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V 000	INITIAL COMMENTS An annual and follow up survey was completed on 10/19/18. 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 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to develop and include strategies in 1 of 3 audited client's (#1) treatment plans to address the client needs. The findings are: Review on 10/17/18 Client #1's record revealed: - 53 year old male admitted to facility 3/25/09. - Diagnoses of Psychotic Disorder, Not Otherwise Specified, Moderate Intellectual/Developmental Disability, Autistic, Cerebral Palsy, Hypertension. - Individual Support Plan dated 1/23/18 and signed on 1/28/18 - Update to Individual Support Plan dated 2/13/18. - No strategies to address client #1's level of supervision and support when ambulating due to increased risk of falls. Review on 10/17/18 of Client #1's Individual Support Plan dated 1/23/18 revealed: - "...What is important to me:...It is important for [Client #1] to have wake staff at night due to the random times of the night he may get up. [Client #1] has to use a walker when in the home and community and needs to be supported by staff when he wakes up to ensure that he does not fall...Especially since he is having more knee issues this current year and this has put him more at risk of falling..." - "...What others need to know to best support me..:[Client #1] requires 24-hour supervision with wake staff to ensure safety and that he is able to access his environment without falling. [Client #1] requires the use of a walker when navigating his environment at all times..." - "...Medical/Behavioral:...Staff needs to be within arm's reach during self -mobilization at all times	V 112		

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V 112	Continued From page 2 to assist with fall risks and any injuries that can occur from this..." - "...Past History:..[Client #1] usually does not use his walker when he is at home by choice and requires reminders to use his walker if he is unstable..." - "...List of target behaviors that can be experienced by [Client #1]:...7. Purposely falling to the ground...the act has got to visually be observed by provider-prompt [Client #1] to get up...Make sure that [Client #1] has not sustained any injury during fall..." - "...What is not working and needs to change... [Client #1's] knees are not working well and he has seen a doctor...This has increased the fall risk for [Client #1] and closer/constant supports have been provided to prevent falls for him... [Client #1] throwing and slamming his walker around when he gets upset is not working... [Client #1's] unsteady gait does not work for him and creates fall risk.." - "...Long Range Outcome:3...[Client #1] is required to use a walker to navigate through his community and home to decrease falling and shortness of breath...[Client #1] will use his walker appropriately...[Client #1] does not use his walker much when in his home and needs reminders to use it to prevent falls in the home..." Review on 10/17/18 of Client #1's record revealed: - Update to Individual Support Plan dated 2/13/18. - "...Action Plan...Long Range Outcome:2...[Client #1] requires sound monitor system in his bedroom for safety due to him getting up any time of the night and being a fall risk..." - "...Long Range Outcome:4...Staff must be in close proximity when [Client #1] is ambulating to support any fall risk..."	V 112		

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- "...Long Rang Outcome:6...[Client#1's] fall risk has increased this year due to him having further issues with his knees and sometimes he chooses not to use his walker so staff have to support him closely at all times when he is ambulating..."

Review on 10/17/18 of Client #1's Risk/Support Needs Assessment revealed:
- "...Assessment completed 1/23/18..."
- "...B. Material Supports (Mark all that are in place now)...Walker...Orthopedic Braces-back brace... Environmental controls(Describe) Sounding monitoring system in bedroom...Other:...[Client #1] moves very slow and requires staff to be within arm's reach during self mobilization...When [Client #1] becomes agitated or upset he will not use his walker and can run and when this occurs he shuffles his feet which causes him to fall eventually during his run..."

