

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL065-221</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/02/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KERR HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>514 OLIVE STREET</b> <b>WILMINGTON, NC 28401</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p><b>INITIAL COMMENTS</b></p> <p>An annual, complaint, and follow up survey was completed on August 2, 2024. The complaint was unsubstantiated (Intake #NC00219365). A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 290	<p><b>27G .5602 Supervised Living - Staff</b></p> <p>10A NCAC 27G .5602 STAFF</p> <p>(a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs.</p> <p>(b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time.</p> <p>(c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present:</p> <p>(1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the</p>	V 290		

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

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL065-221</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/02/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KERR HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>514 OLIVE STREET WILMINGTON, NC 28401</b>
---	---

(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 290	<p>Continued From page 1</p> <p>emergency back-up procedures determined by the governing body; or</p> <p>(2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body.</p> <p>(d) In facilities which serve clients whose primary diagnosis is substance abuse dependency:</p> <p>(1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and</p> <p>(2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to maintain staff-client ratios above the minimum numbers to enable staff to respond to individualized client needs, affecting one of four audited clients (#5). The findings are:</p> <p>Review on 8/02/24 of client #5's record revealed: - Admission date of 6/01/21. - Diagnoses of Down Syndrome, Severe Intellectual Developmental Disabilities, and other specified mental disorders due to known physiological condition.</p> <p>Review on 8/02/24 of client #5's Individual</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL065-221</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/02/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KERR HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>514 OLIVE STREET WILMINGTON, NC 28401</b>
---	---

(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 290	<p>Continued From page 2</p> <p>Support Plan (ISP) dated 4/01/24 revealed:</p> <ul style="list-style-type: none"> <li>- "What a Crisis looks like for me: [Client #5] will begin to Curse, throw items at people, flip tables, and push chairs. She may also throw items at others, scream, continually tap others on their arms, spill drinks and food, and flop to the floor and refuse to move. She will flash others (pull up her shirt), walk in the hallway at the group home naked to get staff's attention then sit in hallway and not want to move until staff comes to her."</li> <li>- "Member has aggressive tendencies directed toward others and specialty services are needed: Client #5 has aggressive behaviors while at home, in the community, and at the day program."</li> </ul> <p>Review on 8/01/24 of facility incident reports dated 1/12/24 - 6/10/24 for Client #5 revealed:</p> <ul style="list-style-type: none"> <li>- 1/22/24: She hit two peers in the head.</li> <li>- 1/30/24: She was screaming and banging on van window.</li> <li>- 2/12/24: She threw food and drink at peer.</li> <li>- 2/15/24: She pulled staff's hair while being assisted in restroom.</li> <li>- 3/11/24: She hit a peer in the back of the head while watching television.</li> <li>- 3/23/24 and 4/8/24: She stomped on a peer's foot.</li> <li>- 5/15/24: She hit peer in the back of the head.</li> <li>- 5/22/24: She threw a plate at staff during dinner.</li> <li>- 5/30/24: She flipped kitchen table over twice.</li> <li>- 6/10/24: She threw her shoes at a peer.</li> </ul> <p>Review on 8/01/24 of Plan of Action (undated) revealed:</p> <ul style="list-style-type: none"> <li>- "1.2 Staff on duty during peak hours 6am-6pm. 1 staff will be assigned to [Client #5], to increase supervision of [Client #5]. This staff will have the responsibility of maintaining personal space close to [Client #5] for intervention. The assigned staff</li> </ul>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL065-221</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/02/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KERR HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>514 OLIVE STREET WILMINGTON, NC 28401</b>
---	---

(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 290	<p>Continued From page 3</p> <p>will be next to [Client #5] to intervene, position themselves between [Client #5] and other roommates when transitioning, to decrease [Client #5] opportunities to act toward others."</p> <p>Interview on 8/01/24 - 8/02/24 client #1 stated: - She had lived at the group home for a "long time." - She had been in the group home when client #5 was present and there was only 1 staff. - She had been hit by client #5 and had witnessed others hit and yelled at by client #5.</p> <p>Interview on 8/01/24 - 8/02/24 staff #1 stated: - She had worked at the group home for over 30 years. - She had worked several shifts this week between the hours of 6am to 6pm where she was the only staff on for part of the shift and client #5 was at the group home. - She had witnessed client #5 scream, throw objects, and display disruptive behaviors.</p> <p>Interview on 8/01/24 - 8/02/24 staff #2 stated: - He had worked at the group home for 4 years. - He had worked several shifts between the hours of 6am to 6pm where he was the only staff on for part of the shift and client #5 was at the group home. - He had only experienced shifts alone when someone had called out and it had only been a few times. - He had witnessed client #5 scream, spit, throw objects, and attempt to hit staff and clients. - The other clients in the group home had demonstrated an increase in behaviors in recent months.</p> <p>Interview on 8/01/24 - 8/02/24 staff #3 stated: - She had worked at the group home for 26 years.</p>	V 290		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL065-221</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/02/2024</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>KERR HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>514 OLIVE STREET</b> <b>WILMINGTON, NC 28401</b>
---	---

(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 290	<p>Continued From page 4</p> <ul style="list-style-type: none"> <li>- She had not worked alone between the hours of 6am to 6pm when client #5 was at the group home.</li> <li>- She had witnessed client #5 expose herself, smear feces, and disrupt the other clients while they watched television.</li> <li>- She had witnessed an increase in behaviors from other clients in the group home over the last several months.</li> </ul> <p>Interview on 8/01/24 - 8/02/24 the Director of Operations stated:</p> <ul style="list-style-type: none"> <li>- The agency had coordinated with two behavior specialists to provide observations, monitoring, and suggestive feedback since client #5's admission.</li> <li>- A safety plan had been implemented by the agency, increasing staffing between peak hours when client #5 was at the home, implementing additional measures of safety, and placing a request for a higher level of care.</li> <li>- Client #5 had maintained monthly/quarterly physician appointments to address medication changes and monitoring.</li> <li>- She would address staffing to ensure the Plan of Action was followed.</li> </ul>	V 290		