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 000	INITIAL COMMENTS A complaint survey was completed on February 11, 2022. The complaint was substantiated (intake #NC00185333). Deficiencies were cited This facility is licensed for the following service categories: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities and 10A NCAC 27G .5100 Community Respite Services for Individuals of All Disability Groups. The survey sample consisted of audits of one deceased client.	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	V 291		

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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 maintain coordination between the facility operator and the professionals who are responsible for the client's treatment, affecting one of one deceased client (DC) (#1). The findings are:

Review on 02/09/22 of DC #1's record revealed:
- 39 year old female.
- Admission date of 09/09/12.
- Diagnoses of Moderate Intellectual Developmental Disability, Rhett's Disorder, Seizure Disorder, Major Depressive Disorder and Autism Spectrum Disorder.
- Deceased 01/15/22.

Review on 02/09/22 of a North Carolina Incident Response Improvement System (IRIS) report for DC #1 revealed:
- Date of incident: 01/15/22.
- Incident Comments: "On 1/15/22 @ approximately 7:03am QP (Qualified Professional) [QP] received a phone call from staff [Staff #1] ([Staff #1's initials]) sting that member [DC #1] 'was gone; she's (DC #1) dead' QP responded 'what!! Staff replied that the paramedics are here. She's gone! QP called (approx 7:10- 7:13am) and contacted [Owner] and informed her as to what was going on. QP a relayed the information received from staff [Staff

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V 291	Continued From page 2 #1's initials]. QP explain to (CEO) (Chief Executive Officer) that staff called to report [DC #1] had died. QP stated that the paramedics were called to the residence because 3rd shift staff [Staff #3] found [DC #1] unresponsive at approximately 5:30 am. QP called the guardian and informed her that the member was found unresponsive in her bedroom. QP informed guardian (and CEO) that QP was enroute to the residence and would call them when more information was known. QP arrived to the residence @ approximately 7:20-7:25 am. QP observed 3 police cars with officers in the vehicle parked on the street in front of the member's residence. QP observed member on the floor motionless in her room. QP went outside to the police and inquired if the Medical Examiner had been notified. Officer replied 'yes'. It is to be noted that 1st shift staff ([Staff #4]) was instructed to take individual to [Urgent Care Name] or ER (emergency room) should pain continue. The staff reported that [Urgent Care Name] did not answer phone. It was reported that individual began to feel better and staff ([Staff #4]) reported to RD (Residential Director) that member was acting her normal self. Meclizine (antihistamine that is used to prevent and treat nausea, vomiting, and dizziness) prn (as needed) medication was given for stomach issues. [Staff #1], 2nd shift staff reported to [Staff #3], 3rd shift staff that member had complained about her stomach hurting on 2nd shift (1-14-22 pm). Staff ([Staff #3]) told QP she checked on member (@12:10 am 1-15-22) upon arrival at work. Staff ([Staff #3]) reported member was in bed watching television and said 'hello Ms. [Staff #3]' to staff when staff checked on her upon arrival. Staff [Staff #3] said she checked on member throughout the night. Staff [Staff #3] reported member got out of bed @ 2:00 am, went to the	V 291		

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bathroom and noted that her stomach was hurting at that time. Staff ([Staff #3]) reported that at approximately 5:30-6:00am and noticed member was motionless. Staff ([Staff #3]) called 911. 911 dispatch instructed staff ([Staff #3]) to perform CPR (cardiopulmonary resuscitation). Staff ([Staff #3]) reported she followed the dispatcher's instructions until EMS arrived. Staff ([Staff #3]) reported she attempted to contact the RD and there was no answer. Staff ([Staff #3]) reported she telephoned the oncoming Staff ([Staff #1]). Staff [Staff #1] ([Staff #1]) told QP staff ([Staff #3]) called her on the phone hysterically saying '[DC #1]. [DC #1]. [DC #1]. [DC #1].' Staff [Staff #1] came into the residence and observed staff ([Staff #3]) in the office talking to Law enforcement. Staff ([Staff #1]) reported staff ([Staff #3]) said [DC #1] was gone. Staff ([Staff #3]) said she tried to call [RD], Residential Director, and there was no answer. Staff ([Staff #1]) contacted QP [QP] on the phone @ 7:00 am and arrived @ 7:15 RD [RD] arrived @ 7:30am. QP made telephone call to provide the guardian with the phone number for the morgue where member's body (DC #1) was taken."
- "INTERNAL REVIEW FOR [DC #1] On 1/14/22 Mrs. [Staff #3] '3rd shift staff' called [RD] 'Rd' @ 8:21am stating that [DC #1] not feeling well that she was complaining that her stomach was hurting. 3rd shift informed RD that she gave her PRN medication for pain. RD asked, has 1st shift arrived yet? 3rd shift said no. When 3rd shift and RD hung up the phone [Staff #4] '1st shift' called around 8:22am stated that [DC #1] wasn't feeling well, RD instructed 1st shift to call [urgent care name] to see if they have any walk-ins if not to take her to Emergency room 'ER'. 1st shift and Rd hung up the phone. RD called [QP] 'QP' to inform her that [DC #1] is sick and that I informed 1st shift to take her to [Urgent Care Name] if they