Review on 10/17/18 of the Facility's Level I Incident Reports for Client #1 revealed:
- "...Date of Incident: 26 July 2018...Location: Day Treatment...[Client #1] walked up the ramp; once he entered the room upstairs [Client #1] began cursing and attacking another client, by calling him the other client the "N" word and physically going after the other client. As [Client #1] was attacking the other client with his walker [Client #1] fell to the floor..."
- "...Date of Incident: 9-23-18...[Client #1] woke up and was trying to go to bathroom. He didn't have his walker with him, while he was trying to go to bathroom. He stumble and fell and hit his butt..Cause of Incident: This incident occurred as a result of consumer not utilizing his walker as recommended when being mobile...this incident may have been prevented if the consumer had utilized his walker as recommended as well as

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sought assistance from staff when deeded. in the future staff will continue to encourage consumer to use his walker as recommended..."
- "...Date of Incident: 9-28-18...While provider was in living room [Client #1] was in his room watching television. [Client #1] decided to leave his room and was not utilizing his walker, as he is required to do...after the provider asked him where it was and why he was walking without...he turned around to go grab it to quickly and fell into the door of another clients room...Cause of incident...This incident occurred as a result of consumer not utilizing his walker as recommenced when attempting to walk...This incident may have been prevented if consumer had utilized his walker as recommended..."
- "...Date of incident: 09-29-18...[Client #1] woke up at 3 to go to use the bathroom fell and hit his elbow and butt after being instructed to use his walker..Cause of incident...This incident occurred as a result of consumer not utilizing his walker as recommended when attempting to walk...This incident may have been prevented if consumer had utilized his walker as recommended..."
- ' Date of Incident: 10-2-18... the client began gripping his heart and almost fell over but the living room furniture caught him before he fell...paramedics arrived they took the consumer to the emergency room for treatment...[Client #1] released same day no follow up"
- "... Date of Incident: 10-4-18... The provider reminded him to take his walker and he preceded to his room using his walker. When the consumer enter his room the provider heard a loud thud sound...rushed into room to find consumer lying on the floor...The client stated that his arm hurt afterwards and that he had fallen on his knee...Cause of Incident ..this incident occurred as a result the consumer accidentally falling when attempting to independently sit on his

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bed without assistance...Could have been prevented if consumer may have asked for assistance when needed while trying to enter room..."
- "...Date of Incident: 10-9-18...he was not using his walker correctly and it caused him to fall...Cause of incident...incident occurred as a result of consumer attempting to be mobile with out any assistance from staff or his walker...Prevention:...Staff will continue to encourage consumer to use walker..."
- "...Date of Incident:10-8-18...[Client #1] attempter to go back in his room and feel on his side. I immediately went to [Client #1] room and assisted him in getting up...Cause of incident...incident occurred as a result of consumer attempting to be mobile with out any assistance from staff or his walker...Prevention:...Staff will continue to encourage consumer to use walker..."

Interview on 10/18/18 Client #1 stated:
- He used a walker when he is at home and at the day program.
- He did fall down but he got back up.
- His room did not have a sound monitor. He had one in his old room at the same house.
- He changed rooms when Client #2 moved in. He couldn't remember the date when he switched rooms.

Interview on 10/1718 Staff #2 stated:
- She had no problems with Client #1; she encouraged him to use his walker when she worked with him. When he fell she completed the incident forms.

Observation on 10/18/18 at approximately 11:30 am at the facility revealed:
- No sound monitor observed in Client #1's room.

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V 112	Continued From page 6 Interview on 10/17/18, 10/18/18, and 10/19/18 the Facility Clinical Director stated: - She was not aware of the lack of the sound monitor in Client #1's room. - Client #1 had been experiencing physical issues and would be reassessed to follow up with the increase in incidents. - She would follow-up with the strategies and treatment plan.	V 112		
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; (D) date and time the drug is administered; and (E) name or initials of person administering the drug.	V 118		

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V 118	Continued From page 7 (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 as ordered by physician and to ensure medications administered were recorded on each client's MAR immediately after administration affecting 2 of 3 audited clients (#1, and #3). The findings are: Finding #1: Review on 10/17/18 Client #1's record revealed: - 53 year old male admitted to facility 3/25/09. - Diagnoses of Psychotic Disorder, Not Otherwise Specified, Moderate Intellectual/Developmental Disability, Autistic, Cerebral Palsy, Hypertension. - Physician's orders for Ammonium Lactate 12% Cream (used to treat dry skin), apply body twice daily, signed 6/27/18; Cogentin 2 milligrams (mg) (used to treat muscle spasms, stiffness, tremors, poor muscle control,) one tablet daily, signed 9/26/18; Klonopin 1 mg (used to treat seizures, panic disorder, and anxiety) 1 tablet three times daily, signed 9/26/18; Dove soap (used to treat dry skin) signed 2/15/18; and Ladies Pumice Stone (used for dry rough skin), used on all calluses every evening once a week on Friday; signed 2/15/18. Review on 10/17/18 and 10/18/18 of Client #1's MARs for August - October 2018 revealed: - Documentation that the following medications	V 118		

