Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-456	A. BUILDING: ______ B. WING ______	R 11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SECURING RESOURCES FOR CONSUMERS, I	**10 MEADOW CREST DRIVE** **DURHAM, NC 27703**

(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 000	INITIAL COMMENTS An annual, complaint and follow-up survey was completed on November 8, 2023. The complaint was substantiated (intake #NC00209579). Deficiencies were 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 5 and currently has a census of 4. The survey sample consisted of audits of 3 current clients.	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 reviews and interviews, the facility staff failed to implement strategies or goals in the treatment/habilitation plan to address the needs of 1 of 3 audited clients (#2). The findings are:

Review on 11/2/23 of Client #2's record revealed:
-Admission date of 12/8/12.
-Diagnoses of Autism; Moderate Mental Retardation; Seizure Disorder; Hydrocele Right Testicle.
-Treatment Plan dated 5/1/23.
-Long range Outcome: Maintain good personal hygiene and live in a clean environment. Maintain Optimal health. Engage in his home environment and community safety.
-Short range goals:
-Will remain neat and clean in appearance by appropriately completing personal care/hygiene.
-Will learn steps to complete his laundry from start to finish.
-Will chose weather appropriate outfit to wear.
-Will follow directions and remain focused. Through completion of tasks/activities.
-Will complete tasks/activities to increase his understanding of social norms.
-While at home or in the community, will

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appropriately engage in activities with others.
-Will respect the belongings of others.
-Will participate in activities that increase his health and safety.
-Will appropriately transition between the day program and home.
-Will follow routine requests and participate in activities with appropriate behaviors.

Review on 11/8/23 of the facility's Incident Reports revealed:
-Incident dated 9/4/23- "[Client #2] was at the kitchen table drinking his juice. Later, [Client #2 dropped his cup. As he went to pick up the cup, he lost his balance and fell to the floor."
-Incident dated 9/6/23- "Staff was assisting [Client #2] with transitioning to his day program. Staff noticed [Client #2] looking weak and offered water. [Client #2] then tried to drink the water and drops his cup. By the time staff tried to pick the cup up, [Client #2] was already reaching for the cup and fell out of his wheelchair onto his face. As staff was trying to help [Client #2], he tried grabbing his chair resulting in the chair falling on him."
-Incident dated 9/14/23- "[Client #2] was at the kitchen table eating when he knocked his food on the floor. [Client #2] tried to reach and pick up his food and lost his balance and fell to the floor."
-Incident dated 10/7/23- "Staff was wheeling [Client #2] out the door when he leaned forward resulting in [Client #2] to fall forward and scraping his ear."
-Incident dated 10/12/23- "[Client #2 was in his room sweeping his floor when he lost his balance in his chair resulting in [Client #2] falling forward and inuring his head."
-Incident dated 10/15/23- "[Client #2] was at the kitchen table eating when he dropped his fork on the floor resulting in him loosing his balance and

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falling out of his chair making his chair to fall on top of him."
-Incident dated 10/28/23- "Staff was wheeling [Client #2] out the door when [Client #2] leaned forward and fell out his chair. Fell on the side of his face, injuring his side of his face and ear."
-Incident dated 10/30/23 (10:30 am)- "[Client #2] was sitting in his wheelchair when he leaned forward and fell out of his chair. As staff was trying to pick him up, he screamed and fell to the ground. As he sat on the ground he repeatedly flopped to the ground."
-Incident dated 10/30/23 (10:30 pm)- "[Client #2] was selecting his night clothes when he suddenly flopped over onto the floor."
-Incident dated 10/31/23- "Yesterday I called [Client #2] for breakfast. Staff was assisting him when he was coming to the table, he thrust his self into the floor and pulled his wheel chair on top of his self. Then gets to the table and does it again. Then I noticed that his lip was bleeding."

Interview on 11/8/23 with the House Manager revealed:
-Client #2 had a fracture foot.
-They did not know how he had broken his foot. The fracture occurred in August.
-They did a follow up on October 5th and the fracture had not healed. Client #2's foot was recast.
-Follow up was given for November 5th, but he was in the hospital already.
-Client #2 had been falling at the house because of the cast on his foot.
-Client #2's knees and elbows had been scrapped because of him falling recently.
-Provisions made was that staff was to help him out of the wheelchair, but he continued to do it on his own.
-He believed it was Client #2's natural instinct to

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V 112	Continued From page 4 get up. -Client #2 may not understand that staff needed to help him get up. -Client #2 required 24/7 supervision. He was a level 4 client. Required 1:1. -Plan from the house was to continue to supervise him 24/7. There was nothing else written down. Plan was to assist him the best they could. To be on top of him. -Unlike the hospital, they were not able to strap him to the side of the bed. The only thing they could do was to increase supervision, which he was already getting. -They feel that Client #2 does not want to be in the wheelchair. He wants to get up and then he may fall because of the cast. Interview on 11/8/23 with the Chief Operating Officer revealed: -She recognized that a new plan had not been updated. -Reported that they had tried to have the whole Client #2's treatment team meet to discuss any goal changes. -She acknowledged that Client #2's situation and agency ' s goals had changed since he got the cast on his leg. -Facility staff had been dealing with his injury. -Client #2 always had a staff assisting him, but he still managed to fall. -They had implemented a tighter supervision on Client #2, but nothing had been updated in his plan.	V 112		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS	V 367		

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(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
(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

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V 367	Continued From page 6 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 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.	V 367		

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This Rule is not met as evidenced by:
Based on record review and interviews the facility failed to ensure a Level II incident report was completed within 72 hours and submitted to the Local Management Entity/Managed Care Organization. The findings are:

Review on 11/2/23 of Client #2's record revealed:
-Admission date of 12/8/12.
-Diagnoses of Autism; Moderate Mental Retardation; Seizure Disorder; Hydrocele Right Testicle.

