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
	MHL0411121	A. BUILDING: _____ B. WING _____	12/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERVANT'S HEART IV	3215-A STONEBURG COURT GREENSBORO, NC 27409

(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 and complaint survey was completed on December 29, 2023. The complaints were substantiated (intake #NC00210936, #NC00210977, #NC00210987 and #NC00211374). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 3 and currently has a census of 2. The survey sample consisted of audits of 2 current clients and 1 deceased 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	V 112	RECEIVED JAN 30 2024 DHSR-MH Licensure Sect	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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V 112	Continued From page 1 obtained. This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to develop and implement strategies for 1 of 2 current clients (Client #1) and 1 of 1 deceased Client (DC#3). The findings are: Cross-Reference: 10A NCAC 27G .5603 Operations (291). Based on record review, observation and interview, the facility failed to maintain coordination between the facility's operator and qualified professionals to address the treatment needs for 1 of 2 clients (Client #1). Review on 12/15/23 of DC #3's record revealed: -Admission date of 10/15/23. -Date of death on 12/14/23. -Diagnosed with Profound Intellectual Developmental Disability (IDD), Autism, Anxiety Disorder, PICA, Gastroesophageal Reflux Disease (GERD), Moderate Pharyngeal Dysphagia, and Epilepsy. -Non-verbal. -A facility emergency data form dated 10/18/23 stated her food texture was "pureed" and "liquid consistency was pudding." Review on 12/18/23 of DC #3's physician orders dated 8/2/23 revealed:	V 112		

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V 112	Continued From page 2 -A prescribed diet of pureed consistency and pudding-thickened liquids. -"Strict aspiration precautions" included "full supervision," and eat and drink slowly. Review on 12/15/23 of DC #3's behavioral support plan dated 6/23/23 revealed: -A thickener was to be added to all liquids and food was to be pureed due to "high risk of choking." Review on 12/15/23 of a facility's internal incident report dated 12/14/23 for DC#3 revealed: -On 12/10/23, while eating breakfast, Staff #1 observed DC#3 was "convulsing" and "lethargic." -DC #3's breakfast was "partially eaten. At that point, staff (Staff #1) began to suspect [DC#3] was chocking (choking)." -Staff #1 checked DC#3's breathing " ...it was fine, but [DC#3] was not responding." -Staff #1 called 911 which led to an emergency medical services (EMS) response to the facility. -DC #3 was transported by EMS to a hospital. -On 12/10/23, DC#3's guardian informed the facility's Qualified Professional #1/Director (QP #1/Director) that DC#3's medical emergency was due to "an obstructive airway." Review on 12/15/23 of facility video camera footage dated 12/10/23 that ranged from 5:56 am to 6:31 am revealed: -6:20 am, DC#3 followed Staff #1 into the kitchen. -6:22 am, DC #3 walked from the kitchen and sat down on the couch in the living room. -6:23 am, DC #3 stood up from the couch and walked toward the kitchen and into a room where the medication cabinet and a dark brown dining table were located; she went out of camera view due to the obstruction of a Christmas tree in the living room.	V 112		

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-6:26 am, Staff #1 walked from the direction of the kitchen into the living room where she picked up a cell phone from near the couch.
-6:27 am, Staff #1 looked in the direction of the medication cabinet area, looked back at the cell phone, looked back in the direction of the medication cabinet area, and walked toward the medication cabinet area.
-6:31 am, Staff #1 was bent at her waist and was looking toward the floor.
-DC #3 was out of camera view starting at around 6:23 am to the end of the video footage.

Review on 12/15/23 of a 911 Communications report from local EMS dated 12/10/23 revealed:
-6:32 am, an emergency call was received from the facility for DC#3 who "fainted ...breathing not completely nl (normal) ...not responding ..."
-6:45 am to 6:53 am, cardiopulmonary resuscitation (CPR) was in progress.
-7:32 am, DC#3 was transported by EMS to a local hospital.

