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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-069	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/06/2024
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NAME OF PROVIDER OR SUPPLIER TAYLOR HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 43 EAST CRAWFORD STREET OLD FORT, NC 28762
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(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
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V 000	<p>INITIAL COMMENTS</p> <p>An annual, complaint, and follow up survey was completed on June 6, 2024. Two complaints were substantiated (NC#00211019 and NC#00213134) and two complaints were unsubstantiated (NC#00210960 and NC#00214016). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living.</p> <p>A sister facility is identified in this report. The sister facility will be identified as sister facility A. Staff and/or clients will be identified using the letter of the facility and a numerical identifier.</p> <p>This facility is licensed for 3 and currently has a census of 2. The survey sample consisted of audits of 2 current clients, 1 former client, and 1 deceased client.</p>	V 000		
V 117	<p>27G .0209 (B) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(b) Medication packaging and labeling:</p> <p>(1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible;</p> <p>(2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate;</p> <p>(3) The packaging label of each prescription</p>	V 117	<p>V117</p> <p>Qualified Professional is reviewing medication policy with current AFL employee. QP is ensuring that staff is aware of labeling protocols. Employee will sign the medication policy after the one on one training.</p> <p>CEO has added a medication section on QP AFL visit forms to ensure QPs are checking MARs, scripts, and medications in the facility on a quarterly basis.</p> <p>Compliance officer is doing un-announced visits to AFL home to ensure compliance.</p> <p>Staff 1 is no longer employed with CCHC.</p>	7/3/24

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Aimee Smith, CEO

TITLE

(X6) DATE

7/3/24

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JUL 11 2024

DHSR-MH Licensure Sect

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V 117	<p>Continued From page 1</p> <p>drug dispensed must include the following:</p> <p>(A) the client's name;</p> <p>(B) the prescriber's name;</p> <p>(C) the current dispensing date;</p> <p>(D) clear directions for self-administration;</p> <p>(E) the name, strength, quantity, and expiration date of the prescribed drug; and</p> <p>(F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner.</p> <p>This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to maintain labeling of dispensed medication affecting 1 of 1 deceased client (DC #3). The findings are:</p> <p>Observation and interview with Alternative Family Living (AFL) Staff #1 at 10:13 am on 12/20/23 of medications revealed:</p> <ul style="list-style-type: none"> -Requested DC #3's medications from AFL Staff #1. A plastic bag of medications was presented. -A small red see-through container with round white pills inside was found inside the plastic bag. -No label or identifying information was on the container. -Without opening the container, at least 17 round white pills were able to be counted. -Other medication bottles with labels were in the plastic bag for Deceased Client (DC) #3. -Identified the plastic bag as medications for DC #3. -Did not know what the pills in the red container 	V 117		

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V 118	<p>Continued From page 4</p> <p>on observation and interviews, the facility failed to maintain labeling of dispensed medication affecting 1 of 1 deceased client (DC #3).</p> <p>Cross Reference: 10A NCAC 27G .0209 Medication Requirements (d) (Tag V119). Based on observation, record reviews and interviews, the facility failed to dispose of medications in a manner that guarded against diversion or accidental ingestion affecting 1 of 1 deceased client (DC #3).</p> <p>Review on 12/21/23 of Client #2's record revealed: -Admit Date: 11/15/21. -Diagnoses: Moderate Intellectual Developmental Disabilities; Chronic Pain; History of physical and sexual abuse; Hypothyroidism; Hyperlipidemia; Scoliosis; Obsessive-Compulsive Disorder; Anxiety Disorder; and Incontinence. -Physician's orders dated 10/19/23: -Gabapentin (anticonvulsant), 300 milligrams (mg), 3 times daily via g-tube (gastrology tube). -Diazepam (anxiety), 5mg, ½ tablet (tab) 3 times daily via g-tube. -SSD (Silver Sulfadiazine) cream (wound care) 1% topical cream apply topically to affected areas daily. -Aripiprazole (antipsychotic) 15 mg tab, take 2 tablets (tabs) via g-tube once daily. -Levothyroxine Sodium (hypothyroidism) 25 microgram (mcg) tab, take 1 tab via g-tube once daily (along with 50 mcg = 75 mcg dose). -Levothyroxine Sodium (hypothyroidism) 50 mcg tab, take 1 tab via g-tube once daily (along with 25 mcg = 75 mcg dose). -Levocetirizine Dihydrochloride (allergies) 5 mg, take 1 tab via g-tube once daily. -Clomipramine HCL (hydrochloride) (anxiety) 50 mg capsule (cap), take 1 via g-tube each</p>	V 118		

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V 118	<p>Continued From page 5</p> <p>morning, and take 3 caps (via g-tube) at bedtime.</p> <ul style="list-style-type: none"> -Hydroxyzine HCL (allergies) 25 mg tab, take 2 tabs via g-tube three times daily. -Cyproheptadine HCL (allergies) 4 mg tab, take 1 tab via g-tube three times daily. -Nystatin 100000 unit/gm (gram) topical cream (fungal cream), apply to affected areas two times daily. -Diaper Goop (diaper rash), apply to affected areas three times daily and as needed. -Ketoconazole 2% topical shampoo (fungal infection), apply 1 application topically twice weekly. -Jevity 1.5 calorie liquid ML (milliliter) (supplement), 2ml at 8 am, 2 ml at 2 pm and 2 ml at 8 pm. <p>Observation on 12/20/23 at 10:30 am of Alternative Family Living (AFL) Staff #1 revealed:</p> <ul style="list-style-type: none"> -AFL #1 administered and signed the December 2023 MAR for 12/20/23 for Client #2's 8 am doses of medication. <p>Review on 12/20/23 and 1/4/24 of Client #2's MARs from 10/1/23 to 12/31/23 revealed:</p> <ul style="list-style-type: none"> -Gabapentin 300mg, take 1 tab g-tube three times daily 8 am, 2 pm, and 8 pm. Only 8 am initialed as administered on all 31 days for December 2023. -Diazepam 5 mg, Take ½ tablet g-tube three times daily 8 am, 2 pm, and 8 pm. Only 8 am initialed as administered on all 31 days for December 2023. -Ketoconazole 2% topical shampoo, apply 1 application topically twice weekly. Not initialed as administered. <p>Review on 12/21/23 of DC #3's record revealed:</p> <ul style="list-style-type: none"> -Admit Date: 7/13/15. -Date of Death: 12/14/23. 	V 118		

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V 118	Continued From page 6 -Diagnoses: Intellectual Developmental Disability (IDD), Severe; Post Traumatic Stress Disorder, Unspecified; Autism; Cerebral Palsy Unspecified; Bipolar Disorder, in partial remission; Gastroesophageal Reflux Disease without Esophagitis; Anxiety Disorder, Unspecified; Anemia, Unspecified; Other Encephalopathy; Allergic Rhinitis; and Constipation, Unspecified. -Physician's orders dated 1/26/23: -Seroquel (Bipolar), 400mg tab, ½ tab am and 1 tab pm. -Magnesium oxide (supplement), 400mg tab, 1 tab daily in am. -B-12 (Vitamin) 5000 mcg/mls, give 0.2 ml once daily in am. -Multivitamin, 1 tab once daily in am. -Prozac HCL (depression), 20mg cap, 2 caps once daily in am. -Protonix (reflux) 40mg pack, 1 pack once daily in am. -Zyrtec (allergies), 10mg tab, 1 tab once daily in am. -Linzess (constipation) 145 mcg cap, once daily in am. -Folic Acid (supplement) 1 mg tab, 1 tab once daily in am. -Pepcid (heartburn) 40mg/5ml, 5ml once daily in am. -Tri-sprintec (birth control) 0.18/0.215/0.25 mg-3, 1 tab once daily in am. -Olanzapine (anti-psychotic) 10 mg tab, 1 tab twice daily. -Lactulose (constipation) 10 gm/15ml solution, 30 mls twice daily. -Colace (laxative) 50mg/5ml, 10mls once daily in am. -Physician's order dated 11/2/22: -Klonopin (anxiety) 1 mg tab, 1 tab each morning, & 2 tabs (2 mg dose) at bedtime.	V 118		

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V 118	<p>Continued From page 7</p> <p>Review on 12/20/23 and 1/4/24 of DC #3's MARs from 10/1/23 to 12/31/23 revealed:</p> <ul style="list-style-type: none"> -Quetiapine Fumarate 200mg tab, 1 tab via g-tube twice daily. Signed once daily for October, November, and December 2023 up to and including the morning of 12/8/23. -Magnesium oxide was not listed on the MARs for October, November or December 2023. -The following medications were documented as having been administered at 8 am on 12/8/23: -B-12 super strength 5000 mcg/mls, give 0.2ml via g-tube once daily (0.2ml = 1,000mcg dose). -Tab-A-Vite Tab, 1 tab via g-tube once daily. -Fluoxetine HCL 20 mg cap, 2 capsules via g-tube each morning. -Protonix 40mg pack, applesauce administration: open packet and sprinkle granules on 1 teaspoon of applesauce, swallow within 10 minutes of preparation, (once daily dosage). -Cetirizine 10mg tab, 1 tab once daily via g-tube. -Linzess 145 mcg cap, 1 cap via g-tube as directed once daily. -Folic Acid 1 mg tab, take 1 tab orally once daily. -Famotidine 40 mg/5ml, give 5ml (40mg dose) via tube once daily. -Tri-sprintec 0.18/0.215/0.25 mg-3, 1 tab via g-tube once daily. -Olanzapine 10 mg tab, take 1 tab orally twice daily. -Quetiapine Fumarate 200mg tab, 1 tab via g-tube twice daily. -Lactulose 10 gm/15ml, 30 ml via g-tube twice daily. -Clonazepam 1 mg tab, 1 tab each morning, & 2 tabs at bedtime via g-tube. -Docusate Sodium 50 mg/5 ml, take 10ml (100mg dose) via g-tube as directed once daily. <p>Interviews on 12/18/23 and 12/20/23 with AFL Staff #1 revealed:</p>	V 118		

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V 118	<p>Continued From page 8</p> <p>-On 12/8/23 woke up and worked with Client #2 before going in to check on DC #3. -"I had gotten [Client #2] changed, dressed, medicated. The nurse was coming. And then I came and did [DC #3]'s meds (medications)." -"She (DC #3) was non-responsive...no response. Called 911...at 9:57 am." -"I started giving her (DC #3) meds when I realized she was not responding." -"I went in and already had meds in my hand...I was giving her (DC #3) meds before I change her." -"I had her (DC #3) meds in the tube. I unzipped her and gave her the meds. Normally she would respond, but she didn't." -"Would typically give DC #3 her medications before waking her up. "It was easier to give it to her in that tube before she got in the chair..." -"Normally I give meds between 8-9 (am)." -"Had medication of her own "...that knocks me out...I took one last night (12/19/23)." -"Sometimes we (the household) are not up by 8 (am)..."</p> <p>Interview on 1/4/24 with Former AFL Staff #4 revealed: -AFL Staff #1 had observed Former AFL Staff #4 administer medication for DC #3 prior to AFL #1 moving into the facility.</p> <p>Interviews on 12/19/23 and 12/21/23 with the Qualified Professional (QP) revealed: -Would not necessarily know about medication issues. The Registered Nurse (RN) would look at that. -The former RN went into the facility and would look for medication errors and issues. Unsure if the current RN goes into the facility. -The RN came in twice a week and was responsible for checking the MARs.</p>	V 118		

