STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on January 8, 2019. Deficiencies were cited. The complaint was substantiated. (Complaint ID #NC00145435.) This facility is licensed for the following service category: 10A NCAC 27G .5600 C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner.	V 117		

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V 117	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility staff failed to assure medication prescribed for 1 of 3 audited clients (#1) retained a current dispensing date. The findings are: Review on 1/3/19 of Client #1's record revealed: - Admission date of 9/15/90 - Diagnoses of Down's Syndrome, Intellectual Disability, Moderate; Disruptive Mood Dysregulation Disorder; Psoriasis, Severe; Cardiac Pacemaker; Hypothyroidism and Allergic Rhinitis. - Assessment documenting the client picks and scratches his skin causing sores. - Physician's orders all dated 8/14/18 for the following medications to treat his psoriasis: 1. Aveeno Moisturizing Bar Soap - Use to bathe daily. 2. Triamcinolone Acetone 0.1% Topical Ointment - Apply sparingly twice a day for patch on right arm until flat 3. Cerave Moisturizing Cream - To keep at bedside and apply liberally as needed. - Documentation on the past six months of the client's MARs (August 2018 through January 2019) that the above medications were administered as ordered. Observation on 1/4/19 of Client #1's medications-on-hand revealed: 1. Aveeno Moisturizing Bar Soap: eight boxed bars with dispense dates = 8/15/18; 10/1/18; 10/16/18; 11/1/18; 12/1/18; 12/15/18; 1/1/19 and	V 117		

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V 117	Continued From page 2 1/16/19. - Box dated 12/1/18 was in an opened box, however, the bar was unused. 2. Triamcinolone Acetone 0.1% Topical Ointment: six boxes with dispense dates = 6/1/17; 12/1/17; 5/10/18; 8/1/18; 10/1/18 and 12/1/18. - Container dated 12/1/18 was partially used and stored (with the original dispense label) in a plastic bag. All other tubes of the medication retained storage in the originally dispensed box and were unopened/unused. - Containers dated as dispensed on 6/1/17 and 12/1/17 were not within the current expiration date. 3. Cerave Moisturizing Cream: four large jars. Three jars appeared full and unused. Jars had expiration dates 5/2/18; 7/2/18; 12/1/18. One jar, dispensed on 8/1/18, was in the client's bedroom and appeared to have been opened. During interview on 1/4/18, the Team Leader, Qualified Professional confirmed: - Confirmed the expiration date of the medications identified above with expired dates. - She confirmed staff documented the soap and creams were being used as directed to address the client's skin disorder. However, she was unable to explain why the client's medication box contained a large quantity of the medications which appeared to be unused.	V 117		
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	V 118		

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V 118	Continued From page 3 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. (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 and interviews, the facility staff failed to administer medication as ordered by a physician for 2 of 3 (#1 & #2) audited clients and failed to keep the MAR current for 1 of 3 audited clients (#2.) The findings are: Cross Reference: 10A NCAC 27G .5603, OPERATIONS, Tag V291 - Based on record reviews and interviews, the facility staff failed to	V 118		

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maintain coordination of care with the physician affecting 1 of 3 (#1) audited client's physical health.

Review on 1/3/19 of Client #1's record revealed:
- Admission date of 9/15/90
- Diagnoses of Down's Syndrome, Intellectual Disability, Moderate; Disruptive Mood Dysregulation Disorder; Psoriasis, Severe; Cardiac Pacemaker; Hypothyroidism and Allergic Rhinitis.
- A "Standing Order" form dated 5/2/18 signed by the client's Family Nurse Practitioner (FNP) included a check next to all of the following over-the-counter medications authorizing the medications to be administered to the client for "cough, cold, headache:"
1. Tylenol 500mg - 2 every 4 - 6 hours for fever over 100 degrees or mild pain. Call RN (Registered Nurse) if fever still over 100 degrees after 24 hours.
2. Tussin Expectorant (Guaifenesin) 10 cc - 2 teaspoons (tsp) four times a day for 4 days for cough and congestion.
3. Chloraseptic Spray - Spray throat five (5) times and swallow. May repeat every 2 hours as needed for irritated throat. Call RN for temperature 100 degrees.
4. Robitussin DM - 10 cc (2 tsp) four times a day for four days (4) as needed for cough without nasal congestion.

Additional review on 1/3/19 of Client #1's chart revealed a hospital discharge summary dated 8/10/18 documenting the following:
- Client was admitted to hospital on 8/4/18 presenting with complaints of wheezing and shortness of breath.
- Diagnoses: Bilateral interstitial pneumonia; Acute hypoxemic respiratory failure (insufficient

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oxygen for body tissues to function;) acute kidney injury (AKI - abrupt loss of kidney function usually developing within seven days; previously identified as renal failure); hyperkalemia - abnormally high levels of potassium in the blood and hyponatremia - low level of sodium in the blood (both related to loss of kidney function;) leukocytosis (above normal expected white blood count) and dehydration.
- All conditions were treated with resolution of the kidney related issues.
- The client was discharged with an "OME (?) supply" - oxygen at 3L per minute via nasal cannula daily.
- Follow-up appointment with his primary care physician for 8/16/18.