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aren't allowing walk ins to take her to the ER. RD and QP called 1st shift on three-way around 9:20am,1st shift stated that [Urgent Care] didn't answer, QP and RD instructed 1st shift to take her to the ER. RD informed the nurse '[Facility Nurse]' through a text message around 9:37am to informed her that QP and I (RD) instructed 1st shift to take [DC #1] to the ER. Nurse responded 'Okay, please keep me update'. RD called 1st shift around 3:20pm to follow up about [DC #1] wellbeing, 1st shift response I (staff #4) didn't take her because she was acting as her normal self. Around 3:30pm [DC #1] sister [DC #1's Guardian] 'guardian' called and asked how [DC #1] doing? I informed her that QP and I instructed 1st shift staff to take her to the ER and that 1st shift said that [DC #1] was feeling better, and she was her normal self and she didn't take her to the ER. RD told guardian that I will follow up with her the next day and Monday. On 1/15/22 I got a Missed phone call from [Staff #3] '3rd shift' around 7:04am [Staff #1] 'weekend 1st shift staff' called at 7:10am stating that [DC #1] passed away. RD responded, 'I'm on the way'. RD arrived at Meadowbrook 'group home' around 7:30 am. [QP] 'QP', [Staff #3] '3rd shift' and [Staff #1] 'weekend 1st shift' was there at the kitchen table. [Staff #2] 'Staff' arrived around 8am, [Staff #4] 'weekdays 1st shif' arrived around 8:20 am each person appeared to be in disbelief as we talked around the kitchen table. [Staff #1] stated on 1/14/22 when she arrived to work, [DC #1] was in the bathroom complain about her stomach after she used the restroom she went into her bedroom and laid down and watch TV and she checked on her every 10 mins and gave her afternoon and night medication during the appropriate time and [DC #1] went to bed after her night medications. [Staff #3] stated [Staff #1] and her debrief like normal at 12am as [Staff #1]

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V 291	Continued From page 5 was ending her shift. 3rd shift stated she checked on each individual 15-minute increments.3rd said around 2am [DC #1] got up to use the restroom and went back to bed. 3rd shift checked on [DC #1] around 5:30am found [DC #1] unresponsive and called 911. [Staff #4] stated that on 1/14/22 [DC #1] was acting as her normal self-that's why she didn't take her to the ER . [DC #1] was laughing and watching tv. [Staff #4] stated that [Day Program Staff] 'day program supervisor 'arrived at 1:30pm and instructed her to keep checking on [DC #1] then she left. [Staff #4] stated [DC #1] was sitting in her room laughing and singing and then before 2nd shift arrived, she went to the bathroom saying her stomach hurt. Management reviewed the details and RD has interviewed the staff involved and concluded that the unfortunate events occurred as reported. We are waiting on Death Certificate to know cause of death. Correct date MCO (Managed Care Organization) notified it says '10'. QP noted that the medical examiner told the guardian [DC #1's Guardian Name], that she probably had a seizure." - "Describe the cause of this incident, (the details of what led to this incident). unknown awaiting death certificate." - "Describe how this type of incident may have been prevented or may be prevented in the future as well as any corrective measures that have been or will be put in place as a result of the incident. unknown awaiting death certificate." Review on 02/09/22 of DC #1's "Certificate of Death" revealed: - Date of death: 01/15/22 at 6am. - Cause of death: Epilepsy (neurological disorder that causes seizures) and Ventriculomeglay of the brain (hydrocephalus). - "Manner of Death Natural."	V 291		

