STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL078-313	A. BUILDING: _____ B. WING _____	R 12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAY SUPPORTS	511 EAST 2ND STREET LUMBERTON, NC 28358

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on December 23, 2024. The complaint was substantiated (intake #NC00219071). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5400 Day Activity for Individuals of all Disability Groups. This facility has a current census of 13. The survey sample consisted of audits of 1 deceased client.	V 000		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section. (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against	V 132		

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V 132	Continued From page 1 a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report an allegation of neglect to the Health Care Personnel Registry (HCPR). The findings are: Review on 7/10/24 of facility records for 7/1/24 - current revealed no documentation the HCPR had been notified of an allegation of neglect against former staff (FS) #14. Review on 7/10/24 of deceased client (DC) #4's record revealed: - 68 year-old male. - Admission date of 3/23/11. - Deceased date of 7/3/24. - Diagnoses of Moderate Intellectual Developmental Disability (IDD), Schizophrenia, Hypertension, Diabetes, Anemia, and Unspecified Impulse Control Disorder. Interview on 7/15/24 the Qualified Professional (QP) stated: - They hadn't completed HCPR requirements yet, but they "were working on it." - They hadn't previously completed a report to HCPR, as they were waiting for the findings of the investigation being conducted by local law enforcement to determine what happened to DC #4 while in FS #14's care.	V 132		

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V 132	Continued From page 2 - He was interviewed by local law enforcement on 7/4/24 and notified that there was an "ongoing investigation." - He had not been made aware that local law enforcement suspected FS #14 of neglect or that they were treating the case as a homicide. Interview on 7/24/24 the QP Supervisor stated: - She was notified that the incident involved DC #4 by the QP. - She completed a level III incident report in the North Carolina Incident Response Improvement System (IRIS) for DC #4 within 24 hours of notification (7/4/24) and included the information she had at that time. - She had no information provided to her from law enforcement on any neglect or abuse to update IRIS for DC #4. Interview on 7/12/24 staff #2 stated: - She observed no physical marks, discoloring, or injuries to DC #4 on the morning of 7/3/24. - DC #4 passed away while in the care of FS #14 on 7/3/24. - She was interviewed by local law enforcement on 7/4/24 and was informed that they were "looking at this as a possible homicide." Interview on 7/25/24 a detective for the local law enforcement department stated: - QP #1 was notified on 7/4/24 that they were investigating FS #14 for "possible wrongdoing." - Facility management and ownership were made aware that the investigation was being treated as a potential homicide. - Facility management and ownership were made aware that the Medical Examiner was notified and evaluated the case as a "potential homicide." Interview on 7/30/24 representative from HCPR	V 132		

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V 132	Continued From page 3 stated: - After a cross reference of multiple potential spellings of DC #4's name, there were no HCPR checks made by the facility which identified FS #14. - She was only able to locate one entry in IRIS for DC #4 (7/4/24) which was an entry which identified he had passed away. Interview on 12/5/24 the Executive Director stated: - They were notified by local law enforcement that FS #14 was being investigated "within a couple of days"of the incident. - The QP Supervisor would have been responsible for updating IRIS with new information.	V 132		
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;	V 366		

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V 366	Continued From page 4 (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal 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;	V 366		

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V 366	Continued From page 5 (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law.	V 366		

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V 366	Continued From page 6 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to meet all elements of response as required for level III incidents. The findings are: Review on 7/10/24 of deceased client (DC) #4's record revealed: - 68 year-old male. - Admission date of 3/23/11. - Deceased date of 7/3/24. - Diagnoses of Moderate Intellectual Developmental Disability (IDD), Schizophrenia, Hypertension, Diabetes, Anemia, and Unspecified Impulse Control Disorder. Review on 7/10/24 of facility incident response documentation between 7/1/24 - 7/10/24 revealed: - Incident response to the level III incident on 7/3/24 did not include a submission of a written preliminary findings of fact within five working days of the incident to the LME/MCO (Local Management Entity/Managed Care Organization) in the catchment area of the facility or the client's residence. Interview on 7/30/24 representative from HCPR stated: - She was only able to locate one entry in the North Carolina Incident Response Improvement System (IRIS) for DC #4 (7/4/24). - There was no internal findings report uploaded within the 5 day timeframe. Interview on 12/5/24 the Executive Director stated: - They were notified by local law enforcement that	V 366		