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V 118	<p>Continued From page 9</p> <p>-Was unaware of any medication issues. -"I have no idea (about DC #3's medications)..."</p> <p>Interview on 1/4/24 with the facility's RN revealed: -Her position was "office based" and she reviewed MARs, verified orders, and verified that all medications had been administered. -"Community Companion (Licensee) has a policy that there is an hour window (for medications to be administered). If scheduled at 8 am, then they have until 9 am." -Expectation was that you signed off once medication was administered.</p> <p>Interview on 1/3/24 with the Chief Executive Officer (CEO) revealed: -The RN reviewed MARs against the prescriptions. -If there were any errors, the RN would get an updated prescription or discontinue order. -The RN would make notes and give them to the office staff and would review the issues again after it had been corrected. -The QP was expected to review MARs in the facility during onsite visits to make sure "...they are signed off daily."</p> <p>Interview on 1/3/24 with the Licensee revealed: -The RN checked the MARs and did not go into the facility. -The RN reviewed prescriptions to make sure things were accounted for. -Unsure how the RN would follow up if there was a problem. -The QP was expected to review MARs. -There was also a compliance officer who was available if there were issues.</p> <p>Due to the failure to accurately document medication administration, it could not be</p>	V 118		

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V 118	<p>Continued From page 10</p> <p>determined if clients received their medications as ordered by the physician.</p> <p>Review on 1/9/24 of the Plan of Protection written by the CEO signed on 1/9/24 revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Alternate staff has been brought into the home as of 5:00 PM on January 9, 2024. The alternate staff was informed to immediately check all medications for members (clients) in the home. They were instructed to remove any medications without labels, to remove any medications that were expired, and to return them to CCHC (Community Companion Home Care) (Licensee) main office for disposal to pharmacy. The staff was also instructed to compare the medication scripts (prescriptions) with the current Medication Administration Record to ensure that the proper medications are given and at the proper times. The staff was instructed to complete a medication transfer log anytime they pick up or return medications. Describe your plans to make sure the above happens. The alternative staff was given copies of the medication transfer log on January 9, 2024. The alternative staff has recently completed re-training in medication administration. CCHC Compliance Officer will conduct a surprise visit within three days of the plan of protection regarding medications. The compliance officer will ensure that all medications are in date, labeled, and match the medication administration record."</p> <p>This deficiency constitutes a re-cited deficiency.</p> <p>Facility clients had diagnoses including Intellectual Developmental Disabilities, Cerebral</p>	V 118		

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V 118	<p>Continued From page 11</p> <p>Palsy, Bipolar Disorder, Autism, Depression, Urinary Incontinence, Spina Bifida, Osteoporosis, Chronic Pain, History of physical and sexual abuse, Hypothyroidism, Hyperlipidemia, Scoliosis, Obsessive-Compulsive Disorder, and Anxiety. AFL #1 did not keep the MARs current as medications had not been initialed as administered and it was unclear if the clients received their medications. AFL #1 administered 8:00 am medications including Aripiprazole, Levothyroxine Sodium, Diazepam, and Gabapentin up to 2 1/2 hours outside of the scheduled time frame at 10:30 am, slept late after she took her own medication that resulted in her not waking up for the clients' scheduled medication administration time. On the morning of 12/8/23, AFL #1 signed the MAR for DC #3 prior to administering medications including Seroquel, Olanzapine, Clonazepam, and Prozac. On 12/20/23, AFL #1 was observed administering medications and signing the MAR medications outside of the scheduled time frame. Medication in the facility did not have a label to identify what the medication was or who it was for. Medications were expired and not disposed of properly. Oversight of medications in the home was not consistently monitored and it was unclear who was responsible.</p> <p>This deficiency constitutes a Type B rule violation which is detrimental to the health, safety, and welfare of the clients and must be corrected within 45 days.</p>	V 118	<p>V119</p> <p>Staff 1 is no longer employed with CCHC.</p> <p>Qualified Professional is doing a one-on-one training with current AFL staff to ensure they are aware of the medication procedures to follow when administering medications.</p> <p>CEO updated our internal QP visit form to include a medication section to remind QPs to monitor the MAR, scrips, and administration of the medications on at least a quarterly basis.</p>	7/3/24
V 119	<p>27G .0209 (D) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal:</p>	V 119	<p>Compliance officer is doing random unannounced visits to ensure medication protocols are being followed.</p>	

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V 119	<p>Continued From page 12</p> <p>(1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion.</p> <p>(2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program.</p> <p>Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction.</p> <p>(3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments.</p> <p>(4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge.</p> <p>This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to dispose of medications in a manner that guarded against diversion or accidental ingestion affecting 1 of 1 deceased client (DC #3). The findings are:</p> <p>Review on 12/21/23 of DC #3's record revealed: -Admit Date: 7/13/15. -Date of Death: 12/14/23.</p>	V 119		

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V 119	<p>Continued From page 13</p> <p>-Diagnoses: Intellectual Developmental Disability (IDD), Severe; Post Traumatic Stress Disorder, Unspecified; Autism; Cerebral Palsy Unspecified; Bipolar Disorder, in partial remission; Gastroesophageal Reflux Disease without Esophagitis; Anxiety Disorder, Unspecified; Anemia, Unspecified; Other Encephalopathy; Allergic Rhinitis; and Constipation, Unspecified.</p> <p>-Physician's order dated 1/26/23: Quetiapine Fumarate 100 milligram (mg), take 1 tablet orally every 2 hours as needed for agitation.</p> <p>Observation on 12/20/23 of DC #3's medication revealed:</p> <p>-Quetiapine Fumarate 100 mg, take 1 tablet orally every 2 hours as needed for agitation. Dispensed 9/1/22, expired 9/1/23.</p> <p>-Medication was in a bottle.</p> <p>Interview on 12/20/23 with AFL Staff #1 revealed:</p> <p>-Was unaware the medication was expired.</p> <p>-Had not administered any medication that was not in a bubble pack.</p> <p>Interview on 1/4/24 with the facility's Registered Nurse (RN) revealed:</p> <p>-Her position was "office based" so she did not go into the facilities to review medications.</p> <p>Interviews on 12/19/23 and 12/21/23 with the QP revealed:</p> <p>-"I don't know. I wouldn't probably know (of any medication issues)..."</p> <p>-The RN would go into the facility, and look for medication errors and issues.</p> <p>-"I have no idea (about former/deceased clients' medications). I would think they (AFL Staff) would have disposed of them (expired/old medications) by now. They should have (been disposed of)..."</p>	V 119		

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NAME OF PROVIDER OR SUPPLIER TAYLOR HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 43 EAST CRAWFORD STREET OLD FORT, NC 28762
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V 119	Continued From page 14 Interview on 1/3/24 with the Licensee revealed: -The RN did not go into the facility. This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type B rule violation and must be corrected within 45 days.	V 119		
V 366	27G .0603 Incident Response Requirements 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: (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.	V 366	V366 CCHC conducts yearly trainings in regards to level 1 and 2 incident reporting. CEO implemented a change in the Qualified Professional for this home. New QP will review incident reporting guidelines with current AFL staff. QP will continue to monitor the AFL home on a monthly basis ensuring that all incidents are reported in a timely manner. Staff 1, 2, 4, and 5 are no longer employed with CCHC.	7/3/24

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V 366	Continued From page 15 (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 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	V 366		

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V 366	<p>Continued From page 16</p> <p>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</p> <p>(3) immediately notifying the following:</p> <p>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;</p> <p>(B) the LME where the client resides, if different;</p> <p>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;</p> <p>(D) the Department;</p> <p>(E) the client's legal guardian, as applicable; and</p> <p>(F) any other authorities required by law.</p> <p>This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to implement policies governing their response to level I and II incidents as required. The findings are:</p> <p>Review on 12/21/23 of Deceased Client (DC) #3's record revealed:</p>	V 366		

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V 366	<p>Continued From page 17</p> <p>-Admit Date: 7/13/15. -Date of Death: 12/14/23. -Diagnoses: Intellectual Developmental Disability (IDD), Severe; Post Traumatic Stress Disorder, Unspecified; Autism; Cerebral Palsy Unspecified; Bipolar Disorder, in partial remission; Gastroesophageal Reflux Disease without Esophagitis; Anxiety Disorder, Unspecified; Anemia, Unspecified; Other Encephalopathy; Allergic Rhinitis; and Constipation, Unspecified.</p> <p>Attempted review on 12/18/23 of the facility's incident reports for period 9/1/23 to 12/18/23 was unsuccessful as no reports were provided. There was no evidence of internal review to determine risk/cause analysis of incidents.</p> <p>Review on 12/18/23 of Incident Response Improvement System (IRIS) revealed: -There were no level II incidents for DC #3 for 2023.</p> <p>Review on 12/18/23 and 12/19/23 of facility "Client Behavioral Notes" dated 10/2/23 to 12/7/23 for DC #3 revealed: -10/02/23, "6:30pm, flipped her wheelchair while sitting in the kitchen...frame of chair hit her left leg." -10/06/23, "8:30am, found [DC #3]'s leg stuck over footboard of bed." -10/14/23, "11:00am, while sitting in wheelchair ...tried to stand up...seatbelted in...and turned chair to the right knocking over the water dispenser and landing halfway on it." -10/15/23, "8:00pm, noticed bruising on inside of [DC #3]'s legs...has been caught climbing on footboard of bed." -10/17/23, "1:30pm, [DC #3] reached over and pushed water cooler over...tried to stand up while seat belted in and almost flipped her chair</p>	V 366		

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V 366	<p>Continued From page 18</p> <p>forward...finished feeding and took her back to room."</p> <p>-10/23/23, "9:00am, [DC #3] was very agitated this morning...got her in her wheelchair and belted in she began reaching and grabbing at things...turned to get her formula and she flipped her wheelchair and knocked water dispenser over...moved water cooler."</p> <p>-10/24/23, "3:30pm, while in her room [DC #3] was beating on the windows and walls."</p> <p>-10/25/23, "5:30am, woke up to [DC #3] beating on her wall...seemed agitated."</p> <p>-10/27/23, "8:00pm, walked in to chec ...she was climbing on her bed."</p> <p>-10/30/23, "8:30am, ...was sitting on her bed bouncing when I walked in room...she flipped off the side of the bed on to the floor."</p> <p>-11/6/23, "6:30pm [DC #3] was sitting in middle of her bed and fell back hitting her head on the wall...seem to be upset and didn't want to be messed with."</p> <p>-11/10/23, "1:30am, woke up to [DC #3] thumping and bumping in her room...found her in middle of her floor...put her back in bed and picked up toys...went back again and she was climbing on the bed."</p> <p>-11/11/23, "8:45am, ...entered...room and she had pulled handles off her dresser and they were in floor...pulling stuffing out of her diaper and had it all over the floor."</p> <p>-11/11/23, "4:15pm, found [DC #3] climbing across footboard of bed...cut footboard off and sanded it to keep...safe."</p> <p>-11/12/23, "8:45am, while having breakfast, tried to flip over her wheelchair."</p> <p>-11/13/23, "1:45pm, heard a big thump...went to check on her and found her stuck between bed and dresser...no marks noted...moved dresser to try and avoid this happening again."</p> <p>-11/15/23, "11:30am, ...seemed to be agitated</p>	V 366		