Review on 1/3/19 of Client #1's hospital follow-up visit with his physician on 8/16/18 revealed:
- Oxygen level in the client's blood was low.
- He was placed on permanent Oxygen at 4L per minute via nasal cannula daily.

Further review on 1/3/19 of Client #1's chart revealed:
- July 2018 thru August 2018 MAR's, staff documented the client was administered Tussin Expectorant DM on the following days with the corresponding response:
1. 7/28/18, 8:45 AM = "Tussin DM - cough and chest congestion; felt better" No indication of dose.
2. 7/29/18, (no time) = "Tussin DM - cough and chest congestion; felt better" No indication of dose.
3. 7/30/18, 9:00AM = "Tussin; felt better" No indication of dose.
4. 7/30/18, 4:30 PM = "Tussin; felt better" No indication of dose.
5. 7/31/18, 8:00 AM = "Tussin; felt better" No

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indication of dose.
6. 8/2/18, 8:00 AM = "Tussin; Sore throat and cough. Decreased cough. Felt a little better." No indication of dose.
- Progress notes during the week (7/26/18) prior to the client's hospitalization through the date of hospitalization (8/4/18) staff documented:
- For 7/26/18 through 7/31/18:
1. No concerns or complaints noted.
2. Client ate all meals, performed all daily tasks and attended the day program each day.
- On 8/1/18:
1. Client informed staff he "didn't feel good" when staff tried to wake him to begin the day.
2. He requested to stay home and not attend the day program.
3. Staff administered his medication and client ate his breakfast.
4. Client "completed some chores" then went to "lie down for a little while."
5. He informed staff he would attend the day program on 8/2/18.
- On 8/2/18:
1. Upon awakening, client again informed staff he "didn't feel good."
2. He requested to stay home and not attend the day program until the following Friday, August 10th.
3. Staff "encourage [Client #1] to eat breakfast and take his meds and then he desired to lay back down."
4. Staff noted "[Client #1] did not attend [day program] today!"
- On 8/3/18:
1. Client did not attend the day program
2. Staff noted the client was "continuously not feeling well."
3. Home Manager made an appointment for Client #1 to see his primary care doctor for "a cold, headache, wheezing."

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V 118	Continued From page 7 - On 8/4/18, Client #1 was admitted to hospital as identified in the information above. - No documentation was found of the client's temperature for this time period. Interview on 1/4/19 with the Residential Manager revealed she: - documented Client #1 "cough and chest congestion." - administered Tussin DM to Client #1 for two days to treat the cough and congestion - 7/28/18 and 7/29/18 - called the client's primary care doctor to make an appointment. - was uncertain when she first began attempting to make the appointment, however, she said the doctor did not have appointments available until 8/3/18. - did not discuss the client's condition with the doctor's office when she attempted to make the appointment. - took the client to the his appointment and his doctor immediately admitted him to the hospital on 8/4/18. During interview on 1/4/19, Staff #1 reported: - "We use over-the-counter medications (as per the standing order) to try to keep them (clients) from having to go to the doctor all the time." - When she reported to work on 7/30/18, she noted Client #1 seemed to have a "common cold" - She thought the client got the cold due to the frequent changes in the weather and exposure to different environments and temperatures - "library, bowling alley, church, meals on wheels, day program, it's much colder - they have a lot of changes." - Client #1 was "doing a little coughing," but did not appear to be in distress and acted normally. "He changed his room around several times	V 118		

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before he went to the hospital."
- "He didn't complain. He doesn't like to miss going to the program (day program.) He has a lot of friends there."
- She looked at staff notes to see if other staff had noted any complaints or began administering any medication to treat the condition and reviewed his MAR.
- She communicated with the managers regarding his condition; had the client cough so she could hear how it sounded and asked him if he was okay.
- She was directed to follow the standing order to treat Client's #1's cough..
- She administered the client Tussin DM for 2 days, 7/30/18 (x2) and 7/31/18.
- She said she took client's temperature however, she did not record the temperature results. "We take their temperature every morning if they're not feeling well."
- Client #1 did not improve so the Residential Manager made an appointment for him to see his doctor.