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V 366	Continued From page 7 FS #14 was being investigated "within a couple of days"of the incident. - The QP Supervisor would have been responsible for updating IRIS with new information.	V 366		
V 500	27D .0101(a-e) Client Rights - Policy on Rights 10A NCAC 27D .0101 POLICY ON RIGHTS RESTRICTIONS AND INTERVENTIONS (a) The governing body shall develop policy that assures the implementation of G.S. 122C-59, G.S. 122C-65, and G.S. 122C-66. (b) The governing body shall develop and implement policy to assure that: (1) all instances of alleged or suspected abuse, neglect or exploitation of clients are reported to the County Department of Social Services as specified in G.S. 108A, Article 6 or G.S. 7A, Article 44; and (2) procedures and safeguards are instituted in accordance with sound medical practice when a medication that is known to present serious risk to the client is prescribed. Particular attention shall be given to the use of neuroleptic medications. (c) In addition to those procedures prohibited in 10A NCAC 27E .0102(1), the governing body of each facility shall develop and implement policy that identifies: (1) any restrictive intervention that is prohibited from use within the facility; and (2) in a 24-hour facility, the circumstances under which staff are prohibited from restricting the rights of a client. (d) If the governing body allows the use of restrictive interventions or if, in a 24-hour facility, the restrictions of client rights specified in G.S. 122C-62(b) and (d) are allowed, the policy shall	V 500		

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V 500	Continued From page 8 identify: (1) the permitted restrictive interventions or allowed restrictions; (2) the individual responsible for informing the client; and (3) the due process procedures for an involuntary client who refuses the use of restrictive interventions. (e) If restrictive interventions are allowed for use within the facility, the governing body shall develop and implement policy that assures compliance with Subchapter 27E, Section .0100, which includes: (1) the designation of an individual, who has been trained and who has demonstrated competence to use restrictive interventions, to provide written authorization for the use of restrictive interventions when the original order is renewed for up to a total of 24 hours in accordance with the time limits specified in 10A NCAC 27E .0104(e)(10)(E); (2) the designation of an individual to be responsible for reviews of the use of restrictive interventions; and (3) the establishment of a process for appeal for the resolution of any disagreement over the planned use of a restrictive intervention. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to report to the Department of Social Services (DSS) in the county where services are provided all allegations of client neglect by health care personnel. The findings are: Review on 7/10/24 of facility records for 7/1/24 - 7/10/24 revealed no reports of allegations of	V 500		

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V 500	Continued From page 9 neglect to the local DSS. Review on 7/10/24 of deceased client (DC) #4's record revealed: - 68 year-old male. - Admission date of 3/23/11. - Deceased date of 7/3/24. - Diagnoses of Moderate Intellectual Developmental Disability (IDD), Schizophrenia, Hypertension, Diabetes, Anemia, and Unspecified Impulse Control Disorder. Interview on 7/15/24 the Qualified Professional (QP) stated: - The facility did not notify DSS of neglect, as they were waiting for the findings of the investigation to be conducted by local law enforcement to determine what had happened to DC #4 while in former staff (FS) #14's care. - He was interviewed by local law enforcement on 7/4/24 and notified that there was an "ongoing investigation." - He had not been made aware that local law enforcement suspected FS #14 of neglect or that they were treating the case as a homicide. Interview on 7/24/24 the QP Supervisor stated: - She was notified of the incident which involved DC #4 by QP #1. - She completed a level III incident report in the North Carolina Incident Response Improvement System (IRIS) for DC #4 within 24 hours of notification (7/4/24) and included the information she had at that time. - She had no information provided to her from law enforcement on any neglect or abuse to update IRIS for DC #4. Interview on 7/12/24 staff #2 stated: - She observed no physical marks, discoloring, or	V 500		

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V 500	Continued From page 10 injuries to DC #4 on the morning of 7/3/24. - DC #4 passed away while in the care of FS #14 on 7/3/24. - She was interviewed by local law enforcement on 7/4/24 and informed that they were "looking at this as a possible homicide." Interview on 7/25/24 a detective for the local law enforcement department stated: - The QP was notified on 7/4/24 that they were investigating FS #14 for "possible wrongdoing." - Facility management and ownership were made aware that the investigation was being treated as a "potential homicide." - Facility management and ownership were made aware that the Medical Examiner would also evaluate the case as a "potential homicide." Interview on 12/5/24 the Executive Director stated: - They were notified by local law enforcement that FS #14 was being investigated "within a couple of days"of the incident. - The QP Supervisor would have been responsible for updating IRIS with new information.	V 500		
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	V 512		

