealed: -In the last 2 months, client #1's health had declined, and he was now on oxygen 24 hours per day. -Client #1's PCP ordered if his oxygen levels drop below 90%, then EMS (Emergency Medical Services) was to be called. -"[Client #1]'s oxygen levels have been between 60% to 70% and he will refuse to go with EMS. On July 5th (2021), he felt bad and was disoriented. His oxygen level was 71. We called the ambulance and they transported him to the emergency room. He was admitted to the hospital and released on July 7th (2021)." -Several days later, the facility staff reviewed his discharge papers and discovered a chest x-ray had shown he had a lung mass. -"Because [client #1] is his own guardian, the medical staff discussed his chest x-ray results with him. He had an appointment on July 9th (2021)with a local oncologist. [TL] took him for that appointment." -Several days later, a state university's medical department called the facility with an appointment for client #1 for 7/23/21	V 291		

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V 291	Continued From page 10 -"[TL] spoke with them and accepted the appointment. They wanted him there on a Friday and it was Thursday afternoon. When [TL] told [PD], she called and canceled the appointment." -A new appointment has been scheduled for 8/13/21 -"It is not that we did not want him to go. We are just trying to figure out the best way for him to go. He has chronic pain and we had been discussing sending him by ambulance." -Was recently told by the local oncologist, there was an 85% to 95% chance client #1's lung mass was cancer. Further interview on 8/9/21 with the QP revealed: -There was no documentation by the facility staff to show why client #1's medical appointments were not kept, rescheduled or canceled. Interview on 8/10/21, the Operations Manager revealed: -He would ensure client #1 made his appointments on 8/13/21 and 8/24/21. This deficiency is cross referenced into 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (V512) for a Type A1 rule violation and must be corrected within 23 days.	V 291		
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC	V 512		

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V 512	Continued From page 11 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, 1 of 5 staff (the Program Director (PD)), neglected 1 of 3 clients (#1). The findings are: CROSS REFERENCE.:10A NCAC 27G .5603 Operations (V291) Based on observations, record reviews and interviews, the facility failed to coordinate services with those responsible for 1 of 3 clients (#1). Review on 8/10/21, of the facility's Plan of Protection, dated 8/10/21 and written by the Operations Manager revealed: -What immediate action will the facility take to ensure the safety of the consumers in your care? "Effective Today, August 10th, 2021, to identify consistent and company-wide method of keeping track of all our clients' medical appointments. All	V 512		

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medical appointments will be put into our Electronic Health Records System, Therap. Staff will also be required to follow-up with documentation related to the appointment as needed."
-Describe your plans to make sure the above happens. "To ensure the plan is followed, the compliance officer will add this process to our policy and procedure manual. In addition, an in-service will be completed regarding the new policy for all staff who schedule/manage medical appointments for our clients within 14 days."

Client #1 had diagnoses of Paranoid Schizophrenia; Major Depressive Disorder; Mild Intellectual Disabilities; Type 2 Diabetes; Seasonal Allergies; Hypogamic: Asthma; Gastro-Intestinal Disorder, Distress; and COPD (Chronic Obstructive Pulmonary Disease) and was on oxygen 24/7. On 7/5/21, client #1 was admitted to the hospital for COPD exasperation. A chest x-ray revealed a lung mass. On 7/9/21, client #1 was taken to a local oncologist by the Team Lead (TL). At this appointment, the local oncologist referred client #1 to a state university's medical department for a PET CT. The TL was aware there was to be an appointment scheduled for client #1 with the second oncologist. On 7/9/21, the TL informed the PD of this information. On 7/12/21 and 7/14/21, the oncologist's office staff made telephone calls to the facility to schedule the PET CT. On 7/22/21, contact was made with the TL and an appointment was scheduled for 7/23/21 for client #1 to be seen by a second oncologist . The TL shared this information with the PD on 7/22/21. The PD canceled client #1's appointment on 7/23/21. Again, the oncologist's office staff attempted to reach the facility on 7/28/21 and 8/1/21 to reschedule the cancelled appointments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL079-106	A. BUILDING: _____ B. WING _____	08/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW HOUSE	1407 EAST MEADOW ROAD EDEN, NC 27288

(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 512	Continued From page 13 The PD was aware client #1 had a lung mass and needed to be seen for a PET CT. The PD cancelled client #1's appointment for the PET CT, failed to reschedule client #1's appointment with the second oncologist, failed to return their calls and failed to coordinate care with other professionals. This failure caused a delay in client #1's medical care for 35 days. The RN from the oncologist's office reported this delay could have resulted in his death or spreading, if it was cancer. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $5,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 512		