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V 366	<p>Continued From page 19</p> <p>and began throwing herself in floor and flipping off end of bed...tried to flip wheelchair when I tried to put her in it...tried to slide out of seatbelts." -11/18/23, "1:30pm, ...she had thrown all of her stuffed animals around her room, pulled sheets of her bed and had diaper filling all over the floor...she was sitting in the middle of the floor bouncing." -11/21/23, "8:45am, [DC #3] had diaper stuff all over room, in bed, etc...intentionally falling on her snowman...while changing her...noticed large bruise on left chest that wasn't there last night...I do believe she might have fallen against bed because toys were everywhere and I caught her falling on her snowman." -11/25/23, "3:15pm, heard loud thumps and walked in her room...was flipping off edge of bed...had to go back four times to put her back in bed...behavior ended 4:15PM" -11/27/23, "11:30am, [DC #3] seemed agitated and has tried to flip her wheelchair, slide out of seatbelts...also slide down foot/edge of bed while being changed..." -11/29/23, "7:00pm, DC #3] was sitting in her chair being tube fed...she reached and grabbed the line to feeding bag and pulled it. When she pulled the line she pulled the feeding tube out of her stomach...had replaced in ER (emergency room)." -11/30/23, "10:00am, [DC #3] has been very agitated today and tried to flip her chair...beating on the windows, walls, hit the doors several times...tried to throw herself in the floor several times." -12/03/23, "11:30am, [DC #3] has not acted like herself today. She seemed agitated and is intentionally falling in her floor, bouncing on her bed and throwing stuff/toys in floor." -12/06/23, "2:00am, I am awakened by a loud noise...[DC #3] is in room making thumping and</p>	V 366		

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V 366	<p>Continued From page 20</p> <p>bumping sounds...I walk in and she has vent cover and padded floor tile up. I go back to room...heard...thump. [DC #3] was back up and laying in floor next to living room door." -12/06/23, "4:30pm, [DC #3] has slept most of the day because she was up most of the night and has strep throat. I went to check on her and change her and found her feeding tube between mattress and bedframe...changed and dressed [DC #3] and took her to ER to have tube replaced." -12/07/23, "2:30am, [DC #3] woke us up thumping and bumping in her room. When I entered her room she had rolled off bed or thrown herself in floor. I sat with her for 45 mins (minutes) to 1 hour to calm her...I went back to my room and then heard another thump a little later...got her back in bed again...she made a loud sound which startled me and when I entered she was upside down at the foot of the bed, made sure she was dry...this went on till 7AM when she went to sleep..."</p> <p>Review on 12/19/23 of facility "Supervision Notes" signed by the QP revealed: -12/4/23; "...[DC #3] is looking good. She has been having some behaviors, which she tends to have during the holidays. She will throw herself against the wall, the floor. or even flipping over the chairs. She pulled her tube out recently and had to be taken to the ER to have it re inserted..." -12/12/23; "...visit with [AFL Staff #1, Former AFL Staff #4, and AFL Staff #2] - discussed member currently in ICU (intensive care unit) [DC #3] at length. [Former AFL Staff #4] linked (shared) to group that [DC #3] usually tended to get something almost like the holiday blues or something. [AFL Staff #1] linked that she had noticed over the last few weeks that she had seen a marked difference in [DC #3]. Linked to</p>	V 366		
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V 366	Continued From page 21 [AFL Staff #1] QP needed documentation that was in notebook. Pictures of papers linked to QP...[AFL Staff #1] linked that she had seen a big difference in [DC #3] the last few weeks. She linked that [DC #3] had pushed over the water cooler, not once but twice. Around thanksgiving [AFL Staff #1] had seen [DC #3] be more physical. She had pulled handles off the dresser as well as bumping on the bed...[AFL Staff #1] linked that she had bruised on her leg from going over the bed foot board." Review on 12/18/23 of three photographs dated 11/24/23 sent from AFL Staff #1 to Division of Health Service Regulation (DHSR) surveyors of DC #3 revealed: -Photograph #1: DC #3's face and chest. She had a yellow chew necklace in her hand and mouth (wearing around her neck) and was wearing a black shirt. The top of her blue seat belt strap was visible across her chest. There was reddish-purple bruising on the top of her chest, that appeared to be in various stages of healing near where her collarbones meet. -Photograph #2: Pictures of both DC #3's legs with her pants pulled back. DC #3's left leg had at least 14 smaller circular bruises that appeared to be similar in color (as the bruises on right leg) from the top of her knee to the upper left thigh area. -Photograph #3: DC #3's right leg had circular brownish-red and green colored bruising from the upper part of her right thigh all the way down past her kneecap. There was an additional bruise on her right leg, next to her shin bone that was lighter in color. There was a sore visible on her left lower arm (next to elbow) that had a black scab over it and had a red ring around it. Interview on 12/18/23 with AFL Staff #1 revealed:	V 366		

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V 366	<p>Continued From page 22</p> <p>-"Already knew..." how to complete incident reports.</p> <p>-DC #3 climbed on the bedroom furniture and got stuck on the footboard which required help to get down.</p> <p>-"[Former AFL Staff #4] is my go-to."</p> <p>-DC #3 "...fell and hit her chest. Didn't do an incident report. Not sure how she (DC #3) did it."</p> <p>-On 11/24/23, found the bruises on DC #3 when she was being changed in the morning. Was told not to do an incident report but couldn't remember who told her that.</p> <p>-Unaware if anyone completed an incident report regarding the bruises found on DC #3 on 11/24/23.</p> <p>-Knew she told Former AFL Staff #4 and #5. "I think I showed (pictures to) [QP]."</p> <p>-Did not call anyone regarding the bruising; "...didn't think anything of it..."</p> <p>-"...I was told not to do an incident report. Felt significant enough to take a picture (of the bruises found on DC #3 on 11/24/23)."</p> <p>-DC #3 had to have her feeding tube re-inserted at the ER on 11-29-23 and 12-6-23.</p> <p>Observation and Interview on 1/4/24 at 1:45 pm with Former AFL Staff #4 revealed:</p> <p>-"One time she (DC #3) had bruise right here (pointed to her chest) and bruises on legs. But nothing unusual. Especially this time of year."</p> <p>-DC #3's behaviors escalated during November and December every year.</p> <p>-With behaviors such as jumping up and flipping the chair over. "...She (DC #3) was just out of control."</p> <p>Interview on 12/19/23 with the QP revealed:</p> <p>-AFL Staff #1 "generally" would call Former AFL Staff #4 if there was a problem "...and then turn around and call me."</p>	V 366		

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V 366	<p>Continued From page 23</p> <p>-Pictures of bruises were taken on 11-24-23. -I tell them (AFL providers) to document (incidents)." -"She (AFL Staff #1) would not have been told to not do it (incident report) from me. I have told her on multiple occasions to document it." -"I feel like some of those (behavioral notes) should have been incident reports. She (AFL Staff #1) had training on incident reports. -Former AFL Staff #4 "...told us (Licensee) that around the holidays she (DC #3) was 'extra' (increased behaviors that required more assistance and attention)..."</p> <p>Interview on 1/3/24 with the Chief Executive Officer (CEO) revealed: -The QP was responsible for oversight of the home including training. -If someone were to "...fail to do something, falls on the company. We have to answer to it..." -Would have expected AFL Staff #1 to call the QP for incidents and not Former AFL Staff #4.</p> <p>Interview on 1/3/24 with the Licensee revealed: -The QP was responsible for trainings. -"The QPs are responsible for themselves. They don't have a supervisor. They know their job and what they are supposed to do ..." -"They (QPs) have consequences for their actions. Who is punished if they mess up? Ultimately, me." -AFL Staff #1 would call Former AFL Staff #4 if there was an incident "...and I am sure she called [QP]..."</p>	V 366	<p>V367</p> <p>CCHC conducts yearly trainings in regards to level 1 and 2 incident reporting.</p> <p>CEO implemented a change in the Qualified Professional for this home.</p> <p>New QP will review incident reporting guidelines with current AFL staff.</p> <p>QP will continue to monitor the AFL home on a monthly basis ensuring that all incidents are reported in a timely manner.</p> <p>Staff 1, 2, 4, and 5 are no longer employed with CCHC.</p>	7/3/24
V 367	<p>27G .0604 Incident Reporting Requirements</p> <p>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR</p>	V 367		

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V 367	Continued From page 24 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 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:	V 367			

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V 367	Continued From page 25 (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 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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V 367	<p>Continued From page 26</p> <p>This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to report level II incidents in the Incident Response Improvement System (IRIS) and notify the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours of an incident. The findings are:</p> <p>Review on 12/21/23 of Deceased Client (DC) #3's record revealed: -Admit Date: 7/13/15. -Date of Death: 12/14/23. -Diagnoses: Intellectual Developmental Disability (IDD), Severe; Post Traumatic Stress Disorder, Unspecified; Autism; Cerebral Palsy Unspecified; Bipolar Disorder, in partial remission; Gastroesophageal Reflux Disease without Esophagitis; Anxiety Disorder, Unspecified; Anemia, Unspecified; Other Encephalopathy; Allergic Rhinitis; and Constipation, Unspecified.</p> <p>Review on 12/18/23 of IRIS revealed: -There were no level II incidents for DC #3 in 2023.</p> <p>Attempted review on 12/18/23 of the facility's incident reports for period 9/1/23 to 12/18/23 was unsuccessful as no reports were provided.</p> <p>Review on 12/18/23 and 12/19/23 of facility "Client Behavioral Notes" dated 10/2/23 to 12/7/23 for DC #3 revealed: -11/29/23, "7:00pm, [DC #3] was sitting in her</p>	V 367		

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V 367	<p>Continued From page 27</p> <p>chair being tube fed...she reached and grabbed the line to feeding bag and pulled it. When she pulled the line she pulled the feeding tube out of her stomach...had replaced in ER (emergency room)."</p> <p>-12/06/23, "4:30pm, [DC #3] has slept most of the day because she was up most of the night and has strep throat. I went to check on her and change her and found her feeding tube between mattress and bedframe...changed and dressed [DC #3] and took her to ER to have tube replaced."</p> <p>Interview on 12/18/23 with AFL Staff #1 revealed: -"Already knew..." how to complete incident reports. -DC #3 climbed on the bedroom furniture and got stuck on the footboard which required help to get down. -"[Former AFL Staff #4] is my go-to." -DC #3 "...fell and hit her chest. Didn't do an incident report. Not sure how she (DC #3) did it." -On 11/24/23, found the bruises on DC #3 when she was being changed in the morning. Was told not to do an incident report but couldn't remember who told her that. -Unaware if anyone completed an incident report regarding the bruises found on DC #3 on 11/24/23. -Knew she told Former AFLs Staff #4 and #5. "I think I showed (pictures to) [Qualified Professiona (QP)]." -Did not call anyone regarding the bruising. "...didn't think anything of it..." -"...I was told not to do an incident report. Felt significant enough to take a picture (of the bruises found on DC #3 on 11/24/23)." -DC #3 had to have her feeding tube re-inserted at the ER on 11/29/23 and 12/6/23.</p>	V 367		

