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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 6/27/22. The complaint was unsubstantiated (intake #NC00189772). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living: Alternative Family Living. This facility is licensed for three and currently has a census of one. The survey sample consisted of an audit of one current client.	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 obtained.	V 112		

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This Rule is not met as evidenced by:
Based on record review, interview and observation, the facility failed to develop and implement strategies in the treatment/habilitation plan to address the client's individualized needs affecting 1 of 1 client (client #1). The findings are:

Review on 6/10/22 of client #1's record revealed:
- An admission date of 11/21/19
- Diagnoses of Moderate Mental Retardation and Schizophrenia, Undifferentiated Type
- A treatment/habilitation plan completed by client #1's Care Coordinator (CC) and dated to begin on 7/1/21 documented "...[Client #1's] gait is unsteady..."
- "...Supports I need: [Client #1] will need 24 hour supervision. At night, a safety gate would be good for [client #1] because he will try to get up and go down the steps. '[Client #1's] gait is not good'. Per Staff, 'I have discussed with guardian about getting a baby monitor because [client #1] likes to get up and go rambling through his closet.'..."
- "Gait is unsteady" is listed as a "Medical support needs..."
- Under "My Action Plan," it is documented "[Client #1] currently resides in AFL (Alternative Family Living) home with [name of company that oversees the facility]. [Client #1] needs 24 hour supervision. [Client #1] needs some monitoring

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because he will try to get up in the middle of the night..."
- No documentation of any goals/strategies to address client #1's unsteady gait, his getting up from his bed during the night or using the stairs in the facility

Review on 6/22/22 of client #1's "Risk/Support Needs Assessment" completed by client #1's CC and dated 6/17/21 revealed:
- "Safety supports in the home and community: Has stairs within the home and requires hands on assistance or close supervision to use stairs. Describe: unsteady gait ..."
- It does not list a safety gate or baby monitor are to be employed by the AFL provider to address client #1's behaviors of getting up in the middle of the night and possibly going down the stairs

Review on 6/9/22 of a Level II incident report completed by the facility's Qualified Professional (QP) for an incident that occurred on 5/31/22 and submitted to the North Carolina Incident Response Improvement System (IRIS) on 6/1/22 revealed:
- "Describe the cause of the incident: [Client #1] was going down the stairs to get something to drink from the kitchen when he stepped out of his slipper and fell and hit his head and hand. AFL provider called 911 and EMS (Emergency Medical Services) transported him to [name of hospital] for further evaluation."
- "Incident Prevention: In the future staff may have to monitor and assist him to assure that he clears each step when going up and down the stairs."

Review on 6/17/22 of a police report completed by a Detective with a city police department on

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V 112	Continued From page 3 6/6/22 revealed: - The Detective met with the AFL provider on 6/6/22 to discuss what happened to client #1 on 5/31/22 - The AFL provider reported client #1 wanted something to drink prior to his going to bed and she (the AFL provider) "went down the stairs first and [client #1] caught the heel of his Nike slides and fell from at least seven or eight steps to the landing in front of the door..." - The AFL provider called 911 and requested EMS - EMS staff transported client #1 to the hospital for further evaluation/treatment on 5/31/22 Review on 6/16/22 of client #1's discharge summary from the hospital revealed: - He was discharged from the hospital on 6/7/22 - His admission diagnosis was a fall - He "suffered hematoma (a collection or pooling of blood underneath the skin due to an injury) to this left forehead along with abrasions. CT (Computed Tomography) head, CT cervical spine and CT face did not show evidence of acute fractures. There was a mention of age indeterminate nasal fracture on CT face. Patient was evaluated by PT (Physical Therapist) OT (Occupational Therapist) who had recommended SNF (Skilled Nursing Facility) rehab with 24/7 care. This was discussed with patient's guardian, sister over phone. Patient's sister currently does not wishes patient to be admitted to SNF however recommended visiting home PT at the group home. Patient will be discharged today with receiving PT arranged by CM (Case Manager). Patient prescribed Tylenol and Ibuprofen for pain control ..." - Additional information documented in the discharge summary revealed: "...Comminuted	V 112		

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fracture distal tuft of the distal phalanges on left third and fourth digits. Likely suffered in the event of this fall, recommended splinting left third and fourth digits. Referral for orthopedics as outpatient provided on discharge..."

