STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-169	A. BUILDING: _____ B. WING _____	11/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH'S PLACE	101 WEST CAMERON COURT JACKSONVILLE, NC 28546

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V 000	INITIAL COMMENTS An annual survey was completed on November 1, 2018. 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 drills were held quarterly and repeated on each shift. The findings are: During interview on 11/1/18 Qualified Professional #1 stated the facility operated with three shifts: 1st 7:00 am - 3:00 pm, 2nd 3:00 pm - 11:00 pm, 3rd 11:00 pm - 7:00 am. Review on 11/1/18 of the facility's disaster drill	V 114		

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V 114	Continued From page 1 documentation revealed no documented disaster drill for the 3rd shift during the third quarter (October - December) 2017; the 1st shift during the first quarter (January - March) 2018; or the 3rd shift for the third quarter (July - September) 2018. During interview on 11/1//18 Qualified Professional #2 stated drills at the facility had not always been completed as required. The Licensee implemented a new system to ensure the completion of drills and the drills were now being completed on a set schedule.	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, observations, and interviews the facility failed to administer medications as ordered by the physician and to ensure medications administered were recorded on each client's MAR immediately after administration for 3 of 3 audited clients (#1, #2, and #3). The findings are: Review on 11/1/18 of client #1's record revealed: - 54 year old female admitted to the facility 4/21/18. - Diagnoses included Moderate Intellectual/Developmental Disability, Down Syndrome, Seizure Disorder, Anxiety Disorder, Obsessive Compulsive Disorder, Dementia, not otherwise specified, and Arthritis. - Signed physician's order dated 3/26/18 for Dilantin (anti-convulsant) 100 mg one tablet twice daily; orders dated 4/3/18 for Aricept (treats confusion related to dementia) 10 mg one tablet at bedtime, Desyrel (antidepressant) 100 mg two tablets at bedtime; order dated 5/11/18 for Mupirocin 2% Ointment (treats skin infections) apply twice daily; order dated 9/5/18 for Voltaren Gel (anti-inflammatory cream) apply 2 grams topically to affected area four times daily.	V 118		

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V 118	Continued From page 3 Review on 11/1/18 of client #1's MARs for August - November 2018 revealed: - Transcriptions for 8:00 pm administration of Dilantin, Aricept, Desyrel, Mupirocin Ointment, and Voltaren Gel. - A "D" written in the staff initial boxes for Dilantin, Aricept, Desyrel, Mupirocin Ointment, and Voltaren Gel, at 8:00 pm 9/14/18. - The reverse side of the MAR included "Charting Codes . . . D - Drug not given indicate reason in Nurse's Medication Notes." - Handwritten note on the reverse side of the September MAR dated 9/14/18 and signed by Qualified Professional #1 "medications not given at 8:00 pm as individual was in hotel due to Hurricane Florence incident report completed." - A "D" written in the staff initial boxes for Voltaren Gel, 12:00 pm, 4:00 pm, and 8:00 pm 8/9/18 and 8:00 am 8/10/18. - Handwritten notes on the reverse side of the August MAR "8-9-18 12pm . . . 8-9-18 8 pm . . . 8-10-18 8 am Voltren Gel . . . out of medication." Review on 11/1/18 of client #1's MARs for August - November 2018 revealed: - Transcriptions for Aricept and Desyrel to be administered at 8:00 pm; Mupirocin Ointment to be administered at 8:00 am and 8:00 pm; and Voltaren Gel to be administered at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm. - No staff initials to indicate Aricept was administered 10/21/18 or 10/24/18. - No staff initials to indicate Mupirocin Ointment was administered at 8:00 am 10/6/18 or 10/7/18. - No staff initials to indicate Desyrel was administered 10/24/18. - No staff initials to indicate Voltaren Gel was administered at 4:00 pm 10/3/18, 10/8/18, 10/17/18, 10/22/18, or 10/30/18. - "Nurse's Medication Notes" on the reverse of	V 118		