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V 367	<p>Continued From page 28</p> <p>Observation and Interview on 1/4/24 at 1:45 pm with Former AFL Staff #4 revealed: -"One time she (DC #3) had bruise right here (pointed to her chest) and bruises on legs. But nothing unusual. Especially this time of year." -DC #3's behaviors escalate d during November and December every year. -With behaviors such as jumping up and flipping the chair over. "...She (DC #3) was just out of control."</p> <p>Interview on 12/19/23 with the QP revealed: -AFL Staff #1 "generally" would call Former AFL Staff #4 if there was a problem "...and then turn around and call me." -Pictures of bruises were taken on 11/24/23. -"I tell them (AFL providers) to document (incidents)." -"She (AFL Staff #1) would not have been told to not do it (incident report) from me. I have told her on multiple occasions to document it." -"I feel like some of those (behavioral notes) should have been incident reports. She (AFL Staff #1) had training on incident reports. -Former AFL #4 "...told us (Licensee) that around the holidays she (DC #3) was 'extra' (increased behaviors that required more assistance and attention)..."</p> <p>Interview on 1/3/24 with the Chief Executive Officer (CEO) revealed: -The QP was responsible for oversight of the home including training. -If someone were to "...fail to do something, falls on the company. We have to answer to it..." -Would have expected AFL Staff #1 to call the QP for incidents and not Former AFL Staff #4.</p> <p>Interview on 1/3/24 with the Licensee revealed: -The QP was responsible for trainings.</p>	V 367		

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V 367	Continued From page 29 - "The QPs are responsible for themselves. They don't have a supervisor. They know their job and what they are supposed to do..." - "They (QPs) have consequences for their actions. Who is punished if they mess up? Ultimately, me." - AFL Staff #1 would call Former AFL Staff #4 if there was an incident "...and I am sure she called [QP]..."	V 367	V512 Staff 1 and 2 were removed from the home as of 5:00 pm on 1/9/2024. Alternative caregiver was brought into the home on 1/9/24. CCHC contacted DSS, updated incident report, and completed health care registry on staff 1 and 2.	6/29/24
V 512	27D .0304 Client Rights - Harm, Abuse, Neglect 10A NCAC 27D .0304 PROTECTION FROM HARM, ABUSE, NEGLECT OR EXPLOITATION (a) Employees shall protect clients from harm, abuse, neglect and exploitation in accordance with G.S. 122C-66. (b) Employees shall not subject a client to any sort of abuse or neglect, as defined in 10A NCAC 27C .0102 of this Chapter. (c) Goods or services shall not be sold to or purchased from a client except through established governing body policy. (d) Employees shall use only that degree of force necessary to repel or secure a violent and aggressive client and which is permitted by governing body policy. The degree of force that is necessary depends upon the individual characteristics of the client (such as age, size and physical and mental health) and the degree of aggressiveness displayed by the client. Use of intervention procedures shall be compliance with Subchapter 10A NCAC 27E of this Chapter. (e) Any violation by an employee of Paragraphs (a) through (d) of this Rule shall be grounds for dismissal of the employee.	V 512	 CCHC has policies in force to ensure that at any time staff or QP suspects abuse or neglect, they are to report immediately. QP completes monthly visits that include viewing the member in person and observing the room. Staff 4 and 5 were ordered to surrender all bank cards that payee checks are deposited into. CCHC informed staff 4 and 5 they were to have no contact with any members of CCHC. CCHC contacted all guardians to switch their member's payee to a paid payee company. CCHC updated policies to reflect that at any time a member leaves the company, the AFL/payee needs to supply a copy of a payee cancelation request to ensure the change process is in the works. CCHC QP will monitor payee information within 30 days of member leaving CCHC.	6/29/24

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V 512	<p>Continued From page 30</p> <p>This Rule is not met as evidenced by: Based on observation, record reviews and interviews, 2 of 6 audited staff, Alternative Family Living #1 (AFL Staff #1 and AFL Staff #2) neglected and failed to protect 1 of 1 deceased client (DC #3) from harm and 1 of 6 audited staff (Former AFL Staff #4) exploited 1 of 1 audited former client #4 (FC#4). The findings are:</p> <p>Finding #1: AFL Staff #1 and AFL Staff #2 neglected DC #3 and failed to protect her from harm.</p> <p>Observation and interview with AFL Staff #1 on 12/18/23 at 11:14am at the facility revealed:</p> <ul style="list-style-type: none"> -a two story home with front, back, and side porches with cameras facing the street and common area(s) inside the home. -the entrance to the facility from the rear of the home had a wheelchair lift and French doors that opened to the kitchen/dining area. -Client #2's bedroom was immediately to the right. -Client #2 had a hospital bed in her room, stuffed animals, baby dolls, and incontinence supplies. -down the hall to the right of the kitchen was a client bathroom with a roll-in tiled shower and door to DC #3's bedroom. -DC #3's bedroom had two doors of entry/exit, one was to the living room and one that led through the client bathroom (ensuite) and into the hallway. -DC #3's bedroom had a twin bed, with a white headboard/footboard that was in the right-hand corner. -the bed had storage compartments underneath. -the footboard had been cut off to be even with the height of the mattress and was covered with foam and carpet pieces. 	V 512		

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V 512	<p>Continued From page 31</p> <ul style="list-style-type: none"> -the floor was covered in dark grey foam tiles that were linked together. -there was a metal grab bar on a separate wall. -there was a white armoire in front of a closet (screwed into the wall) that was full of incontinence supplies for DC #3. -the backside of the armoire had been removed to create an open space so that a person could reach into the closet. -to the left of the armoire on the floor, was DC #3's backpack (that was typically on the back of her wheelchair), a white gait belt, and detachable leg/footrests from her wheelchair. -AFL Staff #2 was observed in DC #3's wheelchair. -AFL Staff #2 fell and he was using DC #3's wheelchair inside the facility. -the windows (in the bedroom) were covered with stickers that frosted the view from the inside and outside for privacy. -on the bed were blankets, a fitted plastic sheet, and comforter(s). -across from the bed in the corner was a laundry basket of stuffed animals. -there was a dent in the wall directly across from the bed that was circular, (approximately a little over half a doorway in height) that was approximately 2-3 inches across. -believed that DC #3 may have hit her head on the wall. -the living room was past DC #3's bedroom and towards the front of the facility/front porch area. -At the front entrance of the facility, there were green carpeted stairs that led up to the second floor which held two additional bedrooms and a bathroom. -there was a large master bedroom/bathroom/multi-purpose room located to the right of the stairs that had a code locked door. 	V 512		

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V 512	<p>Continued From page 32</p> <p>Review on 12/18/23 of DC #3's record revealed: -Admission Date: 7/13/15. -Date of Death: 12/14/23. -Diagnoses: Intellectual Developmental Disability (IDD), Severe; Post Traumatic Stress Disorder, Unspecified; Autism; Cerebral Palsy Unspecified; Bipolar Disorder, in partial remission; Gastroesophageal Reflux Disease without Esophagitis; Anxiety Disorder, Unspecified; Anemia, Unspecified; Other Encephalopathy; Allergic Rhinitis; and Constipation, Unspecified. -38-year-old female. -Health Risk Assessment dated 5/1/23 revealed: -"[DC #3] should receive 24-hour supervision to ensure health and safety...unable to communicate her wants and needs...should be monitored constantly for safety...no concept of danger...puts everything in her mouth...uses a wheelchair for mobility...she has many needs...monitored constantly for wet/soiled self to prevent smearing/eating feces...bite, pinch herself, turn herself over in her wheelchair and turn tables over...has no concept of safe unsafe...feeding tube since February 2022."</p> <p>Review on 12/18/23 of AFL Staff #1's personnel record revealed: -Date of hire: 7/22/19. -Position: Alternative Family Living Provider. -Client specific competencies for DC #3 signed and dated 6/26/23 by AFL Staff #1 revealed: -"SIB (self-injurious behaviors) of pinching skin till it bleeds, agitation, biting self, elopement, crying, non-verbal, limited communication skills, Gait/balance poor, risk of choking, sleeplessness, 24-hour supervision, all meals prepared, total hygiene care dressing, assistance with all daily activities, diapers, pull ups, gait belt, almost total care in all areas."</p>	V 512		

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V 512	<p>Continued From page 33</p> <p>Review on 12/18/23 of AFL Staff #2's personnel record revealed: -Date of hire: 6/27/23. -Position: Direct Care Job Description signed 5/30/2023. -Client specifics competencies noted for a client in sister facility A dated 11/22/23, unsigned.</p> <p>Review on 12/18/23 of North Carolina Incident Response Improvement System (IRIS) revealed: -Level II, "12/8/23, Staff (AFL Staff #1) went to wake member (DC #3) and she was not responding like normal and had temp (temperature) of 102...hospital admitted her (DC #3) to Intensive Care Unit (ICU)...still unresponsive as of 12/11/23." -Level III, "12/14/23, Staff (AFL Staff #1) member noticed member (DC #3) was lethargic on 12/8/23 and was taken to the emergency room (ER) and was admitted to hospital...12/15/23...pronounced dead at 2pm yesterday."</p> <p>Review on 12/18/23 of handwritten facility behavioral notes for DC #3 completed by AFL Staff #1 from 11/1/23 to 12/07/23 revealed: -11/6/23, "6:30pm [DC #3] was sitting in middle of her bed and fell back hitting her head on the wall...seem to be upset and didn't want to be messed with." -11/10/23, "1:30am woke up to [DC #3] thumping and bumping in her room...found her in middle of her floor...put her back in bed and picked up toys...went back again and she was climbing on the bed." -11/11/23, "8:45am...entered...room and she had pulled handles off her dresser, and they were in floor...pulling stuffing out of her diaper and had it all over the floor." -11/11/23, "4:15pm, found [DC #3] climbing</p>	V 512		

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V 512	<p>Continued From page 34</p> <p>across footboard of bed...cut footboard off and sanded it to keep...safe."</p> <p>-11/12/23, "8:45am, while having breakfast, tried to flip over her wheelchair."</p> <p>-11/13/23, "1:45pm heard a big thump...went to check on her and found her stuck between bed and dresser...no marks noted...moved dresser to try and avoid this happening again."</p> <p>-11/15/23, "11:30am...seemed to be agitated and began throwing herself in floor and flipping off end of bed...tried to flip wheelchair when I tried to put her in it ...tried to slide out of seatbelts."</p> <p>-11/18/23, "1:30pm...she had thrown all of her stuffed animals around her room, pulled sheets off her bed and had diaper filling all over the floor...she was sitting in the middle of the floor bouncing."</p> <p>-11/21/23, "8:45am, [DC #3] had diaper stuff all over room, in bed, etc... intentionally falling on her snowman...while changing her...noticed large bruise on left chest that wasn't there last night...I do believe she might have fallen against bed because toys were everywhere and I caught her falling on her snowman."</p> <p>-11/25/23, "3:15pm, heard loud thumps and walked in her room...was flipping off edge of bed ...had to go back four times to put her back in bed...behavior ended 4:15pm."</p> <p>-11/27/23, "11:30am, [DC #3] seemed agitated and has tried to flip her wheelchair, slide out of seatbelts ...also slide down foot/edge of bed while being changed..."</p> <p>-11/29/23, "7:00pm, [DC #3]was sitting in her chair being tube fed...she reached and grabbed the line to feeding bag and pulled it. When she pulled the line she pulled the feeding tube out of her stomach...had replaced in emergency room (ER)."</p> <p>-11/30/23, "10:00am [DC #3] has been very agitated today and tried to flip her chair ...beating</p>	V 512		