Reviews on 12/18/23 and 12/22/23 of an internal investigation report dated 12/17/23 and signed by the QP #1/Director for DC #3 revealed:
-An investigation of the 12/10/23 medical emergency incident involving DC#3 was conducted.
-"[Staff #2] stated she told [Staff #1] that [DC#3] and another roommate (Client #1) must have their food pureed."
-DC#3's death on 12/14/23 was reported by her guardian to DC#3's team who included the QP #1/Director and a Local Management Entity/Managed Care Organization (LME/MCO) Care Coordinator.
-Staff #1's 12/11/23 interview by the QP #1/Director, "[Staff #1] re-iterated she followed her training, which was that [DC#3]'s food had to

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V 112	Continued From page 4 be broken up in small pieces because she tends to eat quickly and could choke." -Staff #2's 12/11/23 interview by the QP #1/Director, "she told [Staff #1] that [DC#3]'s and another roommate (Client #1) must have their food pureed." -The QP #1/Director's summary stated, "this comes down to a matter of she-said, she said," and "it appears that the emergency occurred because of a mistake in [Staff #1]'s training, not out of willful negligence or abuse." Review on 12/29/23 of DC #3's hospital report dated 12/10/23 to 12/14/23 revealed: -On 12/10/23 at 8:06 am, DC#3 arrived "unresponsive" at the emergency department (ED); "noted to have no pulse" and " ...not breathing over ventilation attempts-no spontaneous movements of extremities noted on arrival to ED." "Per (unnamed) staff, [DC#3] was eating breakfast this AM, after she finished (she) began walking when she collapsed." -"EMS reported that [DC#3]'s airway was filled with debris and food." -She "suffered a cardiac arrest as placement of a breathing tube was unsuccessful and she required an emergency cricothyroidotomy (procedure to establish an airway)." -" ...initial cause of (cardiac) arrest is possibly choking on food (or) upper airway obstruction." -Her guardian reported DC#3 was supposed to be on a pureed diet. -DC#3 failed to regain consciousness, a magnetic resonance imaging (MRI) demonstrated "severe anoxic brain injury," and she died on 12/14/23. Interview on 12/18/23 with DC#3's guardian revealed:	V 112		

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V 112	Continued From page 5 -DC#3 was hospitalized from 12/10/23 to 12/14/23. -DC#3's cause of death on 12/14/23 was from "choking, aspiration, and cardiac arrest." -"She choked on something like a pop tart. She was supposed to be on a pureed diet ... and a staff (Staff #1) gave her a pop tart." -Staff #1 was newly hired staff and worked the overnight shift of 12/9/23 by herself. Interview on 12/19/23 with Staff #1 revealed: -On 12/9/23, she started her first work shift (11:00 pm-8:30 am) at the facility as a direct care staff. -On 11/11/23, she received 3 hours of training from Staff #2 at the facility. -Her 3-hour training included meeting Client #1, #2 and DC#3, and she was given client-specifics on their medications, food, and toileting care. -Client #1's food "was to be like a milkshake." -DC#3's food "was to be broken down into small pieces." -On 12/10/23 around 5:50 am, DC#3 woke up, came out of her room, and wanted coffee. -DC#3 sat at the table (beside the medication cabinet) where she gave her a pastry she broke in half and water to drink because there was no coffee. -After she checked on Client #1 who was in bed, she returned to DC#3 and saw DC#3 was "not responding and shaking and then had her head on the table." -She saw DC#3 ate half her breakfast which was "half a pop tart." -DC #3 was breathing and had a pulse when she called "the police." "They (police and EMS) were there in about 3-4 minutes and did CPR ...then they (EMS) cut her throat, and she had a pop tart stuck in her windpipe." -She thought DC#3's diet was "small pieces;" she never had it explained to her that her diet was to	V 112		

