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	MHL096-270	A. BUILDING: _____ B. WING _____	R 07/13/2018

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GRACE	1290 MARK EDWARDS ROAD GOLDSBORO, NC 27534

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on July 13, 2018. The complaint was substantiated (Intake #NC00140263). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure disaster and fire drills were held quarterly and repeated on each shift. The findings are: Review on 07/12/18 of the facility's disaster and fire drill records revealed: - From August 2017-June 2018 no 3rd shift fire or disaster drills were documented.	V 114		

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V 114	Continued From page 1 -From August 2017-June 2018 only two disaster drills were documented. Interview on 07/12/18 client #1, #3 and #4 revealed: They completed fire and disaster drills every month. Interview on 07/12/18 the House Lead revealed -The facility completed fire and disaster drills every month. -He did not know why staff were not documenting when a drill was completed.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug;	V 118		

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V 118	Continued From page 2 (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to administer medications on the written order of a physician and failed to keep the MAR current affecting one of three clients (#4). The findings are: Review on 07/12/18 of client #4's record revealed: - 49 year old male. - Admission date of 03/03/17. - Diagnoses of Schizoaffective Disorder, Depressive Type, Autism Spectrum Disorder, Mood Disorder, Impulsive Control Disorder, Hypertension, Hyperlipidemia, Diabetes, Obesity, Constipation. Review on 07/14/18 of client #4's physician orders revealed: 06/22/18 and 07/11/18 - Clozapine 25mg (used to treat severe schizophrenia, or to reduce the risk of suicidal behavior in people with schizophrenia or similar disorders) Take 3 tablets (75mg) by mouth every evening. Review on 07/14/18 of client #4's April 2018 MAR revealed client #4 had been on Clozapine 25mg	V 118		

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V 118	Continued From page 3	V 118		

until being admitted into the hospital on the evening of April 14, 2018-June 5, 2018 at which point the medication had been stopped until he returned to his physician on June 22, 2018 and the medication was restarted.

Review on 07/14/18 of client #4's June and July 2018 MAR revealed:
-The June 2018 had a hand written transcribed entry of Clozapine 25mg take 3 tablets (75mg) by mouth every evening. Initials were transcribed starting on 06/22/18-6/30/18 to indicate the medication had been administered.
-The July 2018 MAR had a hand written transcribed entry of Clozapine 25mg take 3 tablets (75mg) by mouth every evening. Initials were transcribed from 07/01/18-07/11/18 to indicate the medication had been administered.

Observation on 07/13/18 at approximately 4:30pm and 07/14/18 at approximately 10:30am of client #4's medications revealed the Clozapine was not present and available for administering.

Review on 07/12/18 of an Incident Report for client #4 dated 4/14/18 revealed "Debriefing (section): 4/16/2018 Member (client #4) eloped (4/14/18) from the group and started running down the street yelling that he was going to kill himself. Staff and Clinical Director along with the aid of some individuals passing by were able to stop the member. Member refused to calm down and the police were contacted and member was IVC'd (involuntarily committed) to [local hospital]. Incident Comments: On 4.14.18 around 8:40 pm Clinical Director got a phone call that the member had eloped from the group after the manager left around 8:30pm...Clinical Director arrived on the scene whereby a passenger and family had also helped staff with member (client #4) who was