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V 512	<p>Continued From page 35</p> <p>on the windows, walls, and hit the doors several times...tried to throw herself in the floor several times."</p> <p>-12/03/23,"11:30am [DC #3] has not acted like herself today. She seemed agitated and is intentionally falling in her floor, bouncing on her bed and throwing stuff/toys in floor."</p> <p>-12/06/23, "2:00am, I am awakened by a loud noise...[DC #3] is in room making thumping and bumping sounds...I walk in and she has the vent cover and padded floor tile up. I go back to room...heard...thump. [DC #3] was back up and laying in floor next to living room door."</p> <p>-12/06/23, "4:30pm, [DC #3] has slept most of the day because she was up most of the night and has strep throat. I went to check on her and change her and found her feeding tube between mattress and bedframe...changed and dressed [DC #3] and took her to ER to have tube replaced."</p> <p>-12/07/23, "2:30am, [DC #3] woke us up thumping and bumping in her room. When I entered her room, she had rolled off the bed or thrown herself in floor. I sat with her for 45 mins (minutes) to 1 hour to calm her...I went back to my room and then heard another thump a little later...got her back in bed again...she made a loud sound which startled me and when I entered she was upside down at the foot of the bed, made sure she was dry...this went on till 7am when she went to sleep..."</p> <p>Review on 12/20/23 of facility medical documentation for DC #3 revealed:</p> <p>-10/25/23, consultation with psychiatric provider for medication management.</p> <p>-11/29/23, 9:29pm local ER visit to replace feeding tube that had been pulled out.</p> <p>-12/5/23, consultation with primary care physician (PCP) for 3 month follow up, tested positive for</p>	V 512		

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V 512	<p>Continued From page 36</p> <p>Strep; antibiotics prescribed for 10 days.</p> <p>-12/6/23, 6:09pm local ER visit to replace feeding tube that had been pulled out.</p> <p>-12/8/23, local hospital #1 records, "38-year-old female...history of self-injury was transferred from outside hospital for concern of possible acute traumatic injuries...On arrival at outside ED (emergency department) patient had a GCS (Glasgow Coma Scale) of 3...</p> <p>-Patient was intubated...Computed Tomography (CT) scan...showed patient had generalized swelling of the left parietal and left occipital lobes and left posterior and left occipital lobes and left posterior temporal lobes...showed numerous traumatic injuries to chest including multiple T-spine fractures and rib fractures...patient transferred here for higher level of care and trauma evaluation...also febrile at outside hospital. Additional information provided by staff at...facility...states patient has history of severe self-injurious behaviors such as throwing self against the wall and floor. Reportedly has padding throughout the room...there was no witnessed trauma."</p> <p>-12/14/23, "patient lost all brainstem reflexes this morning. Patient expired at 2:00pm."</p> <p>Review on 12/19/23 of local 911 Communications Log to facility revealed:</p> <p>-12/8/23, "9:58am, caller, [AFL Staff #1], call type emergency, 38-year-old female, conscious, breathing. Chief complaint: Unconscious/Fainting (Near)/Emergency."</p> <p>Review on 12/20/23 of DC #3's medical records from local hospital #1 revealed:</p> <p>-Admission Date: 12/8/23 at 11:20am.</p> <p>-Discharge Date: 12/8/23.</p> <p>-"ED (Emergency Department) Final Diagnoses: Unresponsive Episode (Primary), Trauma, Fever,</p>	V 512		
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V 512	<p>Continued From page 37</p> <p>Community acquired pneumonia, unspecified laterality, Transaminitis, Elevated troponin, Cerebral Edema (CMS-HCC), closed fracture of thoracic vertebra, unspecified morphology, unspecified thoracic vertebral level, initial encounter (CMS-HCC), Closed fracture of multiple ribs of left side, initial encounter, and fracture of manubrium, initial encounter for closed fracture.</p> <p>-ED Assessment/Plan/Course: "History: 38-year-old female...reporting from AFL...with concerns for altered mental status (AMS) and unresponsiveness. Facility states she was normal appearing yesterday evening, however when they went to check her this morning...was unresponsive...Diagnosed with Strep two days ago...Emergency Management Services (EMS) state when they arrived patient was...unresponsive.</p> <p>-Upon arrival patient had GCS (Glasgow Coma Scale) of 3...all extremities are flaccid. Patient is completely unresponsive.</p> <p>-patient was intubated, labs performed, and CT scan/ EKG (Electrocardiogram) completed.</p> <p>-CT imaging of head revealed, generalized swelling left parietal, left occipital lobes and left posterior temporal lobe.</p> <p>-C-collar (neck) was placed. Although there was no reported trauma initially, after imaging results, I was able to contact patient's caretaker at AFL home in [county], [Former AFL Staff #4]. She states patient has a padded bedroom floor due to her autism and has had no recent falls or trauma to her knowledge. She confirms patient was normal appearing yesterday evening and then upon checking on her this morning they found her unresponsive...</p> <p>-...Hospitalist paged to ER transfer due to her multiple spinal fractures with extremity weakness, abnormal CT head in the setting of trauma, and</p>	V 512		

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V 512	<p>Continued From page 38</p> <p>need to be evaluated by neurosurgery/trauma team. Due to concerns for possible abuse. DSS (Department of Social Services) report was filed prior to transfer. Disposition: Transfer to [local hospital #2] ER."</p> <p>Review on 5/1/24 of Glasgow Coma Scale revealed: -"Glasgow Comas Scale (GCS) is a system or 'score' to measure how conscious you are. -It has three categories that apply to a neurological exam (that they measure)...eye response, motor response, and verbal response...and take scores from the three categories and add them together. -The highest possible GCS score is 15 and the lowest is 3. A score of 15 means you're fully awake, responsive...no problems with thinking/memory...A score of 8 or fewer means you're in a coma."</p> <p>Review on 1/9/24 of DC #3's medical records from local hospital #1 revealed: -"Arrival Date/Time: 12/8/23 at 17:39:27 (5:39PM). -Discharge date: 12/15/23. -12/9/23, Magnetic Resonance Imaging (MRI) of the brain revealed...small subdural hematomas measuring up to 4mm (millimeter) in thickness on the left. There is 8mm rightward midline shift due to left hemispheric edema and small subdural hematoma. -12/10/23 Consultation (infectious disease) for Meningitis, nursing notes neuro-status has not improved much...does have a burn wound discovered at her thigh at admission, is unclear how this occurred. Concerns have been raised regarding recent events at her care facility. -Discharge summary diagnoses were listed as Rib Fracture, Thoracic spine fracture, AMS</p>	V 512		

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V 512	<p>Continued From page 39</p> <p>(altered mental status), Leukocytosis, Fever, Death.</p> <p>-38-year-old female with PMH (personal medical history) of autism, cerebral palsy, previous self-injurious behaviors who presented to [local hospital #2] as a transfer from outside hospital. Per outside hospital report, she was found down in her room at facility and was a GCS 3 upon arrival to their ED and was subsequently intubated. Injuries at that time included diffuse cerebral edema, multiple thoracic compression fractures, sternal fracture, second anterior rib fracture...Since arrival...brought to Intensive Care Unit (ICU)...despite optimal medical therapy to reduce intracranial pressure patient's neuro exam did not improve throughout the hospital stay. 12/14 AM, patient had loss of bowel reflexes and further testing revealed that patient had experienced brain death. Official time of death 1400 (2:00pm) on 12/14/23."</p> <p>Review on 12/20/23 of Local Law Enforcement Police Report revealed: -12/8/23, "911 call was received...referencing an unresponsive person...First Responders (FR) with Local Fire Dept arrived on scene and described high intensity smell of urine and feces...located patient in bedroom...unresponsive and had vomited on her arm and bed; she was laying on the bed on her left side. The vomit appeared to be present for a while, as it had time to dry...FR stated she (DC #3) had a diaper on which appeared to have not been changed in some time. This is due to the FR observing the diaper to be full of urine and feces...determined patient needed to be transported to the hospital...after a brief stay at [local hospital #1], medical staff were advised [DC #3's] injuries were significant enough to require a hospital that could provide adequate patient care...transport to [local hospital #2]... staff</p>	V 512		

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V 512	<p>Continued From page 40</p> <p>believed the injuries [DC #3] sustained as suspicious."</p> <p>Review on 12/20/23 at 11:22AM of 911 call from AFL Staff #1 on 12/8/23 revealed: -"I think she had a seizure in her sleep." -AFL Staff #A1 was present (from sister facility). -"her pee smells like pure ammonia." -when the 911 dispatcher asked the question, "is she breathing?" AFL Staff #1 responded, "seems to be...breathing but non-responsive."</p> <p>Interview on 12/18/23 and 12/20/23 with AFL Staff #1 revealed: -moved into the facility over the summer (2023). -law enforcement came on Saturday (12/16/23) and searched the facility and "left it the way they did." -"I have nothing to hide." -"[AFL Staff #2] (her husband) is a caregiver, considered support...not back up...he is an employee of [Licensee]." -"he (AFL Staff #2) will help feed, stay with them (clients)...doesn't do anything with the girls (clients)...(due to a medical condition)...destroyed his muscle mass." -DC #3's behaviors included, "would try and grab food, flip her wheelchair, bounce, and would hold her urine and flood...beat the walls, doors, and would throw herself on the floor." -had to change DC #3 and her bed every morning because of incontinence. -DC #3 started having increased behaviors right before Thanksgiving, climbing on the headboard/footboard, beating on walls, windows, and doors, pull the stuffing out of her diaper, and flopping on the floor. -in November (2023) they (facility staff) took the dresser out of her bedroom and cut the footboard off and wrapped it with foam because (DC #3)</p>	V 512		

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V 512	<p>Continued From page 41</p> <p>kept getting stuck in it.</p> <p>- "She (DC #3) kept flipping off the dresser and the foot of bed."</p> <p>- "I already knew about checking on her every 2 hours from [Former AFL Staff #4]."</p> <p>- "If [DC #3] was agitated and trying to flip her chair, I'd put her in her bedroom."</p> <p>- She'd put DC #3 in her bed or on the floor.</p> <p>- When (DC #3) wasn't in eyesight, she'd check on her every 1.5-2 hours in her room.</p> <p>- on 11/24/23 DC #3 had bruising on her chest and legs, and she took pictures of it.</p> <p>- did not complete an incident report because, "Honestly, I was told not to do it...because I didn't know how she did it." (sustained the bruising)</p> <p>- couldn't remember who told her not to complete an incident report.</p> <p>- thought she showed Former AFLs Staff #4 and #5, and the Qualified Professional (QP).</p> <p>- 12/4/23, she herself, had been diagnosed with Strep.</p> <p>- 12/5/23 took DC #3 to her PCP where DC #3 was diagnosed with Strep and prescribed antibiotics.</p> <p>- 12/6/23 DC #3 pulled her gastrostomy tube (g-tube) out and had to take her to the ER to get the tube re-inserted.</p> <p>- 12/7/23 DC #3 had slept most of the day, "she was sick, I was sick."</p> <p>- DC #3 went to bed at 8:30PM that night after she observed DC #3 asleep in bed.</p> <p>- the morning of 12/8/23, AFL Staff #1 got Client #2 up and ready before checking on DC #3 because the home health nurse was coming.</p> <p>- when she later went into DC #3's room, "she was non-responsive."</p> <p>- On 12-8-23, "I started giving her (DC #3) meds (medications) when I realized she was not responding."</p> <p>- "I went in and already had meds in my hand,..I</p>	V 512		