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V 112	Continued From page 6 be pureed. -Pureed food was "like milkshake." Interview on 12/18/23 with Staff #2 revealed: -She was Client #1's day program support worker during the weekdays and worked Saturday shifts at the facility with Clients #1 and DC #3. -She was familiar with Clients #1 and DC #3 because she worked with them for about 1 year in their previous placement. -Client #1 and DC #3 were admitted to the facility on 10/15/23 and she began working with them on 10/16/23. -She trained Staff #1 for "a couple of hours" before Thanksgiving; "I can't tell you the exact date I trained her." -Her training of Staff #1 included the clients' diets, toileting, medications, and behaviors. -Client #1's food was "ground consistency," with a thickener added in her food. -DC#3's food was "pureed." Interviews on 12/18/23 and 12/20/23 with the Residential Coordinator revealed: -Staff #2, #3, #4 and #5 worked directly with Clients #1, #2 and DC#3 in their previous placement. -"We (she and the QP #1/Director) depended on them (Staff #2, #3, #4 and #5) to know their (Clients #1, #2 and DC#3)'s routines. We didn't know them." -She scheduled Staff #1 to be trained by Staff #2 "for a couple of hours" at the facility to learn the clients' medicines, food, and daily routines. -Staff #1 told her she did not need additional training; "she felt she was ready." -She did not review client treatment plans with newly hired staff who were being trained to provide direct care. -The facility had an electronic record system in	V 112		

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V 112	Continued From page 7 place in which staff were expected to review client treatment plans and "acknowledge" they read the plans before the electronic system "let" staff enter their daily notes. -She did not know if Staff #1 "clicked on the link or not" to review DC#3's treatment plan. Interview on 12/18/23 with QP #2 revealed: -She wrote the clients' (Client #1, #2 and DC#3) short-range goals as part of their treatment plans. -She acknowledged there was no documentation about DC#3's food consistency regarding her meals and snacks in her short-range treatment plan goals. "That's something I definitely need to implement." Interviews on 12/15/23, 12/18/23, 12/20/23 and 12/29/23 with the QP#1/Director revealed: -She received and reviewed Clients #1, #2 and DC#3's treatment plans, risk assessments, and behavior plans prior to their 10/15/23 admission. -It had been "contentious from the start" with Clients #1, #2 and DC#3's admission. Their former facility was closing, and the clients needed to move. "We were hesitant because we didn't know them or their care ...we needed the staff (staff from the clients' former placement) to come over with these ladies (clients)." -Staff #2, #3 and #4 were hired from Clients #1, #2 and DC#3's former facility. -Staff #1 received "intensive client-specifics" where she shadowed Staff #2 for "at least 2 hours" going over specifics of facility procedures and client care (medications, routines, and diets). -Staff #1 told her she thought DC#3's food consistency was food "broke up into small pieces" and she "was surprised" when she learned Staff #1 gave DC#3 a pastry for breakfast on 12/10/23. -DC#3's guardian said DC#3 died from aspiration and choking.	V 112		

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V 112	Continued From page 8 -Staff #1 was terminated from employment on 12/19/23 due to not having followed her training and procedures which were in DC#3's documentation. Review on 12/19/23 of the first Plan of Protection dated 10/19/23 completed and submitted by the QP#1/Director on 12/19/23 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -Created posters and posted at kitchens in group homes with pictures of consumers and client-specific details of dietary needs/restrictions -Competed in-service at staff meeting on (10/15) retraining staff on the different consistencies of food preparation and how to prevent/respond to incidents of aspiration/choking. -Admin (Administration) will re-train each residential staff throughout this week regarding treatment plan policies. Admin will ensure staff understand each policy, know how to implement each one as well as how to reference the policies for any future changes. Describe your plans to make sure the above happens. -Admin will perform random visits to the home throughout the week. These visits will occur during different shifts/times. Staff will be monitored to ensure all elements of a consumer's plan is correctly implemented. -Cameras will be reviewed daily to monitor staff performance in order to ensure procedures and policies are being upheld. -During scheduled monthly clinical supervision reviews, staff will demonstrate their knowledge of client-specific procedures. Any updates/changes will be reviewed during this monthly meeting." Review on 12/29/23 of the second Plan of Protection dated 12/29/23 written by the	V 112		

