

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-621	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 07/12/2022
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NAME OF PROVIDER OR SUPPLIER MORETZ MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 409 EBON ROAD DURHAM, NC 27713
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V 000	<p>INITIAL COMMENTS</p> <p>A complaint and follow up survey was completed on July 12, 2022. The complaints were unsubstantiated (intake #NC00189700 and NC00190176). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>This facility is licensed for 6 and currently has a census of 3. The survey sample consisted of audits of 1 current client and 1 former client.</p>	V 000		
V 111	<p>27G .0205 (A-B) Assessment/Treatment/Habilitation Plan</p> <p>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN</p> <p>(a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to:</p> <ol style="list-style-type: none"> (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. <p>(b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter</p>	V 111		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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V 111	<p>Continued From page 1</p> <p>referred to as the "plan," strategies to address the client's presenting problem shall be documented.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to have strategies in place to address the needs and behaviors prior to providing services affecting one of one former client (FC #4). The findings are:</p> <p>Review on 7/7/22 of FC #4's record revealed: -Admission date of 5/18/22. -Diagnoses of Major Neurocognitive Disorder due to Traumatic Brain Injury with Behavioral Disturbance, Dementia, Moderate Intellectual or Developmental Disability, Constipation, Dyslipidemia, Seizure Disorder, Chronic Obstructive Pulmonary Disease, Vitamin D deficiency and Polydipsia. -Discharge date of 6/11/22. -Admission Application from the local Local Management Entity/Managed Care Organization (LME/MCO) dated 5/10/22-Person requesting services for FC #4 wrote "[FC #4] requires more care and close monitoring due to high elopement risk." -Discharge Progress note from psychiatric hospital dated 11/17/21- "[FC #4] had short-term memory impairment, impulsivity, intrusiveness,</p>	V 111		

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V 111	<p>Continued From page 2</p> <p>emotional dysregulation and thought disorganization...His agitation triggers are usually due to his misunderstanding or forgetfulness around redirection...In addition, he is somewhat hard of hearing and would benefit from a hearing aid...His inability to modulate his emotional affect is as much a process of his head injury as is his short-term memory deficit." -There were no strategies to address FC #4's elopement from the facility.</p> <p>Review on 7/7/22 and 7/11/22 of facility records for FC #4 revealed:</p> <p>(1) Incident reports: -6/11/22-FC #4 eloped from the facility around 2:40 am. Staff tried to encourage him to stay inside. FC #4 grabbed and pushed staff out of the way. Staff called the local police department. A couple hours later the local police department returned to the facility stating FC #4 could not be located. A Silver Alert was issued for FC #4. Staff searched for FC #4 and found him at a grocery store about 6 miles away from the facility. FC #4 told staff he walked to the grocery store to apply for a job. -6/11/22-FC #4 eloped from the facility again around 3:53 pm. Staff followed FC #4 in the van. Staff tried to encourage and redirect FC#4 to get into the van, however he refused. The local police department was called around 5:30 pm for assistance. The local police department responded and took FC #4 to the local hospital. -6/4/22-"[FC #4] was manic and had a behavioral episode...[FC #4] then eloped on 6/4/22 at about 5 pm stating that he needed to go to the car dealership to buy a car and to rent his own house. Staff tried for over an hour driving slowly beside him trying to encourage him to get in the van and return to the group home but he refused...Staff</p>	V 111		

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V 111	<p>Continued From page 3</p> <p>then had to have him IVC'd (Involuntary Commitment) and the police was called to take him to the hospital." -6/3/22-"[FC #4] eloped at 2 am today stating to staff that he didn't want to stay at the group home." -6/2/22-FC #4 eloped from the facility 5 times today. He started leaving the facility around 2 am. Each time FC #4 left the facility the police department was called to assist the staff in bringing him back to the facility. -5/18/22-[FC #4] eloped from the facility around 9:30 pm. Staff on duty was assisting another client when FC #4 left the facility. The police department was contacted to report FC#4 eloped from the facility. When the Police Officers found FC #4, "he seemed very manic." The Police Officers took him to the local hospital.</p> <p>(2) Local Police Department Reports and Calls for Service for FC #4: -6/11/22-Police Report-"At approximately 3:59 am, I responded to 409 Ebon Rd (Road) for a call of a missing person at risk...[Staff #2] stated that at approximately 2:45 am, she was in the living room at the location. [Staff #2] stated [FC #4] then walked into the room and began to walk toward the front door. [Staff #2] then stood and blocked [FC #4's] path to the doorway. [FC #4] then pushed [Staff #2] causing her to fall to the floor...[FC #4] left his group home at least 8 times since May 25, 2022. [FC #4] had been found previously by officers near [Name of six different roads/streets in the area]." -6/11/22-Police Report-"On 6/11/22 I responded to the area of 409 Ebon Rd (Road) in reference to a missing person. Lutheran Services (Licensee) Moretz Manor, an assisted living group home for elderly men with mental health conditions, had called at 4:19 pm to report that one of their</p>	V 111		