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V 512	<p>Continued From page 42</p> <p>was giving her (DC #3) meds before I changed her."</p> <p>"I had her (DC #3) meds in the tube. I unzipped her and gave her the meds (in a syringe). Normally she would respond, but she didn't."</p> <p>"She didn't look right...(DC #3) had slobber coming down her mouth..."</p> <p>-was on the phone with another AFL provider (AFL Staff #A1) that worked at sister facility A next door and told her she needed help.</p> <p>-the staff from next door (AFL Staff #A1) came over to assist her.</p> <p>-Called 911 at 9:57 am.</p> <p>"Called 911, [DC #3] was warm (to the touch)...had one piece sleeper on her...started taking that off her, got a bag of ice to cool her off...her pupils were pinpoint.</p> <p>"her (DC #3's) belly was moving up and down...when we took her PJ's off, she had a bad rattle...guessed maybe she had aspirated."</p> <p>-did not administer Cardiopulmonary Resuscitation (CPR).</p> <p>-EMTs took her to the local hospital and then she was transferred to another hospital.</p> <p>-she herself didn't go to the hospital; she stayed home with Client #1 and Client #2.</p> <p>-Former AFL Staff #4 went to the hospital.</p> <p>-two nights before this (12/6/23), "she (DC #3) had been beating and banging (on walls)."</p> <p>"at one point, [DC #3] had Sepsis, trauma, and broke ribs...that is what they (hospital staff) told [Former AFL Staff #4]."</p> <p>-didn't know why DC #3 was transferred to another hospital.</p> <p>-on Thursday (12/14/23) they pronounced her brain dead.</p> <p>Interview on 12/21/23 with AFL Staff #A1 revealed: -12/8/23 received a call from AFL Staff #1, ""(she)</p>	V 512		

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V 512	<p>Continued From page 43</p> <p>said I need your help."</p> <p>-reported she got the call around 9:40AM-9:45AM.</p> <p>-when she got into DC #3's bedroom she was laying there on her left side facing the wall.</p> <p>-DC #3 was non-responsive, "you could tell she was alive, but nobody was home."</p> <p>-she observed vomit, saliva, and mucus on the bed.</p> <p>-DC #3 was hot so AFL Staff #1 and she took DC #3's onesie off her and put an ice bag on her, "it should have shocked her and it didn't."</p> <p>-DC #3 had vomited and it ran down her face, "it was clear and mucousy...her whole bed was soaked with urine, sweat."</p> <p>-"one of her eyes looked bulged and the other was barely open."</p> <p>-DC #3 was wearing two diapers plus a guard (placed inside the diaper) and her bed was soaked.</p> <p>-"[DC #3's] room always smelled like fecal and urine"</p> <p>-AFL Staff #2 came to facility when EMS got there.</p> <p>-AFL Staff #1 was trying to change DC #3 before they took her to the hospital to clean her up (change her diaper).</p> <p>-AFL Staff #1 stayed behind to take care of Client #1 and Client #2, and Former AFL Staff #4 met the ambulance at the hospital on 12/8/23.</p> <p>Interview on 12/21/23 with AFL Staff #2 revealed:</p> <p>-had been at the facility since the end of June 2023.</p> <p>-had a broken foot.</p> <p>-was AFL Staff #1's husband, support, and guardian/brother of Client #1.</p> <p>-denied providing direct care to the clients in the facility.</p> <p>-denied having personal contact with DC #3,</p>	V 512		

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V 512	<p>Continued From page 44</p> <p>"except from the hall," when passing by her.</p> <p>- "I can't do anything with the clients. I can't lift them...besides they are women...I don't feel right doing anything with the women."</p> <p>- "could sit with the clients but that was about it."</p> <p>- reported that DC #3's behaviors had gotten worse lately.</p> <p>- described hearing DC #3 throwing herself on the floor of her bedroom and playing with her stuffed animals.</p> <p>- "it got worse (behaviors), she would come up and 'BAM' that door (hit door to living room).</p> <p>- reported seeing DC #3 walk into the living room one time.</p> <p>- when asked what happened with DC #3, "I wasn't here ...I left that morning to go to the bank and pharmacy and by the time I got back the ambulance was here...and they were bringing her out."</p> <p>- the morning of 12/8/23 got up between 5:00-6:00AM and was watching television.</p> <p>- "heard a thump and 'Umfff' and that was it ...and I was off to the bank."</p> <p>- described hearing the noise around 7:30AM.</p> <p>- reported telling AFL #1 that he heard a thump and went to run errands.</p> <p>- did not go into DC #3's room to investigate the noise.</p> <p>- "anytime I would hear her (DC #3), I would tell her (AFL Staff #1) she was being active."</p> <p>- "I never go in there (DC #3's bedroom)...there is no need..."</p> <p>- DC #3 had kept them (AFL Staff #1 and AFL Staff #2) up for two nights prior to 12/8/23 from approximately 2:00AM to 7:00AM and he would come sit on the couch while AFL Staff #1 attended to DC #3 until she would fall asleep.</p> <p>Interview on 1/8/24 with AFL Staff #1 revealed:</p> <p>- last time she saw DC #3 was between</p>	V 512		

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V 512	<p>Continued From page 45</p> <p>10:30-11:00pm on 12/7/24 was when she checked on her before bed. -DC #3 was sitting in her bed awake at that time. -Only thing she could remember that AFL Staff #2 told her the morning of 12/8/23 was that he needed to go to the pharmacy and bank.</p> <p>Review on 4/25/24 of interviews with AFL Staff #1 and AFL Staff #2 dated 3/4/24 with the Health Care Personnel Registry staff revealed: -named two individuals as "best friends" who would come over and "help," in addition to AFL staff next door (AFL Staff #A1), and Former AFL Staff #4 and #5. -Regarding taking pictures of the bruising on DC #3's chest on 11/24/23, "I think it happened a couple days before, but I was told not to complete an incident report...I was just told not to bring attention to the house (facility) and not complete an incident report..." -AFL Staff #1 reported she "found her" (DC #3) around 9:00 or 9:30AM on 12/8/23. -when asked about the swelling on DC #3's brain, "I assumed it happened with this hole in the wall...that was there after she left because I picked 4 to 6 pieces of hair out of the wall (hole)...so I assume she hit the wall with her head...know that strep can cause the brain to swell...so I don't know." -AFL Staff #2 reported he woke up around 5:00AM, heard a noise from DC #3's room and left the facility to go the bank and pharmacy. -AFL Staff #2 was back home from his errands around 8:50AM (which would place him home before the 911 call at 9:58AM) and saw the EMTs bringing DC #3 out. -worked one day in the facility as a "day support" around Thanksgiving while the clients were napping.</p>	V 512		

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(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 512	<p>Continued From page 46</p> <p>Interview on 12/19/23 with the QP revealed: -AFL Staff #2 is on the payroll, more of a back-up (staff). -"We (Licensee) have him on the payroll, but he doesn't bill." -"[DC #3] required a lot of eyes on (supervision)." -"probably not appropriate to leave [DC #3] alone for 1 ½ -2 hours unsupervised, unless she was sleeping." -found out about DC #3 not being responsive from AFL Staff #1 that Friday (12/8/23) via text message when they took her to a local hospital.</p> <p>Interview on 12/20/23 with DC #3's guardian revealed: -had been DC #3's guardian for approximately the last 18 months. -was notified by the Former AFL Staff #4 that DC #3 had been taken to the hospital on 12/8/23. -was never told if AFL Staff #2 was providing care to DC #1. -when asked about DC #3's behaviors, "I have never seen anything to the extent of what has been reported. I have seen her throw herself out of the wheelchair, hopping up and down...She had wheelchair for support, but I would see her squat and hop around." -"her (DC #3) injuries seem quite extensive. Not sure she could have done those things to herself." -didn't have concerns prior to the incident..."my concern is due to the extent of the injuries." -spoke with a couple of clinicians at [local hospital #2] and a Neurologist, and they were not sure what was being reported could have caused the injuries.</p> <p>Interview on 1/4/24 with Day Support Worker for DC #3 revealed: -was Former AFL Staff #4's son.</p>	V 512		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-069	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/06/2024
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

TAYLOR HOME **43 EAST CRAWFORD STREET**
OLD FORT, NC 28762

(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 512	<p>Continued From page 47</p> <ul style="list-style-type: none"> -provided day support services to DC #3 and would take her for car rides. -saw DC #3 Wednesday, 12/5/23 (last day of service) before she went into the hospital on 12/8/23. -didn't have any concerns at the time. -confirmed that wintertime was hard for DC #3 and there would be an increase in behaviors. -did not observe any injuries on DC #3 the last time he saw her. <p>Interview on 1/5/24 with DC #3's PCP revealed:</p> <ul style="list-style-type: none"> -saw DC #3 every three months. -last time she saw her on 12/5/23, she was positive for Strep, and antibiotics were prescribed. -had seen her (DC #3) walk only one time, "with help of course...every time I've seen her, she's been in a wheelchair...honestly, up until that time, didn't think she could walk." -didn't have any concerns at the time when DC #3 was seen. -"saw the records coming through from the hospital and was surprised at the extent of the injuries." <p>Interview on 1/4/24 with Former AFL Staff #4 revealed:</p> <ul style="list-style-type: none"> -she provided care for DC #3 for almost 8 years. -on 12/8/23, "I thought she (DC #3) was sick, had no idea that she had fell or hit her head ...they (hospital staff) said bleeding on the brain...I didn't understand...[AFL Staff #1] had no clue either." -found out something had happened because she got a call from AFL Staff #1 and went to the hospital. -"I pulled in right behind the ambulance...they wouldn't let me go back for 2 hours ...I had another client (from sister facility A) at [local hospital #1]...left [local hospital #1] and went to 	V 512		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-069	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 06/06/2024
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V 512	<p>Continued From page 48</p> <p>[local hospital #2]...and then followed her (DC #3) to [local hospital #2]."</p> <p>-when asked if she went to the facility, "not until a few days later."</p> <p>-reported being at the hospital for DC #3 every day until she passed (12/14/23).</p> <p>-when asked what AFL Staff #1 told her about what happened to DC #3, "she (AFL Staff #1) didn't know ...she (DC #3) was just unconscious...the nurse was coming (to the facility) to see Client #2."</p> <p>Interview on 12/19/23 and 12/20/23 with local law enforcement officer (LEO) revealed:</p> <p>-confirmed they executed a search warrant on Saturday, 12/16/23 at the facility and AFL Staff #2 immediately pointed to the hole in the wall as to the cause of injury for DC #3 during the search.</p> <p>-first responders reported to LEO that there was overwhelming smell of urine and feces in DC #3's room and it was disheveled, "had to step over stuff."</p> <p>-when law enforcement went into the facility, "it was neat as a pin, it was cleaned."</p> <p>-was present for DC #3's autopsy.</p> <p>-there was a burn on DC #3's upper left hip that couldn't be identified (as to cause) by the medical examiner.</p> <p>-DC #3's brain was swollen two times the normal size, could see the bruise on the inside of her skin.</p> <p>-DC #3's skull was roughly half an inch thick, "like you are wearing a helmet...if you fall back, you wouldn't do that damage."</p> <p>-AFL Staff #1 reported to LEO that she had turned off her alarm and slept in that day (12/8/23).</p> <p>-AFL Staff #1 reported to LEO that she would strap DC #3 into her wheelchair and leave her in the living room or bedroom.</p>	V 512		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-069	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/06/2024
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NAME OF PROVIDER OR SUPPLIER TAYLOR HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 43 EAST CRAWFORD STREET OLD FORT, NC 28762
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V 512	<p>Continued From page 49</p> <ul style="list-style-type: none"> -first responders didn't see a wheelchair in her room. -AFL Staff #1 reported last checking on DC #3 at 8:30PM. <p>Interview on 12/22/23 with local first responder (FR) regarding an incident that happened on 12/8/23 revealed:</p> <ul style="list-style-type: none"> -DC #3's bedroom was in disarray and there was no wheelchair present. -confirmed there was a strong smell of urine and feces in DC #3's room. <p>Interview on 1/3/24 with the Licensee revealed:</p> <ul style="list-style-type: none"> -"the QPs supervise their employees." -was not part of the death review for DC #3. -received information about what happened to DC #3 from the QP. -the hospitals would not provide information to her because she was not the guardian. -when asked what AFL Staff #2's role was in in the facility, "he lives in the home (facility) and assists like any other family (member)..." -expected that AFL Staff #2 would report incidents. -Would not answer if it was appropriate to leave DC #3 in her room for 1.5-2 hours unsupervised. -did not have current concerns with the facility. <p>Interview on 1/3/24 with the Chief Executive Officer (CEO) revealed:</p> <ul style="list-style-type: none"> -participated in death review for DC #3 and felt the facility did what was in the best interest of DC #3. -a staff went by sister facility A on 12/6/23 to do an inspection and learned that the Taylor Home had Strep. -assumed that DC #3 had gotten worse from being sick. -regarding why DC #3 was transferred to local 	V 512		