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V 112	Continued From page 9 QP#1/Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -Client-specific training documentation has been updated to ensure both staff being trained and are training sign off that all aspects of care is being covered during training. A detailed list of those areas are included in the training sheet. Additional trainings have been added to the onboarding process that ensures that new staff train a minimum of three times in the home and that the last time is no more than three days before the beginning of the first shift. -Client specific updates will be added to mandatory staff meetings to ensure all staff are updated to necessary changes with any client care -A new 'About Me' board are being added to the client bedrooms. This will include a breakdown of client specifics needs and preferences, photos, etc. This gives staff a visual aid of client needs when in the home -Medical orders regarding the daily care during the completion of goals will be added into the language of the client's goals (ex (example): specific physical assistance which must be completed or dietary modifications which need to addressed in order to complete the goal). Describe your plans to make sure the above happens. -Client specific training sheets will be filed in the personnel books of staff. New staff will also have a document showing the days and times of each of their trainings at the residence. -The agenda for each staff meeting will document any updates that are reviewed regarding client-specific care. -These new boards will be implemented within the next two weeks. Information included on these boards will be reviewed at each biweekly	V 112		

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administrative meeting to ensure all client specifics are up to date.
-QPs will complete training demonstrating the ability to implement client-specific needs/modifications into the goals which staff sign off on during shifts."

Review on 12/29/23 of an addendum to the Plan of Protection dated 12/29/23 written by the QP#1/Director revealed:
"What immediate action will the facility take to ensure the safety of the consumers in your care?
-Client-specific training documentation has been updated as of Dec. (December) 20, 2023. A detailed list of those areas are included in the training sheet. This includes dietary needs, food modification, physical assistance and how to provide that assistance, barriers in language, medications etc.
-Existing staff have been re-trained with updated client-specific training sheets. All staff will be re-trained by Jan. (January) 15, 2024.
-Client specific updates will be added to mandatory staff meetings to ensure all staff are updated to necessary changes with any client care effective January 15, 2024. All information will also be added to the 'splash message' which must be acknowledged by staff when logging into our EHR (Electronic Health Record) for daily shift notes. Staff must acknowledge the information in this message before moving forward with providing treatment during their shift. An acknowledgement report can be printed off to ensure all staff have read and acknowledged the information.
-A new 'About Me' board are being added to the client bedrooms. This will be completed by Jan. 15th, 2024.
-Monthly updates will be communicated to the treatment team regarding any changes of care

