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V 000	INITIAL COMMENTS An annual and complaint survey was completed on June 10, 2022. The complaint was unsubstantiated (Intake # NC00189030) Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. The survey sample consisted of audits of 2 current clients and 1 deceased client. The facility is licensed for 3 clients. The current census was 3.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be	V 112		

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obtained.

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to develop and implement goals and strategies to meet the individualized needs for 1 of 1 audited Deceased Client (DC #3). The findings are:

Review on 6/1/22 of DC #3's record revealed:
-Admitted 9/15/20.
-77 years old.
-Diagnoses of Moderate Intellectual Developmental Disability (IDD), Bipolar Disorder, current episode depressed severe, without psychotic features, Generalized Osteoarthritis, Ileus, Chronic Urinary Retention, Urge Incontinence, Prediabetes, Mixed Hyperlipidemia and Coronary Artery Disease.
-Deceased 5/21/22.

Review on 6/1/22 of DC #3's most recent Person-Centered Plan dated 10/2/21 revealed the following goals:
-"[DC #3] risks placement in a more restrictive setting without support.
-[DC #3] requires support to initiate and to complete most of his hygiene routine.
-[DC #3] has a history of exposing himself to minors and becoming verbally and physically aggressive.
-[DC #3] needs constant supervision and

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modeling during wake hours and assistance in improving his social interaction skills..maintaining appropriate behavior in social settings."
-There were no goals and strategies to address his repeated falls and decline in mobility without the assistance of staff, decline in cognitive status, refusal of medications, loss of weight and refusal to eat at times, and the increased level of supervision needed due to these changes.

Review on 6/2/22 of DC #3's Primary Care Physician (PCP) note for visit dated 3/31/22 revealed:
-"Treatment 1. Repeated falls Notes: Patient had a fall today while I am here without any obvious signs of injury. He has been holding on to furniture or staff and is very off balance. In addition, to his functional decline, he is experiencing some weight loss. I have added Ensure, patient needs adequate nutrition to build strength back up...Will continue to monitor and start PT/OT [Physical Therapy/Occupational Therapy]... in an effort to prevent further falls."

Review on 6/2/22 of DC #3's PCP note for visit dated 4/14/22 revealed:
-"Treatment 1. Repeated falls Notes: Patient continues to be fall risk and is up at night ambulating per staff...so far he has not had injuries....Discussed with staff the need to try to keep patient awake during the day so that he will rest at night and not be up wandering on his own...2. Underweight Start Mirtazapine...for benefit of appetite stimulant...3. Diarrhea Notes: Improved after stopping metformin..."

Review on 6/9/22 of PT/OT notes for DC #3 dated 4/6/22 through 5/4/22 revealed:
-Client was unable to transfer himself independently, he was unable to bear weight or

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pivot when assisted by another person.
-He could walk only with the supervision or assistance of another person at all times.
-On 4/7/22, 4/16/22, 4/19/22, 4/29/22 and 5/4/22 client was agitated, uncooperative, not agreeable to participate, and unable to process instructions.
-On 4/18/22 recommended to discharge early from PT due to refusal to participate, inability to follow verbal queuing, and verbal and physical "outbreaks."
-Staff were given in-home exercises and fall prevention strategies to aid in increasing his independence.

Review on 6/2/22 of level I incident reports for DC #3 from December 2021 through May 2022 revealed:
-2/27/22 - Client had been off his baseline, refusing to eat, and bumping into walls. He fell out of bed; received no injuries.
-5/4/22 - Client was lethargic and didn't want to eat. Emergency Medical Transportation (EMS) was called. No injuries.
-5/9/22 - Client fell off the bed, EMS called, staff performed Cardiopulmonary Resuscitation (CPR). Client admitted to hospital.
-There were no additional incident reports documented.

Review on 6/8/22 of DC #3's local Emergency Department (ED)/Hospital records revealed:
-5/4/22 -"EMS was called for patient being noncooperative today and not taking in his home medications. When EMS was present patient did try to run away from them in the facility when he fell hitting his head. Fall was witnessed by EMS and they deny loss of consciousness, vomiting, or complaints after fall..."
"The above-named patient (DC #3) and/or guardian has received the following patient

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instructions: Fall Prevention and Home Safety, Head Injury."
-5/9/22 - "...Patient presented to the emergency department via EMS after being found unresponsive in group home with unknown amount of down time. Patient required CPR and intubation out in the field. According to the group home patient has been without an appetite and not eating well for the last few days...."
-"...CT [Computed Tomography] head on 05/11 showed a subdural hematoma and subarachnoid hemorrhage. The was likely due to fall prior to arrival..."
-"ED Sepsis...Within the first 3 hours of patient presentation: IV Access Obtained...Discharge Diagnosis (1) Sepsis...acute organ dysfunction...severe sepsis with septic shock..."
-"Final Discharge Diagnosis (1) Subdural hematoma, acute...due to fall/trauma prior to arrival...(2) Subarachnoid hemorrhage...(3) Shock...(4) Cardiac arrest...(5) Respiratory failure requiring intubation...Extubated 5/12...(6) Acute kidney injury...most likely secondary to severe dehydration..."
- 5/16/22 - discharged to hospice care.