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V 512	Continued From page 11 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. This Rule is not met as evidenced by: Based on record reviews, observation, and interviews, one of one deceased client (DC #4) was subjected to serious neglect by one of one former staff (FS)(#14). The findings are: Review on 7/10/24 of DC #4's record revealed: - 68 year-old male. - Admission date of 3/23/11. - Deceased date of 7/3/24. - Diagnoses of Moderate Intellectual Developmental Disability (IDD), Schizophrenia, Hypertension, Diabetes, Anemia, and Unspecified Impulse Control Disorder. Review on 7/10/24 of FS #14's personnel record revealed: - Date of hire: 6/13/18. - Date of termination: 7/8/24. - Cardio Pulmonary Resuscitation (CPR) training through the American Red Cross effective 5/31/24	V 512		

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V 512	Continued From page 12 Review on 7/10/24 of a North Carolina Incident Response Improvement System (IRIS) report completed by the Qualified Professional (QP) and the QP supervisor for DC #4 revealed: - Date of incident: 7/3/24 - Provider Comments: "Consumer was receiving periodic services out in the community. Consumer got to hot, staff took him to the hospital. Staff contacted the office." - Manner of Death: "Unknown Cause." - Death Due To: "Other." Review on 7/12/24 of Confidential Investigation Report completed by the QP and dated 7/8/24 revealed: - Allegation/Issue: "Client's Death." - Name/Post of employee(s) subject to investigation: FS #14. - The QP was notified by a community hospital that DC #4 had been admitted to the hospital after "possibly having a heat stroke." - DC #4 was "resuscitated 5 times" prior to passing away. -"[FS #14] left the group home around 10:15am he stated that he and [DC #4] went out in the community visited [local grocery store] around 11:30am and [local antique shop] and looked at a lamp. [FS #14] reported that he had stopped by his home to warm up [DC #4's] lunch for him and to smoke a cigarette. [DC #4] was at the kitchen table waiting for his pizza to be warm in the air fryer. Once he started eating, he only took a few bites and then he wanted to go outside and smoke. [FS #14] told [DC #4] to wash his hand and clean his face in the bathroom. When [DC #4] came out of the bathroom they went outside and [FS #14] noticed [DC #4] was breathing heavy. [DC #4] and [FS #14] had a conversation about side effects of smoking cigarettes. They	V 512		

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V 512	Continued From page 13 stayed in the house until around 2:30pm. [DC #4] and [FS #14] sat on the front porch and sat in the rocking chairs talking about getting [DC #4] a watch when they go back out in the community. As [DC #4] was starting smoking his second cigarette, [DC #4] took 2 puffs off the cigarette and it fell out of his mouth and slump over in his chair. [FS #14] stated that he called his name several times and he did not respond. [FS #14] went in and got a cold rag and placed on his forehead but did not respond. He stated that he did not call 911 because he thought that he could get him there quicker in his car. He drove the car up close to the porch and put [DC #4] in the passenger seat. [FS #14] then rushed him to the hospital personal vehicle." - "Summary finding [FS #14] did not follow [facility] Rules and Regulations by not calling 911 during a crisis situation." - "Recommendations on whether further actions under the relevant employment procedure should be taken. - No longer employed at [facility]" Review on 7/12/24 of local hospital records dated 7/4/24 revealed: - DC #4 arrived to local hospital on 7/3/24 at 3:45pm. - DC #4 was admitted for "cardiac arrest - cause unspecified." - Hospital Course: "Patient with history of depression, essential hypertension, schizophrenia, DM2 (Type II Diabetes) and developmental delay per chart presented to the ED (emergency department) via POV (patient owned vehicle) unresponsive with a core temp of 107.8 (Fahrenheit). He was reportedly found in a vehicle for an unknown amount of time. Patient presentd to the hospital with blistering burns to the left anterior thigh, left groin, and multiple	V 512		