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V 111	<p>Continued From page 4</p> <p>residents, [FC #4], had walked out of the residence and gone missing again approximately 30 minutes prior... Together with [Name of other Officer], I searched for [FC #4] in the area of Ebon Rd (Road). I located [FC #4] a mile and a half away [Name of road]. [FC #4] appeared sweaty and disoriented and stated that he was trying to walk to get a job... Lutheran Services were advised that [FC #4] would be transported to [Name of local hospital]..."</p> <p>-6/4/22-Call for Service at 8:37 pm-"Involuntary Commitment"</p> <p>-6/3/22-Call for Service at 1:25 am-"Missing Person at Risk"</p> <p>-6/2/22-Call for Service at 2:08 am-"Missing Person at Risk"</p> <p>-6/2/22-Call for Service at 5:04 am-"Missing Person"</p> <p>-6/2/22-Call for Service at 7:10 am-"Missing Person"</p> <p>-6/2/22-Call for Service at 8:54 am-"Missing Person"</p> <p>-6/2/22-Call for Service at 10:10 am-"Urgent Welfare Check"</p> <p>-5/29/22-Call for Service at 8:18 am-"Urgent Welfare Check"</p> <p>-5/25/22-Call for Service at 2:16 am-"Missing Person at Risk"</p> <p>-5/25/22-Call for Service at 6:10 am-"Missing Person at Risk"</p> <p>-5/18/22-Call for Service at 9:19 pm-"Crisis"</p> <p>(3) Discharge Summaries from local hospital: -6/4/22- Seen at local hospital Emergency Department (ED) for Agitation. FC #4's diagnosis was a behavior concern. -5/25/22 Seen at local hospital ED for Psychiatric Evaluation. FC #4's diagnosis was a behavior concern.</p>	V 111		

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V 111	<p>Continued From page 5</p> <p>-Between May 18, 2022 and June 11, 2022 it was documented that FC #4 eloped from the facility 12 times; Police Officers responded to calls from facility staff 13 times for "Missing person at risk, Involuntary Commitment, Urgent Welfare Check and Crisis; FC #4 went to the hospital three times for an Involuntary Commitment due to psychiatric concerns."</p> <p>Interview on 7/12/22 with a Police Officer revealed:</p> <p>-He thought he responded to 2-3 calls from facility staff about FC #4 walking away. The Officers he supervised responded other times. The other Officers responded several times, he wasn't sure how many. The times he responded FC #4 was walking down a road not too far from the facility. He thought the other Officers found him walking along that same road or other roads near the facility. He wasn't sure if the other Officers found him at an actual location. FC #4 told him he was going to the store and "rambling about something." He could not always understand what FC #4 was saying. He and the other Officers were concerned about FC #4's safety because he was walking down the road in the dark. Officers were looking for FC #4 early mornings and it was dark outside. FC #4 was leaving the facility around 1:00 am or a little later. They "Police Officers" were concerned FC #4 was going to get hit by a car. "[FC #4] should not be out walking alone because he had a Traumatic Brain Injury and didn't appear to be in control of all of his faculties."</p> <p>-He thought he went to the facility once because staff called and said they could not get FC #4 back into the facility. Officers also responded once out in the community, staff called and said they were following FC #4 in their vehicle. Staff were trying to get FC #4 into the vehicle and</p>	V 111		

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V 111	<p>Continued From page 6</p> <p>return him to the facility. He thought those two incidents were put in as welfare checks.</p> <p>Interview on 7/11/22 with staff #1 revealed: -She was the House Manager for the facility and normally worked 1st shift. -FC #4 walked away from the facility several times. FC #4 mainly left the facility during third shift. FC #4 also left during 1st shift, she thought he left 3-4 times. FC #4 would tell them he was leaving and walk out the front door. FC #4 would say he was going to find a job, look for a car and a place to stay or he no longer wanted to be at the facility. During 1st shift it was normally more than one staff. If FC #4 walked away during 1st shift, staff would load the other clients into the van and search for FC #4. FC #4 would normally leave the facility and walk down one of the roads in this area. They did find him a few times when he was walking down the road. They called the police department each time FC #4 left the facility. "They wanted [FC #4] to be safe and were concerned because he had a Traumatic Brain Injury." -She confirmed FC #4 had no strategies to address his elopement from the facility.</p> <p>Interview on 7/11/22 with staff #2 revealed: -She worked 3rd shift at the facility. -She thought FC #4 left the facility 15 to 20 times between May and June 2022. -Her shift started at 9:00 pm, FC #4 was not always in bed when she arrived. FC #4 would normally be in the kitchen area. -FC #4 was "very loud, screaming and could be disruptive" prior to leaving the facility. Sometimes he "seemed to be in a manic state" prior to leaving the facility. She tried to redirect him numerous times and he would still leave the facility.</p>	V 111		