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V 118	Continued From page 8 were not administered are as follows: - Ammonium Lactate cream: 8/1/18 8:00 am; 8/2/18 8:00 am; 8/4/18 8:00 am; 8/5/18 8:00 am; 8/6/18 8:00 am; 9/27/18 8:00 am; 10/2/18 8:00 am; 10/3/18 8:00 am; 10/5/18 8:00 am; 10/8/18 8:00 am; 10/10/18 8:00 am; and 10/13/18 8:00 am. - Cogentin: 8/18/18 8:00 am - Klonopin: 8/26/18 3:00 pm; 8/30/18 3:00 pm - Dove Soap: 8/13/18 8:00 am; 8/28/18 8:00 pm; 10/2/18 8:00 am; 10/3/18 8:00 am; 10/5/18 8:00 am; 10/8/18 8:00 am; and 10/13/18 8:00 am. - Ladies Pumice Stone: 8/17/18 8:00 pm and 8/31/18 8:00 pm Finding #2 Review on 10/17/18 of Client #1's record revealed: - Physician ordered signed 9/25/18 " ...Voltaren gel 1% (used to treat muscle pains and aches) apply 2 grams rt (right) side ...PRN (as needed) ..." - Client #1' MARs for August - October 2018 read " ...Diclofenac 1% gel apply two grams to right side of chest twice daily sub for: Voltaren ..." - Medication administered twice daily from 8/1/18 thru 10/9/18 at 8:00 am and 8:00 pm. Interview on 10/17/18 with the Facility Clinical Director stated: - She did not realize the order was "PRN" - as needed it must have been left off of the MARs. - The Licensee had been reviewing the MARs since the Certified Medical Assistant had been on leave. Finding #3 Review on 10/17/18 of Client #1's record revealed: - Physicians Order: Trazadone HCL 50 mcg	V 118		

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V 118	Continued From page 9 (used to treat insomnia); take one tablet by mouth as needed at bedtime; signed 8/22/18. Observation on 10/18/18 at approximately 11:00 am of Client #1's medications revealed: - Trazadone Bubble pack had approximately 20 empty punched bubbles. - The reverse side revealed handwritten dates for September and October beside each empty hole: 10/17, 10/16, 10/11, 10/8, 10/4, 10/1, 9/27, 9/26, 9/24, 9/21, 9/10, 9/8, 9/6, 9/3, and 9/1. Review on 10/17/18 and 10/18/18 of Client #1's September and October 2018 MARs revealed: - No documentation for administration of Trazadone HCL 50 MCG medication on 10/17/18, 10/16/18, 10/11/18, 10/8/18, 10/4/18, 10/1/18, 9/27/18, 9/26/18, 9/24/18, 9/21/18, 9/10/18, 9/8/18, 9/6/18, 9/3/18, and 9/1/18. Interview on 10/18/18 the Clinical Director stated: - Staff have been instructed to date the reverse side of bubble packs when giving medications. - Staff had been instructed to document the MAR once the medicine was given with reason and results. Interview on 10/18/18 Client #1 stated he took his medications daily with staff assistance and had not missed any doses. Finding #4: Review on 10/17/18 Client #3's record revealed: - 49 year old male admitted to facility 2/08/03. - Diagnoses of Schizoaffective Disorder, Bipolar Type, Moderate Intellectual/Developmental Disability, Diabetes, Hypertension, Constipation. - Physicians' orders as follows: - Lithium Carbonate (used to treat Bipolar Disorder) 300 mg, one tablet twice daily, signed	V 118		