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V 512	Continued From page 14 blisters to his bilateral hands. Patient with mottling upon arrival to the ICU (intensive care unit) and scrapes to the anterior chest suspected from CPR. Patient immediately coded and had multiple cardiac arrests in the ED with ROSC (return of spontaneous circulation). Cooling measure implemented for suspected heat stroke. He had multiple electrolyte abnormalities that were being replenished. Due to hemodynamic instability, patient was uptitrated to 4 pressors maxed out with tenuous blood pressure not exceeding greater than 50-60 systolic...Despite all aggressive measures, patient suffered another cardiac arrest, PEA (pulseless electrical activity). Minimal cardiac activity on bedside ultrasound. Futility of care evoked. Discussed with attending physician, stopped all efforts. Time of death 2209 (10:09pm)." -HPI (history of presenting illness):"[DC #4] is a 68 y.o. (year-old) male with who presents via private vehicle with a caregiver provided complaint of unresponsiveness. Patient is unresponsive during my evaluation, history obtained from ED provider, nursing staff and medical record. Reportedly he was acting normally this morning, he went outside to smoke a cigarette and then they (caregiver) went to check on him and he was found down with unknown downtime. Patient brought to emergency department by caregiver in the car. He was unresponsive on arrival. Initially he had agonal respirations and a faint pulse and then coded with rosc multiple times." - Intial temperature was recorded as 107.8 (Fahrenheit) on intake (3:55pm) "and immediate cooling measures were initiated." - Body temperature remained at 107.8 (Fahrenheit) at 4:10pm and then dropped to 103.1 (Fahrenheit) by 4:12pm. - 4:12pm: "Aggressive cooling measures	V 512		

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V 512	Continued From page 15 implemented and temp is coming down most recent temp is 39.5 C (Celsius) 103.1 F (Fahrenheit)." Review on 7/12/24 of hospital photos dated 7/3/24 and autopsy photos undated revealed: - A quarter sized fluid filled blister was visible above the left wrist on the left side of DC #4's outer arm. - A nickel sized, irregular shape fluid filled blister was visible approximately 4 - 6 inches above the left wrist on the right side of DC #4's outer arm. - A dime sized, irregular shape fluid filled blister was visible approximately 2 inches below the crook of DC #4's left outer arm. - The left hand displayed purple discoloration and torn skin above the index finger that extended 1 inch from the knuckle to the back of the hand. - Pink and purple discoloration was visible on the back of the left hand, approximately 1 inch in diameter on the top of the wrist. - There were two pencil eraser sized fluid filled blisters, pink in color, identified in the center of the back of the left wrist. - Pink and purple discoloration striped 3 x 5 inches down the sternum. -A volleyball sized pink and purple discoloration was visible on the right side of the abdomen with multiple fluid filled blisters varying in size and shape. - Pink and purple discoloration and blistering which extended 3 - 5 inches in width and extended from above the knee to below the groin of the left thigh. - A quarter size wound on the outside right knee exposed the second layer of skin where the top layer had peeled back. - An irregular shaped section of skin, approximately 2 - 3 inches in diameter on the upper left thigh, below the groin, had peeled back	V 512		

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V 512	Continued From page 16 and exposed the second layer of skin. Review on 12/2/24 of DC #4's REPORT OF INVESTIGATION BY MEDICAL EXAMINER dated 7/24/24 revealed: - Death: 7/3/24 at 10:09pm - "Complication of Hyperthermia." - Manner of Death: "Undetermined." - FATAL INJURY OR ILLNESS - Specific location: "Worker's house." - MEDICAL EXAMINER PRELIMINARY SUMMARY OF CIRCUMSTANCE SURROUNDING DEATH: "Decedent 68 year old brought into emergency room in private vehicle in cardiac arrest. Decedent was identified by worker from group home. According to worker decedent was checked out of group home by worker for a day out and was at the workers house to heat up food. Decedent was sitting on worker's front porch when he became unresponsive and was placed in car and brought to emergency department. Worker stated that he was on a covered porch and he had just handed him a cigarette when the incident happened. Decedent temp was 107.8 (Fahrenheit) and was in cardiac arrest when he arrived at emergency room. Decedent gained return to spontaneous circulation and was admitted to ICU where he was later pronounced (deceased). According to medical records patient had blistering to hands, anterior thighs, left groin and abdomen. Decedent has no history of suicidal ideation or overdose and no known admission to inpatient rehab (rehabilitation). Regional autopsy center was notified and decedent was sent for autopsy." Review on 12/2/24 of DC #4's REPORT OF AUTOPSY EXAMINATION completed by the medical examiner on 7/8/24 and digitally signed and dated 11/25/24 revealed:	V 512		