Interview on 6/2/22 with the facility's Head Supervisor revealed:
-DC #3 died 5/21/22 at the hospice facility.

Interviews on 6/2/22 and 6/7/22 with Staff #2 revealed:
-He was working during the incident on 5/9/22 with DC #3.
-He described DC #3 as "bedridden," unable to walk without his assistance and being this way for the past 5-6 months.
-Him falling was "...like a daily thing...always had to hover" over him to try and prevent him falling.
-"...it was getting bad, he wouldn't eat, wouldn't

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take his meds...looking at things that weren't there, something was wrong with him...before that day of the incident couldn't get him to say or do anything...gave him oatmeal and he took the spoon and tried to put the spoon up to his ear...."
-The client would sleep all day and be up all night, he had to get up 3-4 times a night due to hearing him fall.
-He didn't document any of the client's falls, if he didn't have any injury he didn't feel it was necessary to do an incident report/shift notes.
-He told Staff #2 and the Director of Operations/Qualified Professional about all of these things and the Director of Operations/Qualified Professional said if it continued, to send him to the hospital.
-He was not given any new strategies to help prevent DC #3 from falling, to assist with him refusing to eat and refusing his medications.
-He wasn't trained on the level of supervision the client required, he didn't want the client to get out of bed and hurt himself and this was why he watched the client so closely.

Interview on 5/31/22 with Staff #1 revealed:
-DC #3 wanted to be left alone most of the time.
-His legs were weak and he had PT to walk around and work his legs.
-One time he heard DC #3 fall in the middle of the night, and during another fall he scraped his head on the wall.
-He "kept an eye on him" and wouldn't go to sleep until he knew DC #3 was okay.
-He also walked with him to the bathroom and helped guide him, but at night he wore depends.
-He was not given any new strategies to help prevent DC #3 from falling, to assist with him refusing to eat and refusing his medications.
-He was not advised of any supervision level changes for the client.

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Interview on 6/2/22 with the facility's Head Supervisor revealed:
-DC #3's attitude did not change, he would always say "get away from me, don't touch me...he would jerk away and say I can do it."
-She received phone calls from staff stating he was not eating, not taking his medications and he was sent to the hospital during those times.
-He "wasn't really falling," it started with staff telling her he needed more assistance getting out of the shower.
-This was about 6-7 months ago, she brought a shower chair to the facility for him, around December 2021.
-To her knowledge he only fell once before, "maybe a couple months ago" since the last incident of 5/9/22.
-They sent him to the hospital (5/4/22), they didn't find anything wrong and they didn't suggest to do anything different.
-After the hospital visit on 5/4/22, Staff #2 told her about his falls, "but it didn't seem like it was that often."
-His PCP visited him at the facility once a month and he had PT as well.
-Staff were not given new goals or strategies to implement to further assist DC #3.

Interviews on 6/2/22 and 6/10/22 with the Director of Operations/Qualified Professional (QP) revealed:
-He was the QP for the facility.
-DC #3 was having a gradual decline since he had been with them but around February 2022 was when he "hit a benchmark."
-He then started seeing his PCP on a monthly basis who made medication adjustments and started PT.
-We thought his decline stemmed from joint

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problems and seemed to perk up after the medication changes and PT.
-We knew it was a matter of time before we needed to seek a higher level of care.
-Staff concerns were more about personal care, not wanting to change his depends, help bathe him and wash his sheets all the time.
-Staff never expressed the client was falling all the time, refusing to eat, or refusing his medications.
-He assumed staff was telling the PCP about his falls as documented in her visits starting in March 2022.
-They were not relaying this to him or the Head Supervisor at the time.
-He was responsible to keep the treatment plan updated and tried to do this "as much as possible."
-He confirmed the most recent treatment plan was October 2021.
-He did not advise his staff on any new strategies to assist DC #3 due to his declining health.

Review on 6/10/22 of the Plan of Protection dated 6/10/22 written by the Director of Operations/QP revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care? [DC #3] is no longer in our facility. We will review all treatment plans to ensure that they accurately reflect the needs of each person served. This will be completed by 6/14/22. Beginning immediately and ongoing, with first meeting completed by June 17th, each clients' team will have monthly meetings to discuss any changes in their needs or levels of care. The information gained from these meetings will be reflected via updates in the treatment plan. Beginning 6/10/22, all staff will be instructed and required to use shift notes to document any incidents or issues that arise on