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V 512	<p>Continued From page 50</p> <p>hospital #2, "I think I read the report, and it said something about old fractures or something...and brain swelling...and to make sure she had adequate care."</p> <p>-DC #3 had received Cardiopulmonary Resuscitation (CPR) before from a prior incident ...and the rib fractures could have been from that.</p> <p>-Former AFL Staff #4 was the one that knew AFL Staff #1 and moved her and AFL #2 into the home to provide care for the clients.</p> <p>-Former AFL Staff #4 owns the house where the facility was located and gets paid for all the clients, except Client #1.</p> <p>-AFL Staff #2 was Client #1's guardian.</p> <p>-AFL Staff #2 was brought in for training as direct care, "in case he needed to step in."</p> <p>-The QP was responsible for training and the licensee is responsible ultimately.</p> <p>-would expect AFL Staff #1 to report incidents.</p> <p>-when asked if it was appropriate to leave DC #3 in her room for 1.5-2 hours unsupervised, "AFLs cannot 24-hour supervise...clients do have times where they are alone...I do expect walk-bys and checking in, especially someone who jumps around...that would be my expectation."</p> <p>-did not have current concerns with the facility.</p> <p>Interview on 1/4/24 with the Palliative Care Social Worker at the local hospital #2 revealed:</p> <p>-DC #3 came to the hospital sedated and on ventilation.</p> <p>-DC #3 was assigned to palliative care on 12/13/23 based on her trauma (injuries).</p> <p>-was concerned about DC #3's injuries.</p> <p>-hospital staff were concerned about abuse/neglect and told the current guardian it needed to be thoroughly investigated.</p> <p>Interview on 1/8/24 with local hospital #1 (ER) physician revealed:</p>	V 512		

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V 512	<p>Continued From page 51</p> <p>-spoke with Former AFL Staff #4 about what happened, and she reported there were no recent falls with DC #3, and she had a padded room.</p> <p>-DC #3 was "transferred to [local hospital #2], due to the trauma."</p> <p>-"Based on the severity of injuries, it was either an extreme fall or abuse."</p> <p>Interview on 1/9/24 with local hospital #2 admitting physician revealed:</p> <p>-"Kind of a bizarre story. I remember she (DC #3) had...history of self-injurious (behaviors).</p> <p>-"The extent of injuries she came-in with not typically something self-imposed."</p> <p>-"She (DC #3) had thoracic spine and rib fractures...in her head there were signs of swelling."</p> <p>-She was admitted to the trauma unit.</p> <p>Interview on 1/10/24 with the Medical Examiner (ME) revealed:</p> <p>-this came to the ME for autopsy because there was concern for DC #3's injuries.</p> <p>-DC #3's skull was very thick.</p> <p>-"I saw...significant brain trauma...subdural hemorrhage that covered the left side of her brain."</p> <p>-"...no reason why I'm not going to call it complications from blunt force trauma."</p> <p>-"definitely died from head trauma."</p> <p>Interviews on 5/1/24 and 6/6/24 with local LEO revealed:</p> <p>-confirmed they did not get DNA (Deoxyribonucleic acid) evidence from the hole in the wall in DC #3's bedroom, by the time they went in to search, the facility had been cleaned.</p> <p>-"[AFL Staff #1 and AFL Staff #2] were no longer cooperating with law enforcement."</p> <p>-DC #3's death was still under investigation.</p>	V 512		

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V 512	<p>Continued From page 52</p> <p>-AFL Staff #1 and AFL Staff #2 have told different stories to different agencies. -"There is no way the hole in the wall was from [DC #3]'s head." -Still waiting on toxicology and the ME's report to assist in determination of what happened to DC #3.</p> <p>Finding #2: Former AFL Staff #4 exploited FC #4 by continuing to cash his Supplemental Security Income (SSI) checks after he had been discharged from the facility.</p> <p>Review on 4/15/24 of Former Client (FC) #4's record revealed: -Date of Admission: 4/13/22. -Date of Discharge from the facility: 1/21/23. -Date of Discharge from the Licensee: 2/10/23. -Age: 17 years old. -Diagnoses: Mild Intellectual Developmental Disability.</p> <p>Review on 4/19/24 of Social Security Administration (SSA) letter dated 10/31/23 revealed: -Addressed to Former AFL Staff #4 at the facility address. -Social Security payments were being stopped beginning December 2023. "...we need correct information about his (FC #4) name, address, or bank account..." -"Your Reporting Responsibilities:...eligibility may change if his situation changes... You are required to report any changes...report any of the following changes...He moves..." -"...If you disagree, with this decision, you have the right to appeal ..."</p> <p>Review on 4/19/24 of SSA letter dated 4/17/24 revealed:</p>	V 512		

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V 512	<p>Continued From page 53</p> <ul style="list-style-type: none"> -Addressed to Former AFL Staff #4 at the facility address. -There had been an overpayment of \$8,570.00 between February 2023 to November 2023. -A detailed explanation of overpayment that showed \$857.00 paid per month for 10 months. -Repayment of \$8,570.00 was due by 5/17/24. <p>Interview on 4/19/24 with local SSA employee #1 revealed:</p> <ul style="list-style-type: none"> -Former AFL Staff #4 was the current payee for FC #4. -SSA was alerted that FC #4 was no longer in the facility and payments would be stopping next month. -Payments were put on a prepaid debit card through a bank. -Payees were able to go online and see statements, including deposits. -Former AFL Staff #4 was overpaid \$8,570.00 from February 2023 through November 2023. -Former AFL Staff #4 was sent a letter dated 4/17/24 informing of the overpayment. -Payments would only have one payee at a time. It was not possible for payments to be split between payees. "If anything is split, she (Former AFL Staff #4) is doing it." -It was possible to have a legal guardian and authorized representative that was different from the payee. -It would have been documented in a letter if anyone called to change the payee. -It was the responsibility of Former AFL Staff #4 to notify SSA of the change in placement. -A request for accounting records was sent to the Former AFL Staff #4 and FC #4's guardian on 10/31/23 and stated payments would stop. -Someone (unknown who) called and confirmed FC #4 was still in the facility and payments resumed. 	V 512		

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V 512	<p>Continued From page 54</p> <p>Interviews on 4/15/24 and 4/22/24 with Supported Living Supervisor revealed:</p> <ul style="list-style-type: none"> -Had been the payee in the past for other clients and "...I know the process (SSA)." -FC #4's SSI was being deposited to a direct express debit card. -Former AFL #4 was having the money directly deposited to the bank. -The current address on file for the debit card was a city in a neighboring county. -There had not been a Direct Express debit card for FC #4. -FC #4's father had been the co-payee for his SSI. -Did not know who the current payee was for FC #4s SSI. - "As an agency, we require AFLs to complete expenditure forms. To track what she (Former AFL Staff #4) spends his (FC #4) money on." -Former AFL Staff #4 was the current payee for other clients in the facility as well as sister facility A. -The QP should follow up about changes being completed to switch the payee. <p>Interview on 4/18/24 with FC #4's legal guardian revealed:</p> <ul style="list-style-type: none"> -Unsure if FC #4 was getting his SSI checks. -Had made Former AFL Staff #4 the payee when FC #4 was residing in the facility. -Reported to SSA that FC #4 had moved. -Had thought Former AFL Staff #4 had signed over being the payee. -FC #4 was currently in a facility in a neighboring state. -Former AFL Staff #4 had continued to get FC #4's SSI after his discharge from the facility. <p>Interview on 4/18/24 with local Department of</p>	V 512		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-069	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 06/06/2024
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V 512	<p>Continued From page 55</p> <p>Social Services Supervisor revealed: -Former AFL Staff #4 had continued to receive FC #4's SSI. -Local SSA office had opened an investigation.</p> <p>Interview on 4-18-24 with FC #4's current placement provider revealed: -FC #4 had been in this current placement since July 2023. -FC #4 had not received any personal funds. -This placement had not received any money from FC #4's SSI check.</p> <p>Review on 4/22/24 of facility's "AFL Household Expenditures" form for FC #4 revealed: -Amount of SSI check: -May 2022 - \$784 -July - Dec 2022 - \$841 -Jan 2023 - \$914 -Client received \$66 each month with the balance divided between room, board, and expenses. -Every month "any remainder due to resident" equaled \$0.</p> <p>Interviews on 4/15/24 and 4/22/24 with QP revealed: -SSI typically would be paid directly to the AFL provider. "That is the easiest, simplest." -It would be the responsibility of the AFL (payee) to contact SSA when a change occurred, not the QP. -Former AFL Staff #4 reported that she had reported the change (in FC #4's placement) to SSA. -All the checks came in together for all the clients that Former AFL Staff #4 was the payee for. -Former AFL Staff #4 reported that she was no longer the payee for FC #4, and that it had defaulted to FC #4's father as he was getting partial payments the whole time.</p>	V 512		

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V 512	<p>Continued From page 56</p> <ul style="list-style-type: none"> -The QPs did not provide oversight for SSI. -Had never called SSA to update any changes. <p>Interviews and observation on 4/16/24 and 4/23/24 at 10:23AM with the Former AFL Staff #4 revealed:</p> <ul style="list-style-type: none"> -FC #4's SSI "stopped in April or May of 2023." -Called SSA in May 2023 to have the payments stopped. -Called SSA twice to inform them of the change of placement but was unable to provide any details on the calls or documentation of the calls. -FC #4's father would get \$77 per month from FC #4's SSI payment. -Learned of FC #4's father receiving partial payment of the SSI because she had received something in the mail and the legal guardian of FC #4 had contacted her. -FC #4's father was receiving part of the payment but suspected he was receiving the full payment. -The letter from SSA regarding the partial payment to FC #4's father, "...It was shredded...so it wouldn't be seen by someone that didn't need to see it." -Couldn't prove that FC #4's father was receiving the money. -Stated that there was more than one payee distributed from FC #4's SSI. -Disputed the statement from the SSA that there could not be more than one payee for SSI. -The SSI money was put on a debit card. -Was receiving SSI for 3 clients at one time and now only receiving SSI for 2 clients (because FC #4 had moved). -Called the phone number on the back of the debit card on 4/22/24 to get a statement from the bank. -Was unable to pull up bank information on her phone. -"There is money I have to pay back. I don't know 	V 512		