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V 111	<p>Continued From page 7</p> <p>-Sometimes FC #4 would say he was leaving, other times he would just walk out the front door. FC #4 always walked out the front door, FC #4 actually pushed her twice because she stood near the front door trying to prevent him from leaving. FC #4 always left the facility after midnight. She could not follow him because she was working alone. "It was not fair to wake up the other clients and go search for [FC #4]."</p> <p>-Some nights FC #4 walked away from the facility multiple times, 2-3 times a night. She always called 911 to report that FC #4 walked away. She also contacted staff #1 and the Program Director each time FC #4 walked away from the facility.</p> <p>-The Police Officers would normally bring him back to the facility. They would normally find him walking down one of the main roads near the facility. The Police Officers would normally return him to the facility within an hour. FC #4 was away from the facility once for about 6 hours. She thought FC #4 went to the hospital about 3 times for psychiatric reasons after a police officer responded to him walking away from the facility.</p> <p>-She confirmed FC #4 had no strategies to address his elopement from the facility.</p> <p>Interview on 7/11/22 with staff #3 revealed:</p> <p>-She worked 1st shift at the facility.</p> <p>-FC #4 walked away from the facility a few times during 1st shift. She thought FC #4 left the facility 2-3 times. FC #4 would tell them he was going out to get a job and get a house. FC #4 would "cuss them out" if they tried to stop him from leaving. They called the police each time FC #4 left the facility. FC #4 would normally walk along the road adjacent to the facility and other roads in the area. She followed FC #4 in the van whenever he walked away. She tried to convince FC #4 to get back into the van and he often refused. She would follow FC #4 until the police</p>	V 111		

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V 111	<p>Continued From page 8</p> <p>arrived.</p> <p>-She always called management when FC #4 left the facility. The Program Director could sometimes convince FC #4 to get in the van before the police arrived.</p> <p>-She thought FC #4 went to the hospital once when he walked away because he was "combative" when the Police Officers arrived.</p> <p>-She confirmed FC #4 had no strategies to address his elopement from the facility.</p> <p>Interviews on 7/7/22, 7/11/22 and 7/12/22 with the Program Director revealed:</p> <p>-FC #4 left the facility several times. She was aware FC #4 had a history of elopement prior to being admitted to the facility.</p> <p>-Facility staff called the police department several times due to FC #4 eloping from the facility. She thought FC #4 left the facility at least 10 times or more. "It seemed like he was leaving the facility every other day." Staff didn't call the police department every time FC #4 left the facility, she thought the police department was called 6 or more times. FC #4 left more frequently during 3rd shift. She thought FC #4 left during first shift 2-3 times. Sometimes FC #4 would leave the facility 2-3 times in one day. FC #4 would push past staff and leave the facility. FC #4 would just walk out the front door. FC #4 was leaving the facility at 1:00 am or 2:00 am in the morning during 3rd shift. Staff had to call the police department. If it was early morning or late night staff should call the police department because they were normally working alone. During the day staff would go look for FC #4 because there are more staff available.</p> <p>-FC #4 would normally walk along the major highway near the facility. The Police Officers never really said where FC #4 was found when they returned him to the facility. She found FC #4</p>	V 111		

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V 111	<p>Continued From page 9</p> <p>at a church about a mile from the facility in June 2022. She thought the police returned him to the facility because FC #4 was being combative. She also found FC #4 on June 11, 2022 at a local grocery store. FC #4 walked about 6 miles from the facility. She thought he left the facility around 1:00 am. Staff called the police department, however the the Police Officers said they were not able to find FC #4. A Silver Alert was issued for FC #4 and later cancelled because she found him at the grocery store. FC #4 left the facility again on June 11, 2022 in the evening. This time the police decided he needed to go to the hospital due to psychiatric reasons. FC #4 went to the hospital and never returned to the facility.</p> <p>-FC #4 came to the facility with an Individualized Support Plan (ISP) from the local LME/MCO. There were no strategies to address FC #4 eloping from the facility. She reached out to FC #4's Care Coordinator from the LME/MCO to see if the ISP could be revised. She also talked with the Care Coordinator about a Behavioral Support Plan (BSP) being created for FC #4. She was told she had to make the referral for the BSP to be developed. FC #4's Care Coordinator was aware he was leaving the facility at all times of the day. The LME/MCO Care Coordinator was responsible for the long term goals and the facility was responsible for the short term goals. "The long and short term goal must collaborate." She could not update FC #4's ISP without the Care Coordinator making their changes to the plan. FC #4's Care Coordinator never updated his ISP.</p> <p>-She confirmed FC #4 had no strategies to address his elopement from the facility.</p> <p>Review on 7/12/22 of a Plan of Protection (POP) written by the Program Director dated 7/12/22 revealed: "What immediate action will the facility take to</p>	V 111		