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V 291	Continued From page 6 - No referral to the medical examiner. Review on 02/09/22 of DC #1's Individual Support Plan dated 06/01/21 revealed: - "Medical/Behavioral...Seizures: Managed by medications." Review on 02/09/22 of an "Admission/Annual Physical" dated 12/21/21 revealed no change in physical status since last exam. Review on 02/09/22 of an Annual Neurology Consultation dated 10/13/21 revealed no changes and return to clinic in 1 year. Review on 02/09/22 of DC #1's signed medication orders dated 12/21/21 revealed: - Meclizine 25 milligrams (mg) - take one tablet three times a day as needed for dizziness or nausea or vomiting. Review on 02/09/22 of DC #1's January 2022 Medication Administration Record revealed: - Staff #3 administered Meclizine to DC #1 at 6:38am on 01/14/22. Review on 02/11/22 of a facility "Disciplinary Action" dated 02/10/22 revealed: - Employee Name: Staff #4 - Supervisor name: QP - "Most recent date and time of Performance Problem or Misconduct: Insubordination; Disruptive Behavior; Lacking professionalism." - "Explain nature of Problem or Misconduct On 1/14/2022 at approximately 9:20am you (staff #4) were instructed to transport [DC #1] to the emergency room to be seen for her complaint about her stomach hurting at approximately 3:20pm your supervisor contacted you to follow up on the hospital visit. At that it was learned that	V 291		

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you did not take her to the emergency room as instructed to do so by your supervisor. When asked why you did not take her to the emergency room you responded that '[DC #1] was feeling better laughing and eating' [DC #1] was feeling better laughing and eating."
- "Describe any explanation offered by the employee: [DC #1] was feeling better laughing and eating."
- Disciplinary Action Taken: Suspension without pay for 3 days.
- Signed by the QP dated 02/10/22.
- "Employee did not keep scheduled appointment to review this Disciplinary Action."

Interview on 02/11/22 staff #4 stated:
- She had worked at the facility since July 2021.
- She had current training in CPR and first aid.
- She worked 1st shift 8am to 4pm.
- She worked 1st shift at the facility on 01/14/22.
- DC #1 was complaining of stomach pain.
- She called urgent care and they did not answer.
- She notified the RD and he text her "emergency room."
- She had a 3 way call with the QP and RD about taking DC #1 for treatment.
- She was not able to get through to the emergency room by phone.
- "She (DC #1) did the same thing she normally does (on 01/14/22)."
- DC #1 was not complaining on her shift of stomach pain.
- She did not think DC #1 was in any distress or was having any seizures.
- She did not take DC #1 to the urgent care or the emergency room.
- The RD called back in the afternoon and DC #1 was in her room singing.
- She told the RD DC #1's status.
- Another staff came in and she left.

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V 291	Continued From page 8 Interview on 02/11/22 staff #1 stated: - She had worked at the facility for approximately 3 years. - She had current CPR and first aid training. - She worked 2nd shift 4pm to 12 midnight. - She worked 2nd shift on 01/14/22. - DC #1 said her stomach was hurting but was not in any severe pain. - DC #1 did not eat supper but that was not unusual. - DC #1 was laying in her room most of the time and watching television. - When she left that night DC #1 was watching television. - She did not have to give DC #1 any medications for stomach pain. Interview on 02/11/22 staff #3 stated: - She had worked at the facility for less than 2 years. - She had current training in CPR and first aid. - She worked 3rd shift, 12 midnight until 8am. - She worked on 01/14/22 and 01/15/22. - DC #1 had complained of stomach pain the morning of 01/14/22. - She gave DC #1 Meclizine as needed for dizziness, nausea and vomiting. - DC #1 had no previous stomach pain issues. - She notified the RD and shift change staff of DC #1's status on 01/14/22. - She came back on 01/15/22 3rd shift. - DC #1 was in her room "half asleep but watching tv." - DC #2 got up at about 2am and said she had some stomach discomfort. - DC #1 went back to bed as she normally did. - She was doing rounds at about 5:30am and DC #1 was unresponsive. - She called 911 and began chest compressions	V 291		

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until emergency medical services got to the facility.
- DC #1's passing was "very shocking."