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V 118	Continued From page 4 headed towards a bridge nearby. Clinical Director spoke with member and asked him to talk about what happen while instructing the staff to return to the group home with the manager in-route as well. The member started running away from the Clinical Director yelling that he was going to jump off the bridge and kill himself. The Clinical Director and Family (who had stopped to assist) were able to stop the member and talk with him in an effort to calm him down. The member continued to yell and scream that he wanted to kill himself and didn't care about anyone else. At the request of the Clinical Director (after 20 minutes) the police were contacted. The officer who arrived on the scene assessed the situation with the agitated member and recommended having the member IVC'd. At which time the Lead manager for the group home arrived and stayed with the member, family and police while the Clinical Director went to the [local] Police department seeking IVC paperwork. Paperwork was obtained and the member was transported by the police to [local hospital] for a psych (psychological) evaluation....Clinical Director spoke with a nurse who make copies of the member's current medications and indicated that the member spoke of wanting to 'kill himself' therefore he was being admitted and evaluated on 4.15.18 by the staff psychiatrist...Supervisor Comments: Member (client #4) eloped from the group home yelling and screaming that he wanted to kill himself. Staff and Clinical Director along with a family that stopped and provided assistance were able to keep the member from harming himself until the police arrived and recommended that the member be IVC'd...Member will need to be monitored closely especially if medication and food refusals are noted and a good sign that some behavioral outburst might be coming to alert staff."	V 118		

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V 118	Continued From page 5 During interview on 07/13/18 client #4 revealed: -He had not taken the Clozapine 25mg since he had returned to the facility from the hospital. -He had been taken off the Clozapine 25mg at the hospital. During interview on 07/13/18 staff #2 revealed: -Client #4 was no longer taking the Clozapine 25mg. -He was not sure why initials were on the MAR to indicate the medication had been administered. During interview on 07/13/18 the House Lead revealed: -He did not administer medications on second shift because he worked first shift. -He was responsible for making sure the medication was in the home for staff to administer. During interview on 07/14/18 the Certified Medical Assistant (CMA) revealed: -She had transcribed the MAR from the physician order and not the physical bubble pack from the pharmacy. During interview on 07/14/18 a representative from the pharmacy revealed: -The last time the Clozapine 25mg had been dispensed to the facility was on April 2, 2018. -The pharmacy had two new orders for the Clozapine 25mg dated 06/22/18 and 07/11/18 but the medication had not been sent to the facility. During interview on 07/14/18 the Director of Operations revealed: -He had worked very hard with staff on the importance of medication.	V 118		

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V 118	Continued From page 6 -The medication not being in the facility was unacceptable and staff would be terminated due to the mistake. -He did not know why the pharmacy did not send the medication when they received the prescription from the physician. -He understood it was still the responsibility of staff and agency to make sure the medication was available. Review on 07/14/18 of the Plan of Protection dated 07/14/18 and completed by the Director of Operations revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? The missing medication will be immediately filled, and any staff who signed the MAR for the medication that was not there will be terminated immediately. Including the CMA (Certified Medical Assistant). The Group Home Leader will move to 2nd shift to ensure the correct medication is given. Additionally, a med closet audit will be conducted immediately to ensure all current standing orders have matching MAR's, and all medication is present. -Describe your plans to make sure the above happens. We will have 2 layers of supervision for this action to ensure no meds or doctors orders are missed. For staffing, the CMA has already been terminated, and termination appraisals have been written and will be carried out by day's end for all other identified staff." Client #4 presented with diagnoses of Schizoaffective Disorder, Depressive Type, Autism Spectrum Disorder, Mood Disorder, and Impulsive Control Disorder. On April 14, 2018 he eloped from the facility and attempted to commit suicide by threatening to jump off a bridge. In addition, there were several other elopement	V 118		

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V 118	Continued From page 7 incidents and behavioral situations. Client #4 was involuntarily committed to a psychiatric treatment hospital from the April 14 incident. Following his return to the facility and an updated physician's order dated June 22, 2018, the facility failed to administer all of his psychotropic medications as ordered. This failure resulted in client #4 not receiving his Clozapine in the evening from June 22, 2018 to July 12, 2018. Staff were initialing on the MAR that client #4 had been receiving the medication but the pharmacy indicated the medication had not been dispensed to the facility since April 2, 2018 and the medication was not observed to be in the facility during the time of the survey. The failure to ensure client #4 received his psychotropic medication increased the exacerbation of psychosis and hospitalizations. The facility's failure to administer medications as ordered constitutes serious neglect and is a Type A1 rule violation and must be corrected within 23 days. An administrative penalty of $2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 118		