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NAME OF PROVIDER OR SUPPLIER TAYLOR HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 43 EAST CRAWFORD STREET OLD FORT, NC 28762		
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V 512	<p>Continued From page 57</p> <p>how much..."</p> <p>-Was told in September or October of 2023 that they were still putting money on the card.</p> <p>-Would transfer the funds from the debit card to her bank account.</p> <p>-"I call (the number on the card) and get a balance and then transfer."</p> <p>-Did not know how much money each client would receive from the SSA.</p> <p>-"I could have followed it (making sure the payee had been changed) but it wasn't worth it."</p> <p>-"If I knew (about getting the money), I didn't really think about it."</p> <p>-"I just didn't really think about it." (checking the balance of the debit card from month to month)</p> <p>-Did not know how much FC #4 received each month from SSI.</p> <p>-"I don't think I owe that much. I am going to work with them (SSA) to figure out where it (FC#4's SSI payments) went."</p> <p>-"This has cost me so much."</p> <p>-The payments to the debit card were not separated between clients but "...just one big lump sum in the bank."</p> <p>-"I can call this number (pointed to the back of the debit card) and they can tell me if I am not getting it."</p> <p>-"I can't prove that they (SSA) have not been giving us the money."</p> <p>-Did not keep any documents that SSA sent her.</p> <p>-Did not use the online or cell phone application to access bank records.</p> <p>-"My record keeping is horrible."</p> <p>-"Just wasn't doing it (record keeping). Just making sure bills are paid."</p> <p>-Had not given the debit card to anyone else to use.</p> <p>-"I spoil my clients, surely you have evidence of that."</p> <p>-Had no documentation to disprove that she did</p>	V 512		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-069	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/06/2024
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V 512	<p>Continued From page 58</p> <p>not owe any money back to the SSA. -Did not keep documentation of the clients' payments because "It goes to pay their (clients) bills. They get their money." -"Most of the money I make goes into those homes." -"I am not going to deny that (still receiving SSI money)." -"Owed \$8,000.00 (to SSA)." -"I had no idea. I thought I would just pay it (SSI overpayment) back and I would be done. I had no idea it was that bad."</p> <p>Review on 4/23/24 of a text message sent to Division of Health Service Regulation (DHSR) surveyor received from Former AFL Staff #4 revealed: -4/23/24 at 11:17 am " I have forgotten to mention that I am leaving CCHC."</p> <p>Review on 4/25/24 of a text message sent to DHSR surveyor received from Former AFL Staff #4 revealed: -4/25/24 at 12:21 pm "Please don't do this to me! This (continuing to receive FC #4's SSI money) wasn't intentional. I make more than \$853 a day..."</p> <p>Interview on 4/23/24 with the facility's Financial Officer revealed: -Was responsible for payroll, paying bills, "a little Human Resources," and wage verification for employees. -SSI payments would go straight to the AFL provider. -"They (AFL Providers) generally set up a bank account in their and the clients' name. We have expenditure sheets that they fill out and turn in monthly." -Had not dealt with SSA or SSI payments directly.</p>	V 512		

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V 512	<p>Continued From page 59</p> <p>-"I think the QPs look at them (expenditure sheets). They should be looking at them." -Had not looked at the expenditure sheets. -Would be grounds for termination if a provider continued to receive funds for a client no longer being served. -The expectation was that AFL providers reported accurate information.</p> <p>Interview on 4/23/24 with the Chief Executive Officer (CEO) revealed: -Former AFL Staff #4 was trying to move clients from this facility and sister facility to another Licensee. -The AFL Providers would complete monthly expenditure reports. -It was the responsibility of the payee to report any changes to SSA and stop payments. -"They (AFL Providers) should be keeping those bank statements." -"You don't steal funds. You need to keep receipts (of client expenditures)." -The Licensee didn't cross reference AFL expenditures to how much clients get from SSI.</p> <p>Interview on 6/6/24 with the Licensee revealed: -Did not understand how they could be held responsible since the AFLs are the payees and SSA would not share information with the Licensee. -"We aren't a part of it (SSI payments and oversight)."</p> <p>Review on 4/26/24 and 4/29/24 of two documents provided by Former AFL Staff #4 revealed: -Document #1 was a typewritten and printed letter dated 4/26/24 with no letterhead that stated Former AFL Staff #4 attempted to change payee status in January 2023 but did not happen due to error in the SSA system.</p>	V 512		

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V 512	<p>Continued From page 60</p> <ul style="list-style-type: none"> -Document #1 had a signature that was not legible under the typewritten phrase "OFFICE MANAGER". -Document #2 was a printed receipt from the SSA dated 4/26/24 showing a payment of \$8570.00. -Document #2 reflected dated of check was 4/15/24 and reason for payment was "to repay an overpayment." <p>Interviews on 4/29/24 with local SSA employee #2 revealed:</p> <ul style="list-style-type: none"> -Initially said that document #1 "...looks made up to me." -The employee who wrote document #1 felt sorry for Former AFL Staff #4 and believed her story of attempts to change payee. -There was no documentation in the system of Former AFL Staff #4 attempting to change payee status. -The statement about the SSA system error not documenting Former AFL Staff #4's attempts came from the employee who wrote document #1. -There was no history in the system of attempted change. "...there is no start. Not even a blip." (for attempting to change the payee) <p>Interview on 5/2/24 with the local SSA office Operations Manager revealed:</p> <ul style="list-style-type: none"> -Document #1 is "...a stretch...this gave too much leeway." -"No where in the remarks where she (Former AFL Staff #4) was actively trying to get that (change of payee) fixed. Nothing that stated that she was trying to get removed (as payee)." -"She (Former AFL Staff #4) has contacted us but not trying to change status as payee, until she got the notice of overpayment." -"What we normally do is have payee accounting forms. How was the money spent?...The most 	V 512		

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V 512	<p>Continued From page 61</p> <p>recent request when to [Former AFL Staff #4]. The letter from October (2023). We received no response from that request."</p> <p>Review on 5/2/24 of the Licensee's internal investigation revealed: -"...During our conversation [Former AFL Staff #4] stated 'he (FC #4) owed her' but then later was saying that she would never take money intentionally and that she called Social Security two times to switch it out of her name..."</p> <p>Review on 1/9/24 of the 1st Plan of Protection written by the CEO signed on 1/9/24 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Staff have been removed from the home pending internal and external investigations into the allegations of serious harm and neglect as of 5:00 PM on January 9, 2024. The staff is the guardian for member 1 (Client #1) and has been informed that if they choose to take member 1 with them, CCHC will not be able to bill those services. Member 1 is allowed to stay in the home if they choose to do so.</p> <p>Describe your plans to make sure the above happens: An alternate caregiver will be brought into the home as of 5:00 PM on January 9, 2024. DSS has been contacted, the incident report has been updated, guardian for member 2 has been contacted regarding our plan of protection, care coordinators have been notified, and a health care registry report has been completed on both staff."</p> <p>Review on 4/24/24 of the 2nd Plan of Protection written by the CEO signed on 4/24/24 revealed: -"What immediate action will the facility take to</p>	V 512		

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V 512	<p>Continued From page 62</p> <p>ensure the safety of the consumers in your care? [Former AFL Staff #4] and her husband are to have no contact with any members of CCHC (Community Companion Home Care). Payee services are to change from [Former AFL Staff #4] to a paid payee company. [Former AFL Staff #4] is to surrender the bank card that payee checks are deposited onto. Describe your plans to make sure the above happens.</p> <p>CCHC has met with [Former AFL Staff #4] and informed her that she is to have no contact with any members of CCHC effective immediately. CCHC has contacted all guardians and sent them applications to complete to switch member's payee information to a paid payee company. CCHC is retrieving the bank card that payee checks are deposited onto so that [Former AFL Staff #4] has no access to any funds received while waiting for the switch to the paid payee company to happen."</p> <p>This facility is licensed to provide a supervised alternative family living environment for 3 clients with diagnoses including Intellectual Developmental Disabilities, Cerebral Palsy, Bipolar Disorder, Autism, Depression, Urinary Incontinence, Spina Bifida, Osteoporosis, Anxiety, and Obsessive Compulsive Disorder. DC #3 was profoundly disabled and required almost total care in all areas. She could not voice pain or walk unassisted for a long period of time. Her bedroom floor was padded with foam tiles and her bed was placed on the floor due to her needs. Her armoire was secured to the wall and her footboard had been cut, sanded, and wrapped in foam/carpet to keep DC #3 safe. DC #3 was seen by her PCP on 12/5/23 and was diagnosed with Strep and prescribed antibiotics. DC #3 was taken to the ER</p>	V 512		

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V 512	<p>Continued From page 63</p> <p>on 11/29/23 at 9:29PM and 12/6/23 at 6:09PM because she had pulled out her g-tube. Her behaviors increased and included staying up at night beating on the walls and windows in her bedroom. DC #3 was asleep on 12/7/23 at 8:30PM. On the morning of 12/8/23, AFL Staff #2 heard a sound from DC #3's room at approximately 7:30AM. He did not check on DC #3 and instead went to run errands. AFL Staff #1 walked past DC #3's bedroom and went to get Client #2 ready for the day. AFL Staff #1 had turned off her alarm and slept in that day. AFL Staff #1 spent an hour getting Client #2 ready for the day before moving on to DC #3 at approximately 9:30am. AFL Staff #1 discovered that DC #3 was non-responsive and placed a call to emergency services at 9:58AM. EMTs discovered vomit on DC #3 which had been there for a while because it was dry. Neither AFL Staff #1 nor AFL Staff #2 checked on DC #3 for over 12 hours despite being sick with Strep, having documented increased behaviors, and 2 recent ER visits on 11/29/23 and 12/6/23 to have her g-tube replaced after it was pulled out. AFL Staff #1 and AFL Staff #2 provided different stories as to the time frame of events to investigating agencies. DC #3 was rushed to a local hospital on 12/8/23 and was then quickly transferred to a larger hospital that could provide a higher level of care due to her trauma. DC #3 was later pronounced dead on 12/14/23. The medical examiner reported that she died from complications of blunt force head trauma and her death is still currently under investigation by law enforcement. Furthermore, FC #4 was discharged from the facility on 1/21/23. Neither Former AFL Staff #4 nor the Licensee followed through to ensure the SSI payments had stopped or the payee had been changed once FC #4 had been discharged from the facility. Former AFL</p>	V 512		

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V 512	Continued From page 64 Staff #4 did not keep any financial records. Former AFL Staff #4 did not complete expenditure forms accurately and was unaware of the exact amount of FC #4's SSI. Former AFL Staff #4 received 10 months of SSI payments while the FC #4 was not in her care from February 2023 to November 2023. SSA stopped payments to Former AFL Staff #4 when a request for accounting documentation went unanswered. Oversight was not provided to ensure FC #4's SSI followed him to his next placement. Since his discharge, FC #4 had no access to his SSI funds. This deficiency constitutes a Type A1 rule violation for serious exploitation, neglect and failure to protect from harm and must be corrected within 23 days.	V 512		