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V 112	Continued From page 11 which can then be uploaded in the client's treatment plan. This re-trainiing will be completed by Jan. 19th, 2024." Review on 12/29/23 of a second addendum to the Plan of Protection dated 12/29/23 written by the QP#1/Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -Begiinning on Dec 21, 2023, residential coordinator has been meeting daily with existing staff to re-train on client specifics. Existing staff have been re-trained with updated client-specific training sheets. This re-training of ALL staff will be completed by Jan. 5th. -Most staff have attended the [online course] training 'An Overview of Safe Eating and Drinking' which was conducted Dec. 28th, 2023. Any staff not in attendance will compete it by Wed. (Wednesday), Jan. 3, 2024. This training is mandatory. Any staff who have not completed it by this date will not be taken off schedule until the training is completed. This training will be used for all new staff onboarded as part of mandatory training requirements. A new in-person course is being developed by our [training company] to be included as part of our in-person training classes beginning in Feb.(February) 2024." The facility served 3 adult females who were non-verbal and had diagnoses that included Profound IDD, Moderate Pharyngeal Dysphagia, a history of Aspiration Dysphagia, and GERD. Client #1 and DC#3 both had physician-ordered pureed food diets. DC#3 was fed a pastry that was broken in half by Staff #1 instead of having the pastry pureed. DC#3 became unresponsive after she ate half of the pastry and Staff #1 called 911. DC#3's airway was filled with debris and food and EMS performed an emergency	V 112	The detailed plan of protection, which contains the implementation of updated policies, presented in the interview will continue to be followed. All residential clients' treatment plans have been reviewed to ensure that information provided by the treatment teams align to the prescribed diet order as provided by the clients' medical doctors. Any disparities found were immediately shared with the treatment teams so that the client's treatment plan could be updated according to the client's medical orders. Beginning 1/23/24, QPs will monitor and review for any discrepancies between the treat plan and medical orders provided. QPs will also to continue to regularly review treatment plans with staff to ensure that staff are aware of any updates or changes to the client's care. All updates to staff will be documented via Servant's Heart EHR (Therap). Staff will be required to sign off on receiving the updates for the clients. Servant's Heart will use this documentation to ensure that staff are kept abreast of any and all changes to client care. Any future intakes will require Servant's Heart admin to thoroughly review all treatment plans and documentation for any discrepancies before admission for treatment. All discrepancies will need to be corrected before an individual will be able to begin services at Servant's Heart. Director will monitor this review prior to admission of any new clients.	

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SERVANT'S HEART IV	3215-A STONEBURG COURT GREENSBORO, NC 27409

(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 112	Continued From page 12 cricothyroidotomy to establish an airway. DC#3 went into cardiac arrest and was transported to a hospital. DC #3 failed to regain consciousness and died on 12/14/23. On 12/18/23, Client #1 was fed 1½ -2-inch-long cheese puffs by Staff #2. On 12/20/23, Client #1 was fed bite-sized chicken and vegetables by Staff #7. Client #1's physician order for a pureed diet was received by the facility prior to her admission. Client #1's treatment needs were not coordinated between Client #1's treatment team of qualified professionals resulting in her treatment plan having incorrect instructions for the consistency of her food. This deficiency constitutes a Type A1 rule violation for serious harm and neglect and must be corrected within 23 days. An administrative penalty of $10,000 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 of compliance beyond the 23rd day.	V 112		
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	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411121	A. BUILDING: _____ B. WING _____	12/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERVANT'S HEART IV	3215-A STONEBURG COURT GREENSBORO, NC 27409

(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 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, 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 review, observation and interview, the facility failed to maintain coordination between the facility's operator and qualified professionals to address the treatment needs for 1 of 2 clients (Client #1). The findings are: Review on 12/18/23 of Client 1's record revealed: -Admission date of 10/15/23. -Diagnosed with Profound Intellectual Developmental Disability (IDD), Epilepsy, Cerebral Palsy, Gastroesophageal Reflux Disease (GERD), and history of Aspiration Dysphagia. -Non-verbal. -11/1/23 treatment plan: "[Client #1] does not chew and requires food to be finely chopped or mashed with a fork." Review on 12/20/23 of Client #1's physician	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411121	A. BUILDING: _____ B. WING _____	12/29/2023

