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V 000	INITIAL COMMENTS A complaint survey was completed on 5/2/22. The complaint was substantiated (intake #NC00188078). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 3 and currently has a census of 2. The survey sample consisted of audits of 1 former 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 activity opportunities based on her/his choices,	V 291		

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V 291	Continued From page 1 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 former client (FC) (#3). The findings are: Review on 4/27/22 of FC #3' s record revealed: -57 year old female. -Admitted on 7/19/21. -Discharged on 4/8/22. -Diagnoses of Moderate Intellectual Disability, Generalized Anxiety Disorder, Bipolar Disorder, Seizure Disorder, Glaucoma, Type II Diabetes, Sweets Syndrome and Dementia. Finding #1 Review on 4/27/22 and 4/28/22 of FC #3's treatment plan dated 2/1/22 revealed: -Meeting date 12/7/21. "When I may need Extra Help...[FC #3's] weight fluctuates but is within her recommended weight range...[FC #3's] doctors have coordinated care this year due to changes in her physical and behavioral health. [FC #3] has lost weight this year and refuses to eat at times..." -No documented medical reason or medical follow up care for weight loss of 43 pounds over 8 months. Review on 4/27/22 of the facility's Coordination of	V 291		

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V 291	Continued From page 2 Care forms for FC #3 revealed: -8/10/21: Weight 148 (visit to establish care with primary provider) -10/13/21: Weight 132.4 -11/2/21: Weight not documented. -2/24/22: Weight 110 -4/5/22: Weight 105 Review on 4/28/22 and 4/29/22 of hospital medical records for FC #3 from 4/8/22 - 4/21/22 revealed: -Registered Dietitian Note completed on 4/12/22 "The patient was triaged and worked up in the Emergency Room had multiple labs done. Chemistry showed mild hyperkalemia potassium 5.0. Albumin was low at 3.2 and total protein was low at 5.7. Note that patient had a lactic acid of 1.7. CBC (Complete Blood Count) showed a white count of 5.0 with hemoglobin 11.7 ....given treatment for mild hyperkalemia." -Nutrition Focused Physical Exam (NFPE): Completed on 4/12/22 "Malnutrition Diagnosis per AND/ASPEN (American Society for Parenteral and enteral Nutrition) Clinical Characteristics: Severe malnutrition in the context of chronic illness identified by Severe fat loss to triceps, 19.24 % weight loss in 10 months ....Assessment Summary: ...Per NFPE patient does meet severe malnutrition in context of chronic illness." Finding #2 Review on 4/27/22 of the facility's "Coordination of Care" report for FC #3 dated 4/5/22 revealed: -"Name of Agency: [local] Urgent Care" -"Comments/Outcome: Seems reasonable to transfer, appears stable. Due to medical history, also recommend evaluation with Primary Care Physician (PCP). Needs wound care for pressure ulcer." -"Opinion is based upon single examination	V 291		

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V 291	Continued From page 3 today and excludes access to prior medical records." Review on 4/27/22 of a local urgent care "Provider Exam" dated 4/5/22 revealed: -"One assist with standing. Minimally cooperative for exam, able to move extremities. 1+ pitting edema right leg to mid shin 2+ pitting edema left leg to mid shin. At least stage 3 decubitus ulcer to the left upper sacrum." -"Cleared with Exceptions: Needs decubitus ulcer management wound care. Recommend clearance by PCP." -"Opinion is based upon single examination today and excludes access to prior medical records." Review on 4/28/22 and 4/29/22 of hospital medical records for FC #3 revealed: -4/8/22 "Patient brought in by caregiver, spoke with legal guardian [guardian] via telephone. States patient sent in from group home for evaluation of stage 3 bed sores to buttocks that family was just made aware of. Legal guardian requesting patient to be admitted/held until can be placed at new group home on Monday ..." Review between 4/28/22 - 5/2/22 of facility records for FC #3 revealed: -No documentation of when staff discovered the decubitus ulcer. -No documentation of how facility treated stage 3 decubitus ulcer until appropriate medical treatment was rendered. -No documentation of wound care after the stage 3 decubitus ulcer was identified and follow up care for the stage 3 decubitus ulcer was medically recommended by the urgent care. -No documentation that the facility informed the legal guardian of FC #3's stage 3 decubitus ulcer.	V 291		