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V 111	<p>Continued From page 10</p> <p>ensure the safety of the consumers in your care?</p> <p>1 a. Moving forward LSC (Lutheran Services Carolinas) will ensure that additional staff is on shift to assist with client eloping.</p> <p>1 b. LSC (Lutheran Services Carolinas) will consult with a psychologist/psychiatrist to create an elopement precaution plan for clients. Describe your plans to make sure the above happens.</p> <p>2 a. [Program Director] will ensure that LSC (Lutheran Services Carolinas) and the MCO (Managed Care Organization) are in agreement with the proposed plan.</p> <p>2 b. [Program Director] will ensure that all staff are properly trained on the clients plan including but not limited to elopement precaution.</p> <p>2 c. [Program Director] will ensure that all proposed plan including supporting materials, equipment, documents are in place before the client moves into the facility."</p> <p>FC #4's diagnoses included Major Neurocognitive Disorder due to Traumatic Brain Injury with Behavioral Disturbance, Dementia, Moderate Intellectual or Developmental Disability, Seizure Disorder and Chronic Obstructive Pulmonary Disease.</p> <p>FC #4 eloped from the facility 12 times between May 18, 2022 and June 11, 2022. FC #4 was primarily leaving the facility during 3rd shift after 12:00 am when staff was working alone. Staff contacted the police department each time FC #4 left the facility. FC #4 was normally found walking along one of the roads near the facility. The Program Director found FC #4 at a church about 1 mile from the facility. FC #4 was also found by the Program Director at a local grocery store about 6 miles from the facility. The Police Officers were concerned for FC #4's safety because he was walking along the roadway in the dark and</p>	V 111		

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V 111	Continued From page 11 could possibly be hit by a car. They were also concerned due to FC #4's mental capacity. FC #4 went to the hospital at least three times when Police Officers responded out in the community due to psychiatric concerns. FC #4 had a history of elopement, however he had no strategies to address his elopement from the facility. This deficiency constitutes a Type A1 rule violation for serious 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 111		
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: (1) reporting provider contact and identification information; (2) client identification information;	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-621	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 07/12/2022
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NAME OF PROVIDER OR SUPPLIER MORETZ MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 409 EBON ROAD DURHAM, NC 27713
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V 367	<p>Continued From page 12</p> <p>(3) type of incident;</p> <p>(4) description of incident;</p> <p>(5) status of the effort to determine the cause of the incident; and</p> <p>(6) other individuals or authorities notified or responding.</p> <p>(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:</p> <p>(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or</p> <p>(2) the provider obtains information required on the incident form that was previously unavailable.</p> <p>(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:</p> <p>(1) hospital records including confidential information;</p> <p>(2) reports by other authorities; and</p> <p>(3) the provider's response to the incident.</p> <p>(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).</p> <p>(e) Category A and B providers shall send a report quarterly to the LME responsible for the</p>	V 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-621	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 07/12/2022
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NAME OF PROVIDER OR SUPPLIER MORETZ MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 409 EBON ROAD DURHAM, NC 27713
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V 367	<p>Continued From page 13</p> <p>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:</p> <ol style="list-style-type: none"> (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. <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure incidents were reported to the LME for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are:</p> <p>Review on 7/7/22 of FC #4's record revealed: -Admission date of 5/18/22. -Diagnoses of Major Neurocognitive Disorder due to Traumatic Brain Injury with Behavioral Disturbance, Dementia, Moderate Intellectual or Developmental Disability, Constipation,</p>	V 367		

Division of Health Service Regulation

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V 367	<p>Continued From page 14</p> <p>Dyslipidemia, Seizure Disorder, Chronic Obstructive Pulmonary Disease, Vitamin D deficiency and Polydipsia. -Discharge date of 6/11/22.</p> <p>Review on 7/11/22 of facility records for FC #4 revealed:</p> <p>Local Police Department Calls for Service: -5/25/22-Call for Service at 2:16 am-"Missing Person at Risk" -5/25/22-Call for Service at 6:10 am-"Missing Person at Risk"</p> <p>-There was no documentation of an incident report in the Incident Response Improvement System (IRIS) for the above allegation of abuse.</p> <p>Interview on 7/12/22 with the Program Director revealed: -Staff were supposed to document the incident in the web based program the facility uses for incident reporting. As the Program Director she was responsible for putting the incident into IRIS. She didn't think staff #2 made her aware of the incidents with FC #4 walking away from the facility twice on 5/25/22. -She confirmed the facility failed to ensure a Level II incident report was submitted to the Local Management Entity (LME) within 72 hours as required.</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 367		