Review on 6/16/22 of a "medical consultation report" dated 6/10/22 and completed by client #1's primary care physician revealed:
- The visit to his primary care physician was a follow up visit due to his being hospitalized on 5/31/22
- "...Physician Consultation Information, Findings: "Nasal Bones non tender, able to breathe through nose without difficulty. Bilateral hands, wrists, fingers are non-tender and FROM (Full Range of Motion)."
- "Plan/Recommendations: F/U (Follow up) 2 weeks..." "Stop wearing ProCare Wrist Brace - no pain, FROM..."
- His next appointment with his primary care physician was scheduled for 6/24/22

Review on 6/27/22 of a "medical consultation report" dated 6/24/22 and completed by primary care physician revealed:
- "...Sutures removed from forehead today..."
- "...NO Need for Long term Skilled Nurse Facility at this time..."

Observation on 6/9/22 at 2 pm of client #1 revealed:
- Scratches on his head which appeared to be in the healing stage (some scabbing over), a hematoma over his left eye and what appeared to be bruising underneath the left eye

Interview on 6/9/22 with client #1 revealed:
- The AFL provider was coming down the stairs behind him and "pushed him down the stairs."

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V 112	Continued From page 5 - He did not like the AFL provider and stated, "I hate her." - He reported he wanted to move to another facility and stated, "I wanna leave my house." - He did not provide any additional information about the events of 5/31/22 Interview on 6/9/22 with the QP #1 revealed: - On 5/31/22, at 10:33 pm, he received a telephone call from the AFL provider - The AFL provider reported client #1 had fallen down the stairs while "coming down the steps to get something to eat." - Client #1 had gotten to the fourth step and fell to the bottom of the staircase - When client #1 landed at the bottom of the stairs, he "banged his head." - It was documented in client #1's record that client #1 had problems with his gait and it might be documented in the record that he was a "fall risk." - Client #1 was discharged from the hospital on 6/7/22 and returned to the facility - Since his return, the AFL provider assisted client #1 when he went up and down the stairs Interview on 6/9/22 with the AFL provider revealed: - On 5/31/22 at approximately 10 pm, client #1 fell down the stairs while coming to the kitchen to get a drink of water - She planned to assist client #1 with getting the water and had come down the stairs as well - She did not report she saw client #1 fall and when asked where she was when client #1 fell, she stated she was "turning the corner to come into the kitchen when he fell." - She believed client #1 fell from the sixth step from the bottom and landed on the hardwood flooring at the bottom of the stairs	V 112		

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V 112	Continued From page 6 - She believed client #1's "Nike slide caught the step" and that is what caused him to fall - When she realized client #1 had fallen, she called 911 and was instructed by the 911 operator to leave him where he was and to not move him - Client #1 was bleeding and appeared he had some injuries to his face and head - Client #1 had "fallen up" the stairs while at his sister's home while on a visit with her during the weekend of 5/28/22-5/29/22; however, he had not sustained any injuries - Client #1 was "usually super careful" while on the stairs. He had participated in physical therapy in 2021 and had been instructed on how to walk closer to the stair railing and to hold the stair rail as he came down the stairs - Client #1's physical therapy services ended in 2021 - When client #1 began to fall, he did not attempt to "break his fall" and in this instance, he "fell face forward." - Client #1 remained in the hospital from 5/31/22 until he was discharged on 6/7/22 - Client #1's fall had "simply been an accident." Observations of the facility on 6/10/22 between 12:26 pm and 12:34 pm revealed: - Fourteen stairs leading from the front door to the second floor of the facility - Wooden flooring at the bottom of the stairs by the front door with a square area rug (burgundy in color) in front of the door - Client #1's room located at the top of the stairs to the right and next to the bathroom - The kitchen was located on the first floor of the facility - To reach the kitchen, one had to walk down the stairs, turn left at the bottom of the stairs, walk through the living room of the home and turn left again to enter the kitchen/dining area of the	V 112		