Record review on 11/8/23 of internal incident reports revealed:
-On 10/31/23, Staff observed that [Client #2] seemed to be lethargic. During dinner, staff had to provide physical assistance for him to be properly fed as staff noticed that he seemed to be exhibiting difficulty with holding the utensils during the meal. [Client #2] appeared to be somewhat incoherent as evidenced by him not responding to staff in his usual manner. Staff contacted the manager after observing [Client #2] for an additional 30 minutes and noted there was no change in his behavior. [Client #2] had exhibited this same behavior previously when diagnosed with a Urinary Track Infection (UTI), and the decision was made to have him examined medically since it was after hours and his primary care physician could not be reached until the next day.

Reviews on 11/2/23 and 11/7/23 of the North

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V 367	Continued From page 8 Carolina Incident Response Improvement System (IRIS) revealed: -There were no IRIS reports for Client #2 for the months of October 1, 2023 through November 7, 2023. Interview attempt on 11/8/23 with Client #2 revealed: -Client #2 would not respond to questions made. -Client #2 was not talkative. Interview on 11/2/23 with Staff #6 revealed: -Client #2 was not acting himself. Was checked up at the hospital. Tests were ran. -They couldn ' t find anything. -He went back to normal. They did say his blood pressure was too low. Interview on 11/8/23 with Staff #7 revealed: -Staff informed that there were only three clients at the house as Client #2 was at the hospital. -Client #2 had been in the hospital for about a week. She could not remember if he was at the hospital last week when surveyor came by the house or if he was hospitalized on same day. -She was not too familiar on why he may had gone to the hospital because she was only at the house for a few hours each days in the mornings. -Staff also informed that Client #2 had recently broken his ankle as he had stepped down from the vehicle. That happened a while back. -Client #2 was not responding well last week and was taken to the hospital. She believed they said that he may had an infection. Interview on 11/8/23 with the House Manager revealed: -"Client #2 got to the point that he was weak. Lethargic. Could not get up. He was acting like he was not feeling well."	V 367		

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V 367	Continued From page 9 -He informed that Client #2 had previously been at the hospital for an urinary track infection. -Client #2 was taken to the hospital on 10/31/23 by Emergency Medical Services (EMS.) -Client #2 was still at the hospital. -They had been informed that Client #2 had some kind of infection. -He followed up every day. -"They said that they are trying to get rid of the infection." -Client #2 was already in the hospital when survey was opened last week. -He was not in charge of making reports on IRIS. The Chief Operating Officer was in charge of inputting information on IRIS. Interview on 11/8/23 with the Chief Operating Officer revealed: -She was in charge of completing IRIS reports. -She recognized that agency failed to report incident on IRIS. -She was aware that on 10/31/23, the facility contacted emergency services for Client #2. -Client #2 was transported to Emergency Room and was hospitalized. -Client#2 continued to be hospitalized due to his infection.	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility	V 736		

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failed to ensure facility grounds were maintained in a clean, safe and attractive manner. The findings are:

Observation on 11/2/23 at about 11:20 am of the Living area revealed:
-The wall behind the couch needed to be painted over.
-There were scratches made by chair rubbing against it.

Observation on 11/2/23 at about 11:23 am of the Kitchen revealed:
-The cabinets needed to be replaced. They were worn out.
-Bottom cabinets in the corner of the kitchen and next to kitchen range were broken.
-Bottom of cabinets underneath the sink were broken/rotten.

Observation on 11/2/23 at about 11:25 am of the Entrance area revealed:
-The paint on wall by entrance and next to Client #3's room was peeling off.
-There was a hole on wall behind the door made by the door knob.

Observation on 11/2/23 at about 11:27 am of Client #3's Bedroom revealed:
-The ceiling had stain from old water damage. Needed to be repainted.
-The front door was dirty/stained.
-There was baseball size hole on wall next to entrance (right wall.)
-There was a baseball size hole on wall behind bed.

Observation on 11/2/23 at about 11:30 am of the Hall to the Bedrooms revealed:
-Air conditioning return vent had a thick layer of

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V 736	Continued From page 11 dirt/lint covering it. Observation on 11/2/23 at about 11:33 am of the Bathroom inside Client #4's Bedroom revealed: -There was a large section of unfinished wall repair behind toilet. -The air condition vent on ceiling by the tub/shower was heavily rusted. Observation on 11/2/23 at about 11:35 am of the Main Bathroom revealed: -Sink cabinet was disconnected from the wall. -There was a significant number of scratches on wall made by the shower rod. The toilet seat had the wrong size for the toilet. Interview on 11/2/23 with the Supervisor revealed: -He was aware of the things that needed to be replaced. -They also have had a hard time with the landlord fixing other things which he was responsible for replacing. -Landlord for the home informed them that they needed to move out as he was not renovating the lease. They were told to be out by January 2024. -They had found a new facility. They were awaiting for construction to come out and approve it. They had submitted paperwork to the Division of Health Services and Regulation for the relocation. -He confirmed the facility failed to ensure facility grounds were maintained in a safe, clean, attractive and orderly manner. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		