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V 512	Continued From page 17 - Cause of Death: "COMPLICATIONS OF HYPERTHERMIA." - DIAGNOSES: "Hyperthermia, unknown mechanism. A. Transported to hospital by private vehicle, circumstances unknown. B. Area temperatures reported as ranging from 66 to 90 degrees Fahrenheit with no precipitation. C. Body temperature 107.8 degrees Fahrenheit on emergency department presentation. D. Clinical non-ST (ST-segment) elevation myocardial infraction, shock, electrolyte abnormalities, thrombocytopenia, acidosis, acute kidney injury, and respiratory failure. E. Skin blistering of anterior torso, thighs, and right foot." - INJURIES: "Each anterior axilla has an irregular, purple ecchymosis measuring 4 x 3 1/4" on the right and 3 x 2" on the left; their origin is uncertain. On the anterior chest is an 8 x 4" area of linear and curvilinear, red ecchymosis most likely in association with attempted resuscitation. On the anterior torso, primarily centered on the right upper quadrant of the abdomen, is a 12 x 7" area of pink-purple ecchymosis with superficial skin blisters individually measuring up to 3 3/4" in greatest dimension. Similar-appearing areas are on the anterior thighs (13 x 4", right; 12 x 4", left) and dorsum of the right foot (4 1/2 x 2 1/2"). The right upper arm has linear and curvilinear, patchy red ecchymosis in association with blood pressure cuff application. On the right shin are two linear, scabbed abrasions measuring 3/4 and 1/2" in length. On the left shin is a 1", linear, scabbed abrasion.	V 512		

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V 512	Continued From page 18 On internal exam, also in association with attempted resuscitation, there is left upper chest muscular hemorrhage, and parasternal fractures of the left 3rd-10th ribs with associated underlying anterior pericardial ecchymosis." - SUMMARY AND INTERPRETATION: "According to the case calls, medical records, and [local] County Medical Examiner Report of Investigation, this 68-year-old man had a history of hypertension, diabetes mellitus, developmental delay, and psychiatric issues. He was a ward of the state and a resident of a group home under the care of other people. Per medical records, on 7/3/2024 shortly before 1600 hours (4:00pm)(based on initial medication administration time), he was brought by private vehicle to [local] Hospital, with his caretaker stating that he was unresponsive. On presentation, he had agonal respirations, a faint pulse, and a temperature of 107.8 degrees Fahrenheit. He had blistering of his legs and groin. He was given naloxone on his intake. He coded multiple times, but was resuscitated. Cooling measures were applied, and efforts were made to correct electrolyte abnormalities. He was transferred to the intensive care unit on mechanical ventilation, with complications including non-ST elevation myocardial infarction, shock, electrolyte abnormalities, thrombocytopenia, acidosis, acute kidney injury, and respiratory failure. Despite continued care, he coded again; during attempted resuscitation, further efforts were deemed futile, death was pronounced at 2209 (10:09pm) hours the same day. Weather data from the nearest weather station	V 512		

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V 512	Continued From page 19 ([local] Regional Airport) that day showed a temperature range from 66 to 90 degrees Fahrenheit with no precipitation. Conflicting and evidently untruthful information was reported by the caretaker who had charge and custody of the decedent on the day of his death; that caretaker reported initially that the decedent was found unresponsive on a covered porch shortly after being seen alive and well. Follow-up discussion with law enforcement indicated that attempts were made to interview the decedent's caretaker afterwards, but that the caretaker had become ill, gone into hospice care, and died in October of 2024. As such, no additional information regarding the circumstances of death could be uncovered. The autopsy documented skin blistering of the anterior torso, thighs, and right foot consistent with heat exposure. He had rib fractures from attempted resuscitation, but no trauma causative of or contributory to his death. Natural disease documented at autopsy included changes of hypertensive and atherosclerotic cardiovascular disease, including cardiomegaly (430 gm)(grams) with left ventricular hypertrophy (1.7 cm) (centimeters) and moderate coronary artery atherosclerosis. Toxicological testing of blood collected at autopsy detected fentanyl and ketamine; review of medical records indicated these medications were administered in the emergency department at 1610 hours (4:10pm) and 1601 hours (4:01pm), respectively. While the cause of death of complications of hyperthermia is evident from the medical records and autopsy findings, the circumstances by which that hyperthermia occurred are unknown. Considering that the decedent was under the	V 512		

