DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G286	A. BUILDING ______ B. WING ______	C 01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC GREY FOX RUN GROUP HOME	**312 GREY FOX RUN NEWPORT, NC 28570**

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W 000	INITIAL COMMENTS A complaint survey was completed on 1/10 - 1/11/24 for intake #NC00211867. The complaint was substantiated and a Condition of Participation in Client Protections was cited.	W 000	LIFE, Inc. will review the current training plans for current and new employees to ensure that all employees receive sufficient training regarding all client specific needs which will also include dietary needs. Immediate actions included interview	
W 122	CLIENT PROTECTIONS CFR(s): 483.420(a) The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: The facility failed to implement written policies and procedures that prohibited neglect (W149). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated services of client protections to its clients, specifically client #3.	W 122	of staff involved in the incident verbally and obtaining written statements and compared them to verbal statements. In the statements, bystanders were mentioned. To identify them, we requested a copy of the EMS report. We have viewed camera footage of the meal prep, requested camera footage from the park and requested the medical records from the hospital. Plan of correction began immediately to include in-service of all staff to	02-25-2024
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility neglected to ensure all staff were sufficiently trained regarding client specific dietary consistencies and needs. This specifically affected 1 of 1 deceased clients (#3) and potentially affected five clients (#1, #2, #4, #5 and #6) residing in the home. The finding is: Review on 1/10/24 of an IRIS report submitted on 1/9/24 and a General Event Report completed 1/9/24 revealed, "[Client #3] was on an outing with the group home (peers and staff) for lunch at the park on 1/7/24...Staff were unpacking and	W 149	include all diet orders, consistency of all foods served as the OT evaluation that includes the adaptive equipment of all consumers. This in-service was expanded to include emergency response to health emergencies to ensure that staff are prepared to handle these types of emergencies. (This in-service began immediately). The RN (or CPR instructor) will also review emergency medical protocol for a choking or nonbreathing individuals. The facility increased meal observations with no less than 4 per week for the next 3 months. These observations are documented in random inspections and meal observations forms kept in the home and workshop.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Director of ICF Services — (X6) DATE: 01-23-2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 149	Continued From page 1 getting consumers situated at the table and prepared to eat...While passing out the food, [Client #3] began eating." The IRIS report indicated the client was eating "fish sticks". Additional review of the report revealed, "He got choked. Indicated to staff by shaking his hands. Staff stated 'he is choking' and starting attempting to remove him from the table. Staff from another home were called over to assist. Staff were unable to provide effective abdominal thrusts." Further review of the reports noted two bystanders in the park, identified as first responders, came over to assist as "[Client #3] was limp and was lowered to the ground and CPR compressions were continued." The report indicated CPR continued until an ambulance arrived and "[Client #3] was then transported to [local hospital] by ambulance. He expired at the hospital." Interview on 1/10/24 with the Director of ICF Services indicated during staff interviews, it was difficult to determine from the staff at the park exactly what was happening in the moments leading up to the incident as the scene was "chaotic" and the staff were extremely upset. The Director added 2 of the 3 staff present that day had abruptly quit and were no longer communicating with the facility. Review on 1/10/24 of the client #3's medical records from the hospital dated 1/7/24 at 1:22pm revealed, "...They had chopped his food at home however today, he had become unresponsive after eating. He then had EMS contacted. When EMS arrived, they had found him to be pulseless and apneic. They did intubate him with reports of large amounts of food in the throat and airway."	W 149	These observations are documented in random inspections and meal observations forms kept in the home and workshop. We will re-evaluate at that time. As our current policy states, Managers will continue to ensure that all new staff that have not been cpr certified will always be working with trained staff. All new staff will be trained on diet order PRIOR to working the floor regardless of the staff they are working with. Current orientation training will be evaluated and changes made as deemed necessary to ensure staff are properly prepared prior to working their first individual shift. CPR which is currently a 2 year certification, will be reviewed annually. OT has been contacted to update all plans. Once received, these plans will be reviewed, changes to My Life Plan will be made and staff will be in serviced as to any changes. On going monitoring will continue with weekly meal monitoring. as mentioned previously. All staff working with the consumers will receive the training . the company is investigating the purchase and training of anit-choking devises for each home in the event other first aid is not successful. Outing guidelines and substitutions guidelines will also be developed and shared with all staff to ensure the safety of all consumers during community outings.	02-25-2024

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W 149	Continued From page 2 Further review of the General Event Report form from the facility noted under Plan of Future Corrective Actions, "Ensure food consistency is proper texture. Ensure food is distributed in a manner in which all consumers can be monitored and assisted as needed." Review of client #3's Individual Program Plan (IPP) dated 9/20/23 revealed the client has a diagnosis of Dysphagia and consumes a "pureed diet with honey thickened liquids". The plan noted, "I continue to eat fast and need reminders to slow down." Additional review of the IPP revealed, "I also need close supervision at mealtimes (i.e. within arms length). Staff members should redirect me if I attempt to eat too rapidly, puts too much food into my mouth, or takes too much liquid. If verbal cues are ineffective, the assisting staff member may gently guide my hand down towards the table, or control the cup for me. If residue remains post swallow, the assisting staff member may assist me with taking small sips of beverage to clear my palate. All staff members who will assist me should be made aware of my dysphagia diagnosis and diet consistency (pureed diet with Level II [honey thick] liquids." Observation on 1/10/24 of facility video footage dated 1/7/24 from 9:16am - 9:46am revealed Staff A, Staff B and Staff C (all direct care staff) were in the kitchen at various times completing tasks to prepare the meal to take to the local park for lunch later that day. Staff B was noted to place fish sticks onto a pan and into the oven while Staff C placed individual containers of soup into a large picnic bag. At 9:41am, Staff A began placing the cooked fish sticks into a large food processor and began to grind up numerous pieces of fish	W 149	Outing guidelines and substitutions guidelines will also be developed and shared with all staff to ensure the safety of all consumers during community outings.	