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SERVANT'S HEART IV	3215-A STONEBURG COURT GREENSBORO, NC 27409

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V 291	Continued From page 14 orders dated 8/2/23 revealed: -A prescribed "pureed consistency diet." Observation on 12/18/23 at approximately 10:00 am of Client #1 revealed: -She sat in wheelchair with a lap tray attached to her wheelchair and 4-5 cheese puffs laying on the tray. Each cheese piece was approximately 1 ½- to 2 inches long. -She was hand-fed single cheese puffs by Staff #2. -She started coughing; Staff #2 stated "she forces herself to cough to get attention." -Staff #2 told Client #1 she was "okay" and "if you're not going to eat that, I'm taking it out." -Staff #2 took her right finger and removed the cheese puff from Client #1's mouth. Observation on 12/20/23 at approximately 11:32 am of Client #1 being fed lunch by Staff #7 revealed: -The food was chicken and vegetable stir fry chopped into bite-sized pieces and was not pureed consistency. Interview on 12/19/23 with Client #1's guardian revealed: -Client #1 had a history of aspiration and used a thickener in her liquids. -She was not on a pureed diet. Interviews on 12/19/23, 12/20/23 and 12/22/23 with the Qualified Professional#1/Director (QP#1/Director) revealed: -She did not know the food consistency of a cheese puff. -Staff #2 told her she had broken the cheese puff into small pieces when she fed Client #1. -Client #1's treatment plan was completed by the care coordinator with the Local Management	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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SERVANT'S HEART IV	3215-A STONEBURG COURT GREENSBORO, NC 27409

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V 291	Continued From page 15 Entity/Managed Care Organization (LME/MCO), and "when they do the Individual Sup[port Plan (treatment plan), they ask for the latest doctor notes and MARs. I don't understand why she would not write down what the doctor says."" -This was the first time (12/20/23) she "noticed" Client #1's physician order for a pureed diet. -She received the physician's orders "about 4 days" before Client #1's admission to the facility. -"We had been giving her (Client #1) finely ground and pureed foods." -"We went off the risk assessment done by [the Care Coordinator]." -The physician's order for Client #1's diet "trumps" the treatment plan. -She would ensure Client #1 was given a pureed diet. -She would call Client #1's care coordinator with the LME/MCO "immediately" and inform her of Client #1's physician-prescribed pureed diet. -She would call Client #1's guardian and explain the physician's order for the pureed diet. -At Client #1's 12/29/23 physician's appointment, she would clarify the type of diet Client #1 needed. This deficiency is cross referenced into 10A NCAC 27G .0205 (V112) for a Type A1 rule violation and must be corrected within 23 days.	V 291	Care coordinator was contacted to update client's treatment plan to ensure doctor's orders were clearly laid out in her plan of care. Per the client's guardian's request, client was seen by a physician who changed her diet consistency. This new doctor's order was communicated to her treatment team. The treatment plan was again updated accordingly. The client's staff were trained, and all future staff will be trained, on her new food consistency to ensure strict adherence to physician order. Beginning 1/23/24, Servant's Heart QPs have been reminded to communicate with treatment teams regarding client care so that treatment plans can be updated in a timely manner. This will prohibit further miscommunication between treatment team members. QPs were reminded they should not wait until the annual meeting to give treatment team members a full update on a client. Instead, QPs should be corresponding with teams regularly to share updates to client care. Director will monitor and document communication between treatment teams at the bi-weekly administrative QP meetings	
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by:	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411121	A. BUILDING: _____ B. WING _____	12/29/2023

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V 366	Continued From page 16 (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal	V 366		

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V 366	Continued From page 17 review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different;	V 366		

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V 366	Continued From page 18 (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to implement written policies governing their response to Level III incidents. The findings are: Review on 12/15/23 of Deceased Client (DC) #3's record revealed: -Admission date of 10/15/23. -Date of death on 12/14/23. -Diagnosed with Profound Intellectual Developmental Disability, Autism, Anxiety Disorder, PICA, Gastroesophageal Reflux Disease (GERD), Moderate Pharyngeal Dysphagia, and Epilepsy. Refer to V367 for specific details of a level III incident on 12/10/23 which required emergency medical intervention for DC #3. Review on 12/15/23 of the North Carolina Incident Response Improvement System (IRIS) revealed: -There was no level III incident report on 12/10/23 submitted by the facility.	V 366	A level III incident report was filled out on 12/15/23. The form was completed and printed out. However, due to an accidental oversight, the Director did not press the final "Submit" button for the report. She printed out the completed report dated 12/15/23 and gave it to the Interviewer. The Director was not aware of the error until the DHSR interviewer shared the following week that she could not find the report. When the Director went into the report and showed the interviewer that the report was completed, she discovered that the final Submit button was not pressed. She submitted the report in front of the interviewer. As of 1/23/24 all level III incident reports will be reviewed by the CEO before submission to ensure all level III reports are submitted in a timely manner.	