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V 118	Continued From page 10 10/3/18. - Refresh Tears .5% (used to treat dry eyes), 1 drop both eyes four times daily, signed 3/30/18. - Metamucil (used to treat constipation), 1 scoop twice daily, signed 10/10/18. - Risperdal (antipsychotic) 2 milligrams (mg), one tablet twice daily, signed 10/3/18. - Denta 5000 Plus 1.1% (used to prevent dental cavities), use as directed twice daily, signed 10/3/18. - Inderal (used to treat hypertension and chest pain) 20 mg, one tablet three times daily, signed 10/3/18. - Occusoft Lid Scrub (used to treat mild to moderate eyelid conditions), apply one pad to both eyes three times daily, signed 3/8/18. - Haldol (antipsychotic) 5 mg, one tablet at bedtime, signed 10/3/18. - Melatonin (used to induce sleep) 5 mg, one tablet at bedtime, signed 10/3/18. - Desyrel (used to treat insomnia) 300 mg, one tablet at bedtime, signed 10/3/18. - Trileptal (used to treat seizure disorder) 300 mg, two tablets at bedtime, signed 10/3/18. Review on 10/17/18 of Client #3's MAR for August 2018 revealed: -The following medications were not documented as administered: - Melatonin: 8/7/18 8:00 pm. - Metamucil : 8/7/18 8:00 pm. - Occusoft Scrub eyelid Cleanser: 8/7/18 8:00 pm. - Trileptal: 8/7/18 8:00 pm. - Inderal: 8/7/18 8:00 pm. - Refresh Tears Eye Drops: 8/7/18 8:00 pm. - Risperdal 4 mg: 8/7/18 8:00 pm. - Desyrel: 8/7/18 8:00 pm. - Denta Plus: 8/1/18 - 8/31/18 8:00 am and 8:00 pm.	V 118		

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V 118	Continued From page 11 - Haldol: 8/7/18 8:00 pm. - Lithium Carbonate: 8/7/18 8:00 pm. Review on 10/17/18 of Client #3's MAR for September 2018 revealed: -The following medications were not documented as administered: - Risperdal 2 mg: 9/11/18 8:00 pm. - Denta 5000 Plus: 9/2/18 8:00 am; 9/3/18 8:00 am; 9/5/18 8:00 am; 97/18 8:00 pm; 9/8/18 8:00 am; 9/11/18 8:00 pm; 9/12/18 8:00 am; 9/12/18 8:00 pm; 9/23/18 8:00 pm; and 9/26/18 8:00 pm. - Metamucil: 9/2/18 8:00 pm. - Haldol: 9/2/18 8:00 pm. - Lithium Carbonate: 9/2/18 8:00 pm. - Melatonin: 9/2/18 8:00 pm. Client #3 declined to participate in an interview. Interview on 10/17/18 Staff #4 stated: - He had been employed with the facility for about 3 months. - He had received training in medication administration. - Medications were always available in the facility with at least a one week supply being kept on hand; medications were inventoried daily between shifts. Interview on 10/17/18 Staff #2 stated: - One of her responsibilities was to administer medications. - Medication inventory was completed daily with count of the medicines. - If there was a problem then she would contact the Licensee or the Clinical Director. - Medications were always available since she had been working. Interview on 10/17/18 and 10/18/18 the Facility	V 118		

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SIR ARTHUR	409 SOUTH SHORE DRIVE JACKSONVILLE, NC 28546

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V 118	Continued From page 12 Clinical Director stated: - She could not explain the discrepancies on the MARs. -The staff had been trained to follow the prescriptions of the clients and not just the MARs. - Additional medication administration training had been provided since last survey. - She stated that the documentation of the creams and soaps had been an issue discussed in a staff meeting as the 11- 7 shift and 7 - 3 shift were in conflict of who would document. It was in the process of being resolved for the facility. Interview on 10/19/18 the Licensee stated: - She was aware of some issues with the MARs and the facility's Certified Medical Assistant had been on medical leave therefore she had been reviewing the MARS herself. - Facility staff were trained to compare information on the MARs to the medication labels and the signed prescriptions filed in each client's record each time medication was administered. MAR documentation would be reviewed with staff to ensure compliance. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		