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care of a person paid to be responsible for his care, and that the caretaker was apparently untruthful in proffered information, serious concern exists for neglect rising to the level of homicide. However, the lack of information coupled with the inability to attain additional details precludes reaching that conclusion with a sufficient level of confidence. As such, the manner of death is classified as undetermined."

Observation on 7/24/24 at approximately 2:30pm revealed:
- A recreation of the drive from FS #14's driveway to the local ED entrance returned a travel distance of 5.1 miles.
- Travel time was recorded as 15 minutes.
- There were no variables which impeded progress to the ED entrance.

Interviews on 7/10/24 and 7/15/24 staff #15 stated:
- He had worked with DC #4 on the evening of 7/2/24 and assisted him hygiene that evening.
- His shift had started at 4pm and ended at 8am on 7/3/24.
- DC #4 completed his hygiene and was in bed by 8pm on 7/2/24.
- There were no cuts, abrasions, blisters, bruises, unusual markings, or unusual discoloration observed when DC #4 went to bed on the night of 7/2/24.

Interviews on 7/10/24 and 7/12/24 staff #11 stated:
- She had worked with DC #4 on the morning of 7/3/24.
- DC #4 awoke around 6am on 7/3/24, ate breakfast, took his meds, and displayed "nothing out of the ordinary"that morning.
- FS #14 arrived around approximately 10:30am

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V 512	Continued From page 21 to pick up DC #4. - FS #14 met DC #4 at the door, came into the house, and they picked up DC #4's lunch before leaving for the day. - There were no cuts, abrasions, blisters, bruises, unusual markings, or unusual discoloration observed on the morning of 7/2/24. - DC #4 made no comments of feeling ill on the morning of 7/2/24. Interviews on 7/10/24, 7/12/24, and 7/24/24 staff #2 stated: - She had worked with DC #4 on the morning of 7/3/24. - She observed no injuries, abnormal markings, or discoloration on DC #4 on the morning of 7/3/24. - DC #4 made no mention of injuries, pain, or discomfort on the morning of 7/3/24. - FS #14 arrived at the group home around 10am to pick up DC #4. - She reviewed behavior tendencies of DC #4 and what she had packed him for lunch before FS #14 left the facility with DC #4. - At approximately 3 - 3:30pm on 7/3/24 she received a call from FS #14 asking if DC #4 was a "heavy sleeper." - She responded to the question with "No, why would you say that?" - FS #14 then stated that he "couldn't get him up." - FS #14 asked her if he should take DC #4 "to the hospital" and she stated "I don't know. I'm not right there to see him. But if you think he needs to be taken to the hospital, then you should take him to the hospital." - She detected no urgency in the call and at that point believed that DC #4 may be reluctant to get up from a nap. - She offered to come over to FS #14's residence to "help wake him up" and FS #14 stated he was	V 512		

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V 512	Continued From page 22 going to transport DC #4 to the hospital but asked if she could meet him at a halfway point just to check on him. - She agreed to meet him at a designated point (local store/parking lot) that was 1.9 miles from ED. - She arrived within 5 minutes (uncertain of time) and waited an unknown amount of time for FS #14 to arrive. - As FS #14 pulled up into the parking lot, she got out of the van and observed FS #14's convertible top was up and DC #4 sat in the front passenger seat with a rag on his head. - As the car approached closer, she could tell that "something wasn't right" with FC #4 and that "you could just tell that it wasn't good." - Before FS #14 could even stop the car, she waved for him to continue to the hospital and told him "go, go, go!" - She did not speak to FS #14 at that time and did not call the hospital. - She got into her van and also proceeded to the hospital. - As she pulled in to the ER entrance, she saw FS #14's car and observed FS #14 running into the entrance to get help. - She pulled in behind FS #14's car and went over to check on DC #4 who was in the passenger seat of the car. - DC #4 was breathing but it was labored (described as big gasps for breath). - She ran inside the entrance, spoke to a hospital employee, and told her she needed help in the parking entrance. - There were 3-4 nurses that ran out to attend to DC #4. - She recalled a male nurse who grabbed DC #4's hand as they attempted to pull him out and stated that DC #4's hand was warm. - She asked FS #14 what happened and he	V 512		