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V 366	Continued From page 19 Interview on 12/20/23 the Qualified Professional #1/Director revealed: -She was responsible for completing level III incident reports and determining the risk/cause/analysis for each incident. -She did not determine the cause, or issue written preliminary findings of fact to the Local Management Entity/Managed Care Organization within 5 working days of the level III incident involving DC#3 on 12/10/23.	V 366		
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; (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	V 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 367	Continued From page 20 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 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	V 367		

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V 367	Continued From page 21 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. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure Level III incidents were reported to the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours of becoming aware of the incident. The findings are: Review on 12/15/23 of Deceased Client (DC) #3's record revealed: -Admission date of 10/15/23. -Date of death on 12/14/23. -Diagnosed with Profound Intellectual Developmental Disability, Autism, Anxiety Disorder, PICA, Gastroesophageal Reflux Disease (GERD), Moderate Pharyngeal Dysphagia, and Epilepsy.	V 367		

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V 367	Continued From page 22 Review on 12/22/23 of the facility's internal report dated 12/14/23 for the incident involving DC #3 on 12/10/23 revealed: -DC#3 became unresponsive while eating breakfast at the facility. -Staff #1 contacted Emergency Medical Services (EMS) and DC #3 was transported to the hospital. Review on 12/15/23 of the North Carolina Incident Response Improvement System (IRIS) revealed: -There was no level III incident report for the 12/10/23 incident submitted by the facility. Interview on 12/20/23 with the Qualified Professional #1/Director revealed: -She acknowledged she had not submitted a report into IRIS for the Level III incident involving DC#3 on 12/10/23.	V 367	As shared in the explanation above, the lack of submission of the incident report was an oversight on the part of the Director. The incident report was filled out, completed, and printed out within 24hrs of the notice of the death. The lack of submission was an error that was immediately corrected as soon as it was discovered. In our facility's 26-year history, there has never been a failure to submit an incident report in the required timeframe. As noted above, beginning 1/23/24, the CEO will now review all level III incident reports before submission.	

Cassidy Pierce 1/26/24

Division of Health Service Regulation
Mental Health Licensure and Certification Section
(Top portion completed by DHSR staff)

Facility Name: Servant's Heart IV MHL Number: 041-112

Rule Violation/Tag #/Citation Level: 10A NCAC 27G .5603 Operations/(V291); Cross Reference into 10A NCAC 27G .0205 Assessment and Treatment Plan or Service Plan/(V112) for a Type A1 Rule Violation

Plan of Protection – Completed by Facility Staff

(Attach additional pages if needed)

What immediate action will the facility take to ensure the safety of the consumers in your care?

Client-specific training documentation has been updated as of Dec. 20, 2023 ensure both staff being trained and are training sign off that all aspects of care is being covered during training. A detailed list of those areas are included in the training sheet. This includes dietary needs, food modification, physical assistance and how to provide that assistance, barriers in language, medications etc. Additional trainings have been added to the onboarding process that ensures that new staff train a minimum of three times in the home and that the last time is no more than three days before the beginning of the first shift.

Begiinning on Dec21, 2023, residential coordinator has been meeting daily with existing staff to re-train on client specifics. Existing staff have been re-trained with updated client-specific training sheets.
This re-training of ALL staff will be completed by Jan. 5th

Client specific updates will be added to mandatory staff meetings to ensure all staff are updated to necessary changes with any client care effective January 15, 2024. All information will also be added to the "splash message" which must be acknowledged by staff when logging into our EHR for daily shift notes. Staff must acknowledge the information in this message before moving forward with providing treatment during their shift. An acknowledgement report can be printed off to ensure all staff have read and acknowledged the information.