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V 291	Continued From page 4 Finding #3 Review on 4/29/22 of medical records of FC #3's from PCP revealed: -8/10/21: Chief Complaint Seen to establish care. "Caregiver requested a wheelchair. However, patient does not use any equipment for ambulation at home but caregiver reports that patient has difficulty ambulating some times. Will place a referral for Physical Therapy (PT)...Physical Therapist Referral ...To strengthen patient to ambulate, evaluate to see if she needs any equipment for ambulation ...Patient Instructions Please follow up with [provider] in 2-4 weeks ..." -9/1/21: 11:15am appointment cancelled "Patient No Show" Type: Follow Up -10/7/21: 3:30pm appointment cancelled "Patient No Show" Type: Sick Visit -10/13/21: "Chief Complaint pt(patient) fell 2 weeks ago/hit head-had stitches on forehead/request referral to neurology/seen at [local hospital]...Suture/Staple removal ...3. Blood in urine - patient incontinent and due to stress from suture removal, decided to defer repeat UA (urinalysis) as she will require a straight catheter follow up in 1 - 2 weeks with PCP to revisit this concern." Appointment scheduled for 11/2/21. -11/2/21: Chief Complaint follow up. "#Physical Therapy - has no been seen -has been falling -walking with assistance. #Lethargic - Care-giver from group home reports that she appears to be more lethargic since starting cyclobenzaprine three times a day - was started on cyclobenzaprine TIB (3 times daily) ...complains of dizziness ...constitutional: patient appears tired today. She moves her eyes but is not really responding to questions. Caregiver states that she has been like this since taking Flexeril TIB ...She has drool on shirt ...in wheelchair. Has brace over left knee ...Plan - have discontinued	V 291		

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V 291	Continued From page 5 Flexeril as there is no indication for this ...recurrent falls- caregiver reports that she does fall frequently. Will replace referral to Physical therapy. Will also order walker to family supply store ...Physical Therapist Referral ...she has had frequent and recurrent falls ...four wheeled walker with seat and brakes ...may need referral to psychiatry. Please follow up with [provider] only in 1-2 months." -11/19/21: 3:00pm appointment cancelled "Patient Canceled" Type: Established Patient -1/14/22: 9:45am appointment cancelled "Patient No Show" Type: Established Patient -2/21/22: 9:45am appointment cancelled "Patient Rescheduled" Type: Established Patient -3/7/22: 9:15am appointment cancelled "Patient No Show" Type: Established Patient -4/6/22: 1:00pm appointment cancelled "Cancelled by SMS (Short Message Service)" Review on 4/27/22 of the facility's "Coordination of Care" report for FC #3 dated 11/2/21 revealed: -"...To follow up with [provider] in 1 - 2 months Next appointment 1/14/2022." Interview on 4/28/22 FC #3's legal guardian stated: -She notified the facility at the beginning of March 2022 that she was removing FC #3 from the facility. -FC #3 "never thrived" at the facility. -FC #3 weighed between 140-150 pounds when she was admitted to the facility in July 2021. When she was admitted into the hospital in early April 2022 from the facility, she weighed only 105 pounds. -After being admitted to the facility, FC #3 wouldn't hardly eat, began to wear incontinence undergarments full time and became dependent on a wheelchair full time.	V 291		

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V 291	Continued From page 6 -The facility took FC #3 to an urgent care to get an FL2 signed and medical personnel diagnosed FC #3 with a stage 3 bedsore (no date provided). -FC #3 had been approved for admission into a skilled nursing facility but FC #3 was denied admission due to having the stage 3 bedsore. -She had requested an FL2 and notified facility at the beginning of March 2022 that she was taking FC #3 out of facility. -She was told by the Qualified Professional (QP) that she was required to give a 30-day notice, so she obliged and informed the QP that she "needed the FL2 and client would be removed from facility the beginning of April 2022." -The facility did not get a signed FL 2 from FC #3's primary doctor, but from a local urgent care instead. -Her husband told the facility staff - (no name provided) to take FC #3 to the hospital, and he asked the hospital staff to admit FC #3 because of the stage 3 bedsore. -"She (FC #3) could not move herself while in the wheelchair. When she would not eat her food, staff would just leave it sitting and expect her to go to the food when she wanted, but she could not maneuver the wheelchair herself. [FC #3] was able to feed herself." -Facility was not tracking FC #3's weight as far as she knew. -FC #3 was placed at a skilled nursing facility after she was discharged from the hospital on 4/21/22. Interview on 4/28/22 FC #3's care coordinator stated: -FC #3's legal guardian had concerns with FC #3's weight loss after they took her for a birthday (1/23/22) celebration. -FC #3's legal guardian informed her of concerns that were expressed to QP/group home about	V 291		