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V 512	Continued From page 23 stated that he and DC #4 went outside for only "a little bit" so that DC #4 could smoke a cigarette and that DC #4 took a puff of his cigarette before he slumped over and the cigarette fell out of his mouth. - A female nurse came out and stated his body temperature was 107.8 and also asked what happened. - DC #4 passed away later that day. - The next day (7/4/24) the local police came out to get a statement and spoke with her and QP #1 about the incident. - The local law enforcement detective stated that they would investigate the case as a "possible homicide." Interview on 7/19/24 FS #14 stated: - He was called on the evening on 7/2/24 by a program manager to fill a morning shift on 7/3/24. - He arrived at DC #4's group home at approximately 10am on 7/3/24. - He had never worked with DC #4 so he reviewed some history on DC #4 with staff #2 before he left the group home with DC #4. - He took DC #4 to 2 local thrift shops and was at each one for approximately 30 minutes each. - DC #4 made no mention of any pain or discomfort while on the outings, other than stating that he did not want to pee at the stores because "his thing hurts." - He took DC #4 back to his (FS #14's) residence at approximately 11:30 - 11:45am. - DC #4 smoked on the back porch for approximately 10 minutes before he came inside to eat lunch. - DC #4 washed his hands, and ate a portion of the pizza that had been prepared for him before he decided that he did not want any more. - They went to the living room to watch television at approximately 12:15pm - 12:30pm and at	V 512		

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approximately 2:00pm DC #4 went to use the restroom.
- He stood outside the bathroom door while DC #4 used the restroom and then entered to help him wash his hands after he was finished.
- They both returned back to the living room until about 2:30 - 2:45pm.
- He wanted to take DC #4 back home between 2:30 - 2:45pm so that he would have time to complete his notes before he finished his 3:00pm shift.
- DC #4 asked if he could smoke before they left and he agreed.
- They both went out on the front covered porch, he lit DC #4's cigarette for him, and then walked to the other side of the porch approximately 15-18 feet away.
- While DC #4 smoked his cigarette, FS #14 looked at his phone.
- From his peripheral, FS #14 could see the cigarette fall out of DC #4's mouth and he asked DC #4 if he was alright.
- DC #4 slumped over into the chair and was unresponsive.
- He pulled him up into the chair and DC #4 continued to slump over to the side and slide down the chair.
- He shook DC #4 and called his name but got no response.
- DC #4 displayed labored breathing "like he was gasping" at that point, and had one eye open and one eye closed.
- He immediately called staff #2 to detail what was happening.
- He knew "something was wrong."
- He opted not to call 911 because "it generally takes them about 45 minutes for them to arrive" and he felt he could get him to the ED quicker if he transported him by car.
- He asked staff #2 to meet him at a a local

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grocery store/parking lot on the way "to see what you think" while on the way to the hospital.
- He arrived at a local grocery store/parking lot, pulled into the parking lot, and staff #2 looked at DC #4 and stated that he needed to go the hospital.
- He was in the parking lot for less than a minute and asked staff #2 to call the hospital to let them know they were on the way before he proceeded to the hospital.
- There was an "ER (emergency room) doctor outside when I got there."
- The physician asked if DC #4 had overdosed on drugs and administered Narcan as a precaution.
- A stretcher and additional staff were brought out within 3 minutes and staff #2 pulled in behind him at that point.
- He put the top down on his convertible car to give the hospital staff additional access to DC #4 and they pulled him from the car.
- A nurse came out after a short while and stated that DC #4 had a body temperature of 107.8 (Fahrenheit).
- A second physician came out later and asked him if DC #4 had "been out in the heat for a long time" and he told him "No, just for a few minutes."
- The physician said DC #4 presented "like a heat stroke."
- He "had no idea how he [DC #4] would get overheated."
- There was no space within the home that was not cooled by air-conditioning.
- DC #4 was never out of his sight while in his care, left in his car unattended for any amount of time, or any area of his home unattended.
- DC #4 never took a shower and was never exposed to any hot water at any time while at his residence.
- DC #4 never showed any visible injuries while in

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	MHL078-313	A. BUILDING: _____ B. WING _____	R 12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAY SUPPORTS	511 EAST 2ND STREET LUMBERTON, NC 28358

(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	Continued From page 26	V 512		

his care and never mentioned any injuries or discomfort, outside of his penis hurting when he urinated.
- The doctor did question his body temperature being hot and stated that his skin had "some marks like burns on both arms and groin area."
- He had no knowledge of where the marks came from.
- "There is an emergency protocol and I should have called 911. Honestly, I didn't because I knew that I could get there sooner."