A new "About Me" board are being added to the client bedrooms. This will include a breakdown of client specifics needs and preferences, photos, etc. This gives staff a visual aid of client needs when in the home. This will be completed by Jan. 15th, 2024

Medical orders regarding the daily care during the completion of goals will be added into the language of the client's goals (ex: specific physical assistance which must be completed or dietary modifications which need to addressed in order to complete the goal). Monthly updates will be communicated to the treatment team regarding any changes of care which can then be uploaded in the client's treatment plan. This re-trainiing will be completed by Jan. 19th, 2024.

Most staff have attended the Relias training "An Overview of Safe Eating and Drinking" which was conducted Dec. 28th, 2023. Any staff not in attendance will compete it by Wed., Jan. 3, 2024. This training is mandatory. Any staff who have not completed it by this date will not be taken off schedule until the training is completed. This training will be used for all new staff onboarded as part of mandatory training requirements. A new in-

CITATION LEVEL: Number of days from survey exit for citation correction
Type A = 23 days **Type B** = 45 days
Uncorrected Type A or Type B Imposed = provider should provide written notification of intended correction date

person course is being developed by our training company (Scales Training) to be included as part of our in-person training classes beginning in Feb. 2024.

Describe your plans to make sure the above happens.

Client specific training sheets will be filed in the personnel books of staff. New staff will also have a document showing the days and times of each of their trainings at the residence.

The agenda for each staff meeting will document any updates that are reviewed regarding client-specific care.

These new boards will be implemented within the next two weeks. Information included on these boards will be reviewed at each biweekly administrative meeting to ensure all client specifics are up to date.

QPs will complete training demonstrating the ability to implement client-specific needs/modifications into the goals which staff sign off on during shifts

Facility Staff completing this form:

Cassidy Price /. Director. 12/29/23

Name/Title Date

CITATION LEVEL: Number of days from survey exit for citation correction

Type A = 23 days **Type B** = 45 days

Uncorrected Type A or Type B Imposed = provider should provide written notification of intended correction date

Division of Health Service Regulation
Mental Health Licensure and Certification Section
(Top portion completed by DHSR staff)

Facility Name: Servant's Heart IV MHL Number: 041-112

Rule Violation/Tag #/Citation Level: 10A NCAC 27G .0205 Assessment and Treatment Plan or Service Plan (V112)-failure to ensure the implementation of the client's treatment plan.

Plan of Protection – Completed by Facility Staff

(Attach additional pages if needed)

What immediate action will the facility take to ensure the safety of the consumers in your care?

Created posters and posted at kitchens in group homes with pictures of consumers and client-specific details of dietary needs / restrictions

Competed in-service at staff meeting on (10/15) retraining staff on the different consistencies of food preparation and how to prevent / respond to incidents of aspiration / choking.

Admin will re-train each residential staff throughout this week regarding treatment plan policies. Admin will ensure staff understand each policy, know how to implement each one as well as how to reference the policies for any future changes.

Describe your plans to make sure the above happens.

Admin will perform random visits to the home throughout the week. These visits will occur during different shifts/times. Staff will be monitored to ensure all elements of a consumer's plan is correctly implemented.

Cameras will be reviewed daily to monitor staff performance in order to ensure procedures and policies are being upheld.

During scheduled monthly clinical supervision reviews, staff will demonstrate their knowledge of client-specific procedures. Any updates / changes will be reviewed during this monthly meeting.

Facility Staff completing this form:

Cassidy Price / Director — Name/Title

10/19/23 — Date

CITATION LEVEL: Number of days from survey exit for citation correction
Type A = 23 days **Type B** = 45 days
Uncorrected Type A or Type B Imposed = provider should provide written notification of intended correction date