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V 112	Continued From page 8 their shift and submit them at the end of the shift. All shift notes will be reviewed by a QP [names of four QP's] or a supervisor [names of four supervisor's] within 24 hours of end of shift. KDSS [KD Support Services, licensee] will also update their competency forms to reflect more specifically the needs of each person served. These competency forms will be completed and updated any time there is a change in the needs or level of care of a person served and will reflect information obtained from team meetings and shift notes. Updated competency forms will be approved by KDSS, implement, and completed for all persons served by 6/14/22. All staff will receive training or training refreshers in communication, documentation, and KDSS policies and procedures for reporting incidents or changes in level of care needs. This training will be completed by 6/14/22. Describe your plans to make sure the above happens. At a minimum of twice per week, a QP or supervisor will make a site visit to the facility to evaluate clients' status, verify that client needs are being met, make sure any changes to treatment plans are being fully implemented, and to verify that treatment plans goals are being implemented. [Director of Operations/QP] will update competency forms and oversee training of staff using new form. [QP] will schedule and attend team meetings and update treatment plans as needed based on findings from the meetings. Shift notes will be reviewed as described above, and on the 5th and 20th day of each month [Director of Operations/QP] will review all shift notes from 16th-end of month and the 1st-15th to verify that they have been reviewed during the required 24 hour period and that any information in them has been reflected in the treatment plans if needed. [Head Supervisor]	V 112		

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V 112	Continued From page 9 we schedule and supervise the above described training and training refreshers and the classes will be taught by [Trainer]." DC #3 was a 77 year old male with diagnoses of Moderate IDD, Bipolar Disorder, Generalized Osteoarthritis, Ileus, Chronic Urinary Retention, Urge Incontinence, Prediabetes, Mixed Hyperlipidemia and Coronary Artery Disease. According to staff his health had been declining as early as December 2021. He passed away on 5/21/22. His first documented fall was in February 2022. There were no records of continued falls in March or April 2022. However, in March and April 2022 he was seen by his PCP due to frequent falls, being at further risk for falls, loss of weight and refusing to eat. DC #3 received PT/OT from 4/6/22 through 5/4/22. His refusal to cooperate and inability to follow commands caused him to be discharged from PT/OT services earlier than anticipated. There was no evidence the PCP, PT/OT or hospital measures of trying to keep the client up during the day instead of walking around at night, do in-home exercises, develop fall prevention strategies and to evaluate home safety were attempted or put into place. There were no goals or strategies implemented for prevention of falls, loss of weight, refusing to eat, refusing to participate in PT/OT, refusing medications, and changes in his cognitive status. There were no assessments for changes in level of care and no supervision level changes developed for the client to remain safe and without injury. This deficiency constitutes a Type A1 rule violation for serious harm and neglect and must be corrected within 23 days. An administrative penalty of $8,000 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	V 112		

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of compliance beyond the 23rd day.

V 367 — 27G .0604 Incident Reporting Requirements — V 367

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:

(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

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V 367	Continued From page 11 (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 .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	V 367		

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V 367	Continued From page 12 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 report a level III incident to the LME/MCO (Local Management Entity/Managed Care Organization) within 72 hours of learning of the incident for 1 of 1 Deceased Client (DC #3). The findings are: Review on 6/1/22 of DC #3's record revealed: -Admitted 9/15/20. -77 years old. -Diagnoses of Moderate Intellectual Developmental Disability (IDD), Bipolar Disorder, current episode depressed severe, without psychotic features, Generalized Osteoarthritis, Ileus, Chronic Urinary Retention, Urge Incontinence, Prediabetes, Mixed Hyperlipidemia and Coronary Artery Disease. -Deceased 5/21/22. Review on 5/31/22 of the North Carolina Incident Response Improvement System (IRIS) website revealed: -There were no incidents reported for DC #3. Review on 6/2/22 of level I incident reports for DC #3 from December 2021 through May 2022	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL081-094	A. BUILDING: ______ B. WING ______	06/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLYS CARE #3	**133 KEETER ROAD MOORESBORO, NC 28114**

(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 13	V 367		

revealed:
-5/9/22 - Client fell off the bed, EMS called, staff performed Cardiopulmonary Resuscitation (CPR). Client admitted to hospital.

Review on 6/8/22 of DC #3's local Emergency Department (ED)/Hospital records revealed:
-5/9/22 - "...Patient presented to the emergency department via EMS after being found unresponsive in group home with unknown amount of down time. Patient required CPR and intubation out in the field. According to the group home patient has been without an appetite and not eating well for the last few days...."
-"...CT [Computed Tomography] head on 05/11 showed a subdural hematoma and subarachnoid hemorrhage. The was likely due to fall prior to arrival..."
-"Final Discharge Diagnosis (1) Subdural hematoma, acute...due to fall/trauma prior to arrival...(2) Subarachnoid hemorrhage...(3) Shock...(4) Cardiac arrest...(5) Respiratory failure requiring intubation...Extubated 5/12...(6) Acute kidney injury...most likely secondary to severe dehydration..."
- 5/16/22 - discharged to hospice care.

Interview on 6/2/22 with the facility Head Supervisor revealed:
-DC #3 died 5/21/22 at the hospice facility.

Interviews on 6/2/22 and 6/10/22 with the Director of Operations/Qualified Professional (QP) revealed:
-He did not do a level III IRIS report as he thought it was more of a health issue, not an injury related to a fall.
-He felt the medical issue came first which then caused him to collapse.