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V 291	Continued From page 7 FC #3's weight loss. -On 2/28/22, she informed the QP that FC #3's legal guardian wanted to move FC #3. The QP informed her the 1st available appointment at FC #3's PCP was 4/6/22 for a tuberculosis (TB) test and to complete the FL-2. The legal guardian wanted a sooner appointment. -On 3/22/22, the QP confirmed the doctor's appointment. The legal guardian planned to move FC #3 on 4/9/22. The QP informed her he learned FC #3's insurance changed and the PCP did not accept it. -On 4/4/22, the QP reported FC #3's PCP would not accept her insurance and he would follow up with different options for FC #3 to be seen. She informed the QP the legal guardian planned to move FC #3 on 4/9/22. -On 4/7/22, the QP informed her that FC #3 received a physical and TB test which would be read. The QP stated they asked the PCP to complete an update to the last FL-2 and it would be ready 4/7/22 or 4/8/22. The QP reported he would make contact once he received the FL-2. -On 4/8/22, the skilled nursing facility where FC #3 was supposed to be admitted reported after they reviewed the doctor's notes from the Urgent Care and FL-2, they were not able to admit FC #3 as planned. The doctor had noted a stage 3 wound and the admitting facility could not admit with a stage 3 wound. The admitting facility recommended FC #3 be hospitalized or attend rehabilitation for wound care. The legal guardian did not want FC #3 to remain at the group home. She contacted the QP and informed him of the new information. The group home staff agreed to take FC #3 to the hospital and inform hospital staff of situation. -The QP had not informed her of the stage 3 decubitus ulcer and she was not aware of the ulcer until the FL-2 was rejected by the skilled	V 291		

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nursing facility.
-She was not aware of any referrals for physical therapy.

Attempts to interview staff #1 on 4/28/22 and 5/2/22 were unsuccessful as she did not respond to voice messages left by DHSR surveyor. The Assistant Program Manager or Program Managers also requested staff #1 contact DHSR surveyor.

Attempts to interview staff #2 on 4/28/22 and 5/2/22 were unsuccessful as she did not respond to voice messages left by DHSR surveyor. The Assistant Program Manager or Program Managers also requested staff #2 contact surveyor DHSR surveyor.

Interview on 4/27/22, 4/28/22 and 5/2/22 the Assistant Program Manager stated:
-She had not noticed FC #3's weight loss.
-There were no concerns with FC #3's eating or refusing food.
-She discovered a hardened area near FC #3's bottom area after FC #3 complained of pain around the end of February.
-She immediately scheduled a doctor's appointment for 4/6/22.
-When she learned FC #3 was leaving the facility, she learned the PCP appointment needed to be sooner.
-She observed a "bump that was shiny and red similar to a burn...about the size of a half dollar coin."
-It was not an open wound.
-There was no discharge and the staff put a bandage on it and kept it covered at all times unless FC #3 was being bathed.
-When she previously spoke with Division of Health Service Regulation Surveyor she had her

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"dates mixed up."
-FC #3 had a podiatry appointment in February but she noticed FC #3's "bruise" the beginning of April.
-She was unsure of the exact date.
-Staff took FC #3 to urgent care.
-She had made an appointment for 4/6/22.
-"Everything happened in April."

Interview on 4/27/22, 4/28/22 and 5/2/22 the Program Manager stated:
-She was employed as the Program Manager for a year and half.
-She worked at the facility since January 2022.
-She noticed FC #3 had lost weight.
-There was a discussion among the staff about possible weight loss of FC #3.
-She did not believe FC #3 was 148 pounds when she transported her to the facility at admission.
-Staff had noticed a hardness (ulcer).
-FC #3 was scheduled to have a physical at her PCP but her insurance changed and was not in the PCP network.
-When FC #3 was scheduled to leave they asked the Urgent Care provider to look at the area near FC #3's buttocks which was causing her pain.
-The urgent care physician burst, cleaned and dressed it on 4/5/22.
-The group home was told to keep it covered.
-They did not remove the bandage or clean it because FC #3 was scheduled to leave in 2 days.
-She confirmed there was no documentation of when the decubitus ulcer was initially observed by staff after FC #3 complained of pain.
-She confirmed there was no documentation of how the facility cared for the decubitus ulcer before or after treatment after the recommendation of the urgent care on 4/5/22.
-She confirmed there was no documentation the facility informed the legal guardians of the

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decubitus ulcer.
-FC #3's medical appointments were documented on the facility's coordination of care form or the calendar.
-FC #3 had not missed any appointments the facility was aware of.
-FC #3's PCP appointment for 1/14/22 was not on the facility's calendar.