Interview on 02/09/22 the RD stated:
- He had investigated DC #1's death with staff and the information was put in the incident report.
- It had been 2 years since DC #1 had a seizure.
- DC #1 had recently been on a visit with family and he thought maybe she picked up Covid or a stomach issue.
- He had told staff #4 to take DC #1 to urgent care or the emergency room.
- He called back to the facility later on 01/14/22 and staff #4 had not taken DC #1 for treatment.
- Staff #4 stated DC #1 was doing better.
- The facility did not log DC #1's bowel movements.

Interview on 02/09/22 and 02/11/22 the QP stated:
- She contacted DC #1's guardian for the death certificate.
- DC #1's guardian had no complaints.
- DC #1's cause of death was listed as Epilepsy.
- No autopsy was completed for DC #1.
- The RD had completed a review of DC #1's death.
- She and the RD had spoken with staff #4 on 01/14/22 and requested staff #4 take DC #1 to the hospital for stomach pain.
- Staff #4 reported she did not take DC #1 to the hospital due to the client was feeling better.
- She had requested staff #4 to come to the office on 02/10/22 for a disciplinary action.
- Staff #4 did not show up for the 02/10/22 meeting.
- DC #1 had been to all of her previous medical appointments.

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V 291	Continued From page 10 Review on 02/11/22 of a "Plan of Protection" signed by the Clinical Director and dated 02/ 11/22 revealed: - "What immediate action will the facility take to ensure the safety of consumers in your care? Better Connections inc (Licensee) will ensure that its Qualified Professionals are providing service coordination based on the members needs. QPs will have verbal follow up with the residential directors and /or DCPs (Direct Care Personnel) to ensure service needs are met. QPs and RDs will follow up with phone calls to the DCPs in the home regarding members status as service needs arise. QPs will ensure that any recommendations are followed up on by communicating back regularly to DCPs and Facility Operator to keep parties informed." - "Describe your plans to make sure the above happens. Inservice DCP staff in home regarding following directions and directives from their supervisors. Review and resign job description. Inservice QP regarding responsibilities member service coordination which includes improved communication and follow up with the RDs and DCPs in the home. QP will have daily communication with RD and DCPs in the home regarding members needs and any items that need to be followed up on. QP will ensure all service needs are followed up on to ensure completion. This will be documented via the QP Collaborative note. When QP completes a QP Collaborative note that QP will also send the Collaborative note the the Lead QP and Clinical Director for review." DC #1 was a 39 year old female with diagnoses to include Moderate Intellectual Developmental Disability, Rhett's Disorder, Seizure Disorder, Major Depressive Disorder and Autism Spectrum Disorder. On the morning of 01/14/22 DC #1 was	V 291		

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V 291	Continued From page 11 complaining of stomach pain and staff #3 administered an as needed medication at 6:38am. On 01/14/22 at approximately 9:20am the RD and QP had instructed staff #4 to take DC #1 to an urgent care or emergency room. In the afternoon of 01/14/22 the RD contacted staff #4 regarding the status of medical treatment. Staff #4 reported DC #1 was feeling better and she did not take her for medical treatment. Less than 24 hours later on 01/15/22 DC #1 was pronounced dead at 6am. The facility's failure to coordinate care for DC #1 results in a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $8,000.00 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 291		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:	V 367		

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	MHL074-239	A. BUILDING: _____ B. WING _____	02/11/2022

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MEADOWBROOK	1111 MEADOWBROOK DRIVE GREENVILLE, NC 27834

(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 367	Continued From page 12 (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C	V 367		

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 367	Continued From page 13 .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure a critical incident report was submitted to the Local Management Entity (LME) within 72 hours as required. The findings are. Review on 02/09/22 of a North Carolina Incident Response Improvement System (IRIS) report for DC #1 revealed: - Date of incident: 01/15/22.	V 367		

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 367	Continued From page 14 - Date of Deceased Client (DC) #1's death was 01/15/22. - The IRIS was originally submitted on 01/20/22. Interview on 02/09/22 the Qualified Professional stated: - She had submitted an IRIS report for DC #1's death. - She thought she had submitted the IRIS report on 01/19/22. - She was waiting for DC #1's death certificate to submit the final report in IRIS. - She understood all deaths and critical incidents were required to be submitted within 72 hours to the LME.	V 367		