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V 118	Continued From page 4 the MAR with hand written note "10/30 4 pm Voltaren 1% Gel 2 grams out of facility." - No further documentation of the reasons for the omissions. Observations on 11/1/18 at approximately 12:15 pm of client #1's medications on hand revealed: - Dilantin 100 mg one tablet twice daily 9/21/18 dispensed 9/21/18 - Aricept 10 mg one tablet at bedtime dispensed 9/21/18. - Desyrel 100 mg two tablets at bedtime dipensed 9/21/18. - Mupirocin 2% Ointment apply twice daily dispensed 8/10/18. - Voltaren Gel Apply 2 grams topically to affected area four times daily dispensed 10/30/18. Client #1 did not provide any meaningful information during attempted interview on 11/1/18. Review on 11/1/18 of client #2's record revealed: - 34 year old female admitted to the facility 5/21/07. - Diagnoses included Severe Intellectual/Developmental Disability, Seizure Disorder, Migrational Anomaly Lissencephaly bilateral temporal lobes, and Beta-propeller Protein Associated Neurodegeneration. - Signed physician's order dated 3/21/18 for Lotrisone Cream (treats fungal infections) apply to skin and nails every other day; order dated 5/17/18 for Tylenol (analgesic) 650 mg two tablets every 8 hours as needed; orders dated 7/5/18 for Lamictal (treats seizures) 100 mg one tablet twice daily with 25 mg tablets and Lamictal 25 mg one tablet twice daily with 100 mg tablets; and order dated 8/17/18 for Requip (treats Parkinson's Disease and restless leg syndrome)	V 118		

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V 118	Continued From page 5 .5 mg two tablets three times daily. Review on 11/1/18 of client #2's MARs for August - November 2018 revealed: - Transcriptions for 8:00 pm administration of Lamictal, and Requip. - A "D" written in the staff initial boxes for Lamictal and Requip at 8:00 pm 9/14/18. - The reverse side of the MAR included ""Charting Codes . . . D - Drug not given indicate reason in Nurse's Medication Notes." - Handwritten note on the reverse side of the September MAR dated 9/14/18 and signed by Qualified Professional #1 "medications not given at 8:00 pm as individual was in hotel due to Hurricane Florence incident report completed." - Transcription for Lotrisone Cream to be applied to affected nails and skin every other day at 8:oo pm. - No staff initials to indicate Lotrisone Cream was applied 10/1/18, 10/5/18 or 10/7/18. - "NA" written in the staff initials box 10/3/18. - "Nurse's Medication Notes" on the reverse of the MAR with handwritten note "10-9-18 Clottimazole-Betamethasone [generic for - Lotrisone Cream] 45 gm [grams] med [medication] was not given. - No further documentation of the reasons for the omissions. - Transcription for Tylenol 650 mg two tablets every 8 hours as needed; staff initials indicated the medication had been administered three times in October, 2018. Observation on 11/1/18 at approximately 1:00 pm of client #2's medications on hand revealed: - Lotrisone Cream apply to skin and nails every other day dispensed 7/30/18. - Lamictal 100 mg one tablet twice daily with 25 mg tablets (of Lamictal) dispensed 9/21/18.	V 118		