Interview on 4/27/22, 4/28/22 and 5/2/22 the Qualified Professional stated:
-FC #3's appetite "came and went." FC #3 loved sweets and candy.
-He had not recalled any concerns with FC #3's weight loss and there was not anything recorded.
-FC #3's guardian had not expressed concerns with FC #3's weight loss.
-FC #3's primary care physician had not expressed concerns with weight loss.
-He had not observed a significant change in FC #3's weight.
-FC #3's treatment plan indicated that FC #3's weight fluctuated.
-The ulcer was "discovered around the time of the physical probably a day or two before she (FC #3) was taken to the urgent care."
-Staff reported it looked "like a boil."
-It was about the size of a "nickel or quarter."
-The urgent care doctor drained and treated the ulcer.
-The urgent care doctor treated the ulcer and provided instructions.
-He and the program manager spoke with FC #3's legal guardian about the "pressure ulcer" the same week it was treated and FC #3 was discharged.
-There was no documentation that the facility informed the legal guardians of the decubitus ulcer.
-The "pressure ulcer" was not discovered in

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V 291	Continued From page 11 February. -The Assistant Program "Manager had her dates mixed up" and he told her to "explain what she meant to DHSR surveyor." -The group home sought "immediate treatment." -He was not aware of any referrals for physical therapy for FC #3. -FC #3 received physical and occupational therapy prior to admission at group home. -He discussed physical and occupational therapy with FC #3's legal guardian and she did not want to pursue. -FC #3 had not missed any medical appointments. -If a client missed an appointment there was an emergency reason why. -He would follow up with PCP about missed medical appointments for a possible mistake or error in appointment schedule. Review on 5/2/22 of a Plan of Protection signed by the QP and dated 5/2/22 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? United Residential Services of North Carolina (Licensee) will take the following immediate steps to ensure the safety of consumers 1. Review of care coordination reports and current medical treatment plans. 2. Begin immediate follow-up with each PCP (Primary Care Provider) or care providers to ensure that current orders are being addressed and all recommended follow-up has occurred. 3. PCP shall also be consulted as a part of follow-up to determine if additional follow-up or an office visit is required. 4. Document follow-up instruction and action in the client record. 5. Inform all guardians via email, letter (in writing). 6. Conduct and immediate health and safety check of the facility to ensure that there is a good supply of consumer	V 291		

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medication, supplies and food."
-"Describe your plans to make sure the above happens. Quality assurance efforts shall include: Immediate Action items 1. Conduct an immediate facility health and safety check. Program Manager. 2. Program Manager, Assistant Program manager and QP shall be responsible for reviewing current physician orders and following up to ensure all physician's orders are being followed and documentation is in the client record. 3. Program Manager, Assistant Program manager and QP shall be responsible for communicating with the physician to determine the time and date for office visit if required by a physician. 4. Follow-up with guardians and care coordinators in writing."

FC #3 is a 57 year old female with diagnoses of Moderate Intellectual Disability, Generalized Anxiety Disorder, Bipolar Disorder, Seizure Disorder, Glaucoma, Type II Diabetes, Sweets Syndrome and Dementia. FC #3 became less ambulatory while at the group home and used a wheelchair or walker. Physical therapy referrals were made on 8/10/21 and 11/2/21 but no follow up occurred for physical therapy assessment while admitted to the facility. The facility had not maintained continued medical care as evidenced by missed PCP appointments and lack of follow through on the physical therapy referral. FC #3 was a no show for at least 7 medical appointments with her PCP. FC #3 had a significant change in her weight after her admission to the facility. The facility had not notified the PCP of FC #3's significant weight loss of 43 pounds, from 148 pounds in 8/2021 to 105 pounds at discharge 4/8/2022. FC #3 was diagnosed with severe malnutrition on 4/12/22. FC #3 developed a stage 3 decubitus ulcer prior to her discharge from the facility to a Skilled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-876	A. BUILDING: _____ B. WING _____	C 05/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHOGANY	6852 MAHOGANY ROAD FAYETTEVILLE, NC 28314

(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 291	Continued From page 13 Nursing facility. Due to the delay in medical treatment and missed follow up appointments, the need for treatment of the stage 3 decubitus ulcer delayed FC #3's admission into the skilled nursing facility. The facility also failed to notify the legal guardian and care coordinator of the stage 3 decubitus ulcer prior to information being sent to the skilled nursing facility. The facility's failure to coordinate care for FC #3 results in 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 291		