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and place the ground fish into several containers. Per the video footage, at no time was Staff A observed to add liquid to the food processor while grinding up the fish sticks during processing. Staff C obtained the containers of fish sticks and placed them into the picnic bag along with the soup.

Interview on 1/10/24 with Staff A revealed she had began working at the home on 12/27/23. The staff indicated she was aware that client #3 consumes a pureed diet which would mean liquid would need to be added to his food. The staff also indicated on the morning of 1/7/24, she had ground up the fish sticks in the processor for the client's lunches later that day. Staff A confirmed she did not add any liquid to the fish sticks, however, she had been told by Staff C that it was fine for client #3 to consume his fish sticks at a ground consistency. When asked what training she had been provided since she began working at the facility, the staff noted she had been "shadowing" various other staff working in the home. The staff stated she could not recall which staff had trained her on each client's diets and her training had been "informal". The staff further stated she felt she was not getting proper training on the job.

During the interview with Staff A, when asked what was happening prior to client #3's choking incident, the staff indicated she and the other two staff present (Staff B, Staff C) were all passing out food to the clients when client #3 began choking. Further interview revealed she was not sure how much of his food the client had consumed but thought it was a spoonful.

Review on 1/10/24 of Staff A's training records

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W 149	Continued From page 4 confirmed she began working at the facility on 12/27/23. Additional review of the records revealed she had received General Orientation training and ICF Orientation training, however, no client specific training regarding any clients in the home was located. The records did not include Adult First Aid/CPR training. Review on 1/10/24 of Staff B's training records indicated she began working at the facility on 6/6/23. Additional review of the records revealed she had received General Orientation training and ICF Orientation training, however, no client specific training regarding any clients in the home was located. Further review of the records revealed she had completed Adult First Aid/CPR training on 9/13/23. Review on 1/10/24 of Staff C's training records indicated she began working at the facility on 2/7/23. Additional review of the records revealed she had received General Orientation training and ICF Orientation training, however, no client specific training regarding any clients in the home was located. Further review of the records revealed she had completed Adult First Aid/CPR training on 3/20/23. Interview on 1/10/24 and 1/11/24 with the Director of ICF Services and the facility's nurse confirmed client #3 consumed a pureed diet. The Director acknowledged the video footage from 1/7/24 does show Staff A preparing fish sticks for the client's lunch at the park and does not show any liquid being added to the fish sticks to obtain the pureed consistency prior to being placed in the bag for the park. The Director and facility's nurse acknowledged client #3 was not provided pureed fish sticks during the outing at the park.	W 149		

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When asked about the training the direct care staff involved had received regarding client #3's diet, the Director of ICF indicated she could not be sure as there was no record of any client specific training for the staff. Additional interview with the Director revealed newly hired staff participate in shadowing of other direct care staff for two days over first and second shifts as a part of their training. Further interview indicated during this shadowing they are assigned a staff to follow to learn what they need to know when working with the clients in the home. The Director indicated there is currently no formal policy regarding shadowing as a form of training for direct care staff or any documentation of client specific training completed during shadowing.

The Director confirmed there was no record of training for Staff A, Staff B or Staff C regarding client's diets or other aspects of each client's program plan. The Director acknowledged policy and procedures need to be written and implemented regarding the facility's use of shadowing as a training tool for all direct care staff.

On 1/10/24, the Director provided the following Plan of Correction which noted the actions taken by the facility immediately following the choking incident involving client #3 and prior to the arrival of the survey team:

"Plan of correction began immediately to include in-service of all staff to include all diet orders, consistency of all foods serviced as the OT evaluation that includes the adaptive equipment of all consumers. This in-service will be expanded to include emergency response to health

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W 149	Continued From page 6 emergencies to ensure that staff are prepared to handle these types of emergencies. (This in-service began today). The RN (or cpr instructor) will also review emergency medical protocol for choking or nonbreathing individuals. The facility has also begun to increase meal observations with no less than 4 per week for the next 3 months. We will re-evaluate at that time. Managers will ensure that all new staff that have not been cpr certified will always be working with trained staff. All new staff will be trained on diet order PRIOR to working on the floor regardless of the staff they are working with. Diet index cards are being provided at the table as a reference for staff to use during meals to ensure compliance with all diet requirements. Additionally, LIFE, Inc is considering mealtime substitutions for outings. Company is currently discussing acquiring de-chokers but there is discussion of the pros and cons. No decision had been made. Discussion among managers has included the evaluation of outings of both homes together. This was also a recommendation of some of the staff involved given the chaotic nature of the set up of the dining situation. Outings should be evaluated as the appropriateness of the event, location, purpose and benefits. It is our intention to offer socialization but to ensure proper oversight in the decision-making process of these outings." Review on 1/10/24 of the facility's Consumer Rights Policy (last reviewed 2/20/23) noted, "Neglect is defined as a serious disregard for a consumer's supervision, care or treatment. It is	W 149		

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W 149	Continued From page 7 any action by an employee that results in harm/injury or could potentially result in harm/injury to a consumer. - The failure of a caregiver to provide the goods or services necessary to maintain the health or safety of a consumer. - The failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." The facility failed to ensure oversight of training provided for newly hired direct care staff regarding client #3's diet orders/food consistency and to provide supervision in accordance to his IPP resulting in the client receiving the incorrect food consistency on 1/7/24, his choking and his subsequent death. This constitued neglect.	W 149		