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V 118	Continued From page 6 - Lamictal 25 mg one tablet twice daily with 100 mg tablets (of Lamictal) dispensed 9/21/18. - Requip .5 mg two tablets three times daily dispensed 10/19/18. - Tylenol 325 mg one tablet every 6 hours as needed, dispensed 10/18/18. - No Tylenol 650 mg available for administration. Client #2 did not respond to questions during attempted interview on 11/1/18. Review on 11/1/18 of client #3's record revealed: - 51 year old female admitted to the facility 6/26/02. - Diagnoses included Anxiety Disorder, not otherwise specified, Mild Intellectual/Developmental Disability, Traumatic Brain Injury (post-concussion syndrome). - Signed physician's order dated 2/24/18 for 4/5/18 for Saline Mist (moisturizes dry nasal passages) 2 sprays to each nostril twice daily; orders dated 6/18/18 for Zyrtec (antihistamine) 10 mg one tablet at bedtime, Pravachol (treats high cholesterol) 20 mg one tablet at bedtime; order dated 6/22/18 for Miralax (laxative) mix 1 capful in 8 ounces of fluid and drink every other morning; order dated 6/29/18 for Tylenol 500 mg one tablet every six hours as needed; order dated 7/12/18 for Nystatin (treats fungal infections) apply by topical route twice daily to affected area until clears (left groin); orders dated 10/25/18 for Ativan (anti-anxiety) 1 mg one tablet three times daily, Seroquel (anti-psychotic) 200 mg one tablet every evening, Seroquel 100 mg one tablet every morning and after lunch, Desyrel 100 mg one tablet at bedtime. Review on 11/1/18 of client #3's MARs for August - November 2018 revealed: - Transcriptions for 8:00 pm administration of	V 118		

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V 118	Continued From page 7 Saline Mist, Zyrtec, Pravachol, Ativan, Seroquel, and Desyrel. - A "D" written in the staff initial boxes for Saline Mist, Zyrtec, Pravachol, Ativan, Seroquel, and Desyrel at 8:00 pm 9/14/18. - The reverse side of the MAR included ""Charting Codes . . . D - Drug not given indicate reason in Nurse's Medication Notes." - Handwritten note on the reverse side of the September MAR dated 9/14/18 and signed by Qualified Professional #1 "medications not given at 8:00 pm as individual was in hotel due to Hurricane Florence incident report completed." - Pre-printed transcription for Miralax to be administered once a day at 8:00 am with "every other" handwritten at the end of the transcription. - No staff initials to indicate Miralax was administered 10/3/18, 10/5/18, 10/6/18, 10/8/18, 10/9/18, or 10/10/18. - Transcription for Seroquel to be administered at 8:00 am and 12:00 noon. - No staff initials to indicate Seroquel 100 mg was administered at 12:00 pm on 10/17/18. - No documentation of the reasons for the omissions. - Transcription for Nystatin Cream to be applied "twice daily to affected area until clears . . . " - "D" written in the staff initial boxes 27 times on the October MAR. - The reverse side of the MAR included ""Charting Codes . . . D - Drug not given indicate reason in Nurse's Medication Notes." - "Nurse's Medication Notes" on the reverse of the MAR with hand written notes 10/8/18 - 10/14/18, and 10/17/18 - 10/18/18 "Nystatin . . . not in home." - Transcription for Tylenol 325 mg one tablet every six hours as needed with a line drawn through "325 mg" and "500 mg" handwritten; staff initials indicated Tylenol had been administered	V 118		

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V 118	Continued From page 8 twice in October. Observation on 11/1/18 at approximately 12:40 pm of client #3's medications on hand revealed: - Saline Mist .65% 2 sprays to each nostril twice daily dispensed 10/8/18. - Zyrtec 10 mg one tablet at bedtime dispensed 9/21/18. - Pravachol 20 mg one tablet at bedtime dispensed 10/19/18. - Miralax mix 1 capful in 8 ounces of fluid and drink every other day dispensed 10/8/18. - Tylenol 325 mg one tablet every six hours prn dispensed 8/1/17. - Nystatin 1000,000 units/gram apply by topical route twice daily to affected area until clears dispensed 8/15/18. - Ativan 1 mg one tablet three times daily dispensed 9/25/18. - Seroquel 200 mg one tablet in the evening dispensed 10/22/18. - Seroquel 100 mg one tablet in the morning and one at lunchtime dispensed 9/25/18. - Desyrel 100 mg one tablet at bedtime dispensed 9/21/18.. - No Tylenol 500 mg available for administration. During interview on 11/1/18 client #3 stated she took her medications every day with staff assistance. Review on 11/1/18 of "DHHS Incident and Death Reports" for each of the clients dated 9/26/18 and signed by QP#2 revealed: - "Briefly describe the incident . . . At 9pm, Provider attempted to administer [client #3] meds [medications] while staying at the hotel in Charlotte, NC [North Carolina] (mandatory evacuation from Hurricane Florence. Another Provider (Directors Daughter) stated; you don't	V 118		