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V 112	Continued From page 7 facility - A wall separated a portion of the kitchen/dining area from the living room Interview on 6/27/22 with the AFL provider revealed: - She, the CC and the facility's QP had discussed the possibility of installing a safety gate at the top of the stairs; however, it was never implemented - She had spoken with client #1's legal guardian about a baby monitor; however, it had never been implemented - These interventions had only been discussed with no plan ever made to put the items in place - Not aware of the information listed in client #1's "Risk/Needs Support Assessment" regarding his need for "hands on assistance or close supervision" while navigating the stairs; however, she typically walked in front of client #1 if he was coming down the stairs or behind him if he was going up the stairs - On the night of 5/31/22, she was a "little bit ahead of him." - The AFL provider again reported that when client #1 fell, he never attempted to "break his fall." - "When [client #1] fall, he is not going to break his fall, he falls so violently, he's just gone fall." - Client #1 wore a size 15 shoe and she believed the shoes he had on that evening may have caused him to fall because they were such large shoes - Had purchased another pair of shoes for client #1 to use as bedroom slippers - She believed the new shoes would be safer for client #1's use - Client #1 had seen his primary care physician on 6/10/22 for a follow up appointment after his release from the hospital on 6/7/22 and again on	V 112		

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V 112	Continued From page 8 6/24/22 - On 6/14/22, a physical therapist visited the facility and evaluated client #1's need for physical therapy - As a result of this evaluation, the physical therapist determined client #1 did not require physical therapy at that time - On 6/24/22, client #1's primary physician removed the sutures from client #1's head and noted on a "medical consultation form" client #1 did not need to be admitted to a skilled nursing facility at that time Interview on 6/23/22 and on 6/27/22 with the Operations Manager/QP #2 (OM/QP #2) revealed: - She learned of client #1's fall from the QP #1 - In a review of client #1's record (since his fall) and in discussions with the QP #1 and the AFL provider, she learned the safety gate and baby monitor had been a part of the discussion when the CC was in the process of developing client #1's treatment plan - Although the CC noted these items might be of support to client #1, she never documented in his treatment plan they were to be put into place in the facility - The CC had not documented these items were needed for client #1's support when the CC completed client #1's "Risk/Support Needs Assessment." - She understood the severity of client #1's injuries and planned to have a nurse evaluate client #1 to assess his mobility and determine if he should be classified as a "fall risk." - If client #1 were defined as a fall risk, then guidelines could be developed based on his level of need and would be utilized as part of his treatment going forward - Although, she had not participated in the	V 112		

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treatment team meeting held for client #1 on 6/14/22; she had reviewed client #1's new treatment plan scheduled to go into effect beginning on 7/1/22
- Planned to contact client #1's CC to inform her there will most likely need to be some modifications to the plan based on his recent fall

Review on 6/27/22 of the facility's Plan of Protection completed by the AFL provider and dated 6/27/22 revealed:
- "What immediate action will the facility take to ensure the safety of the consumers in your care? Facility staff will ensure the safety of [client #1] by: 1. Staff will escorte [client #1] by walking in front of him when going down the stairs. Walk in back of him when he goes up the stairs. 2 [Client #1] will some no skid socks. Staff will put door rings on his door so bell will alert staff he's leaving his room.
- Describe your plans to make sure the above happens: [Management Company] Operations Manager/QP (Qualified Professional) will complete a weekly observation to ensure Plan of Protection is being implemented for the next 23 days."

This facility is in a private residence and is currently serving one client. The client's diagnoses are Moderate Mental Retardation and Schizophrenia, Undifferentiated Type. The client's treatment plan and other documents completed by his Care Coordinator indicated the client had an unsteady gait. Due to there being stairs in the facility and the client having an unsteady gait, the Care Coordinator documented in the client's treatment plan that a discussion had been held regarding the possible use of a safety gate to prevent the client from going down the stairs during the night and a baby monitor to indicate

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V 112	Continued From page 10 when the client was up and moving about; however, there were no specific goals or strategies listed in his plan to address either of those concerns. The Care Coordinator did, however, note in the client's record; he required hands on assistance or close supervision when he used the stairs due to his unsteady gait. While going to the kitchen to get a drink of water, the client fell down the stairs and sustained injuries that required the AFL provider to call 911 and request emergency medical services on his behalf. The AFL provider did not assist nor supervise the client as he came down the stairs, but had instead gone down the stairs ahead of him and was walking towards the kitchen when the client fell. The client was admitted to the hospital for treatment of a hematoma on the left side of his forehead, cuts to his forehead that required sutures, fractures of the third and fourth fingers on his left hand and abrasions. This deficiency constitutes a Type A1 rule violation for serious harm and neglect and must be corrected within 23 days. An administrative penalty of $2000.00 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 112		