Interviews on 7/10/24, 7/15/24, and 7/24/24 the QP stated:
- He was notified on 7/3/24 by the local community hospital that DC #4 had ben admitted.
- DC #4 passed away later that evening.
- An investigation was started on 7/4/24.
- FS #14 was interviewed on 7/4/24 and stated that he picked up DC #4 on the morning of 7/3/24, took him to two stores, and brought him back to FS #14's home for lunch at approximately 11:30am.
- Following lunch, FS #14 stated he followed DC #4 to his front porch so that DC #4 could smoke a cigarette.
- FS #14 stated that DC #4 smoked one cigarette while they talked and then lit up a second cigarette, took two puffs, and slumped over as the cigarette fell out of his mouth.
- FS #14 then pulled his car to the front of the house and dragged DC #4 to the car to transport to the hospital.
- FS #14 stated he did not call 911, as he felt he could get him to the hospital faster if he drove him.
- After the internal investigation, FS #14 was terminated for not contacting 911.
- He was interviewed by local law enforcement on 7/4/24 and told that they were investigating the

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V 512	Continued From page 27 incident. Interview on 7/15/24 the Assistant Director for [local] County Communications stated: - When an emergency unit is requested for cardiac arrest, "standard procedure is to send out" fire department, local law enforcement, and emergency medical technicians. - On 7/3/24, at approximately 3:45pm, "there were 3 EMT (emergency medical technician) trucks" running in the vicinity of where FS #14 resided and "no calls" for service. - A medical responder would have been able to respond to FS #14's address in "approximately 5 - 8 minutes" on 7/3/24 at 3:45pm. - The first responder would have been equipped with an AED (automated external defibrillator) machine and would have been able to begin life saving measures upon arriving. Interview on 7/25/24 a detective for the local law enforcement department stated: - The QP was notified on 7/4/24 that they were investigating FS #14 for "possible wrongdoing." - Facility management and ownership were made aware that the investigation was being treated as a "potential homicide." - Facility management and ownership were made aware that the Medical Examiner would also evaluate the case as a "potential homicide." Review on 12/23/24 of the facility's Plan of Protection signed by the QP and dated 12/23/24 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? 5 day follow-up incident reporting. Personnell Registry - Reporting situation to local DSS. - Report to LMCO (Local Management Entity/Managed Care Organization) -This incident	V 512		

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V 512	Continued From page 28 in relations to [FS #14]. Report within 24 hr (hour) to healthcare personnell Registry Describe your plans to make sure above happens. During the end July, training was held to discussing the methods of handling situations during extreme weather conditions." DC #4 was a 68 year-old male with diagnoses of Moderate IDD, Schizophrenia, Hypertension, Diabetes, Anemia, and Unspecified Impulse Control Disorder. On 7/3/24, at approximately 10:00am, DC #4 was picked up from his group home by FS #14 and transported to two community stores before they arrived at FS #14's residence for lunch. At approximately 3:00pm, DC #4 became unresponsive per FS #14's reports while smoking a cigarette on FS #14's porch. FS #14 contacted staff #2 prior to transport of DC #4 and met staff #2 in a parking lot en-route to the emergency department only to be told to continue to transport DC #4 to the emergency department. DC #4 arrived and was admitted at 3:45pm to the local community hospital with a body temperature of 107.8 (Fahrenheit) and with multiple areas of skin discoloration and blistering to the abdomen, thighs, groin, shins, left arm, and hands. DC #4 was pronounced deceased at 10:09pm and the cause of death was later determined as hyperthermia. FS #14 did not attempt CPR or contact 911 and he transported DC #4 by his personal vehicle and made a stop prior to the arrival at the emergency department. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 512		