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V 118	Continued From page 9 have to go in the girls rooms, they have already had meds and showers; 8pm meds were missed." - "Describe the cause of the incident; why did the incident occur? Relocation from Hurricane Florence. Confusion, out of routine, miscommunication. Describe how this type of incident may be prevented in the future and any corrective measures that have been or will be put in place as a result of the incident. Regular dosing resumed next day. Director spoke to staff regarding shift responsibilities and assignments." During interview on 11/1/18 QP #1 stated she was responsible for checking the MARs for accuracy and completion. She felt sure the medications had been administered as ordered, but the staff failed to document their initials on the MARs at the time the medications were administered. Omissions of medications were medication errors. If a client missed medications she would complete a level 1 incident report and notify the physician or pharmacist. During interview on 10/31/18 QP #2 stated the entire community was under mandatory evacuation during a recent hurricane. The clients were evacuated to a hotel in Charlotte, approximately 4 ½ hours away. The clients missed their 8:00 pm medications on 9/14/18 due to a miscommunication between staff while at the hotel. She learned of the missed medications when the clients returned to the facility approximately one week later. She completed level 1 incident reports but did not notify the doctors or pharmacist of the missed medications because of the amount of time between the missed doses and the clients' return to the facility. The clients did not seem to suffer any adverse effects from missing their medications.	V 118		

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V 118	Continued From page 10 Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician.	V 118		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to obtain drug regimen reviews for 1 of 3 audited clients (#2) who received psychotropic drugs. The findings are: Review on 11/1/18 of client #2's record revealed: - 34 year old female admitted to the facility 5/21/07. - Diagnoses included Severe Intellectual/Developmental Disability, Seizure Disorder, Migrational Anomaly Lissencephaly bilateral temporal lobes, and Beta-propeller	V 121		

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V 121	Continued From page 11 Protein Associated Neurodegeneration. - Physician's orders signed 7/5/18 for Lamictal (treats seizures) 100 mg one tablet twice daily with 25 mg tablets and Lamictal 25 mg one tablet twice daily with 100 mg tablet. - Medication regimen review signed by the pharmacist 12/14/17. - No documentation of subsequent drug regimen reviews by the physician or pharmacist. Review on 11/1/18 of client #2's MARs for August - November 2018 revealed transcriptions for Lamictal 100 mg one tablet once daily with 25 mg tablets, and Lamictal 25 mg one tablet twice daily with 100 mg tablets. During interview on 11/1/18 Qualified Professional #2 stated the Licensee changed pharmacies at the beginning of the year and the drug regimen reviews had not been done since December. She would request the new pharmacy to conduct drug regimen reviews every six months as required.	V 121		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview the facility was not maintained in a clean and safe manner. The findings are:	V 736		

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V 736	Continued From page 12 Observations of the facility on 11/1/18 at approximately 11:50 am revealed: - Dried food splatters inside the microwave. - The air return in the hall ceiling had a heavy coating of dust and lint. - Client #2's bedroom ceiling was dusty around the ceiling fan. - There was a dried brown stain on the rim of the toilet bowl in the hall bathroom. - A throw rug at the front door presented a tripping hazard for the clients. - There was no handle on the latch of the front storm door. - 6 full garbage bags and a window screen were lined against the outside garage wall. During interview on 11/1/18 Qualified Professional #1 stated she saw the stain on the toilet bowl, but was not aware of the other issues discussed.	V 736		