During interview on 1/3/19, the Team Leader/Qualified Professional reported:
- Client #1 was placed on daily oxygen use after hospitalization for pneumonia last year. He has a backpack with his oxygen when out of the facility and for the day program.
- Client #1 did not have a cough. He said he didn't feel good.
- Staff then attempted to treat Client #1 at the facility.
- She was uncertain if staff took Client #1's temperature.
- Staff administered Tussin DM as per the standing order because the client did not have nasal congestion.
- Staff followed the standing order because they

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thought the client had a cold.
- She confirmed staff:
1. administered Client #1 Tussin DM for more than four days as directed on the doctor's order and
2. did not document the dose of Tussin DM administered to Client #1.

Review on 1/4/19 of Client #2's record revealed:
- Admission date of 5/18/18
- Diagnoses of Major Neurocognitive Disorder Due to Traumatic Brain Injury; Hypothyroidism; Anxious Depression and Asthma
- A "Standing Order" form dated 5/2/18 signed by the client's FNP included a check next to all of the following over-the-counter medications authorizing the medications to be administered to the client for "cough, cold, headache:"
- Documentation the client was taken to the doctor's office on 8/3/18, the same day as Client #1 and with similar symptoms. However, she was not admitted to the hospital.
- During the 8/3/18 visit, her physician ordered the following medications to treat her respiratory illness:
1. Prednisone 20 mg, 2 tablets for 3 days, 1 tablet for 3 days and one-half tablet for 3 days with food (a total of 9 days)
2. Mucinex DM Maximum Strength 1200 mg, Oral tablet, Extended Release - One tablet twice a day for 10 days.
- An August 2018 MAR documenting:
1. Staff administered the Prednisone 20 mg for five days - 8/4/18 to 8/9/18. No documentation was found of the specific daily dose the client was administered for that five day period.
2. Mucinex DM was administered as ordered for 10 days - 8/4/18 through 8/14/18.

Further review on 1/4/19 of Client #2's record

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revealed:
- A physician's order dated 10/3/18 - Celexa 20 mg, one half tablet at hour of sleep.
- October 2018, November 2018, December 2018 and January 2019 documenting the medications Client #2 was administered.
- However, the above MARs did not have transcription nor documentation the Celexa 20 mg. one half tablet at hour of sleep was administered to Client #2.

During further interview on 1/4/19, the Residential Manager reported:
1. In response to questions related to administration and documentation of the Prednisone 20 mg ordered by the client's physician on 8/3/18:
- Staff administered the client's Prednisone 20 mg for 9 days in the dose ordered by her physician for each day beginning on "8/1/18."
- The medication was not on the pharmacy transcribed August 2018 MAR so staff wrote it on the pharmacy printed MAR, however, the daily dose was not separated out for staff to document each specific daily dose.
- The agency's RN later provided a typed August 2018 MAR with Client #2's daily dose of Prednisone transcribed with the specific dose to be administered each day.
- The correct documentation was on the typed August 2018 MAR. However, she was initially unable to locate this typed MAR.
- She later corrected and said staff did not begin administering the Prednisone 20 mg to the client until 8/4/18 as documented on the MAR. She also said staff began administering the medication on 8/4/18 because:
a) the pharmacy did not have the medication
b) the pharmacy had to wait on the guardian for permission to order it and receive payment (the

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V 118	Continued From page 11 client is self pay) 2. In response to questions related to administration and documentation of the Celexa 20 mg ordered on 10/3/18 by the client's physician: - Initially reported Client #2's doctor discontinued Celexa 20 mg after 7 days. - She later corrected and reported Client #2's doctor wanted to talk to the client's guardian regarding continuation of the Celexa. - She believes the doctor talked to the guardian who made a decision not to continue the Celexa because Client #2 "was crying a lot." - She "thinks" the doctor notified the pharmacy regarding discontinuing the Celexa. - She was unable to provide a discontinue order, however, she would obtain one from the pharmacist. Review on 1/8/19 of additional documents for Client #2 submitted by the Residential Manager (RM) revealed: 1. A typed August 2018 MAR as documentation related to the above concerns about Client #2's Prednisone 20 mg. The MAR documented the client was administered Prednisone in the following doses on the following days: - 8/15 thru 8/17 - three tablets - 8/18 thru 8/20 - two tablets - 8/21 thru 8/23 - one tablet - 8/24 thru 8/26 - one-half tablet. 2. A copy of a handwritten prescription for Remeron: - The order was dated 10/8/18 and signed by the client's physician. - "D/C (discontinue) Remeron 15 mg. Start Remeron 30 mg." - Across the top of the order a note was written under the Client #2's name on the address line. "Discontinue Celexa 20 mg ??? as necessary"	V 118		

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V 118	Continued From page 12 (The prescription was a faxed copy which made the writing unclear/unreadable.) During further discussion on 1/8/19, the Residential Manager said: - Client #2's condition did not improve so she returned to the doctor on 8/14/18 and received a prescription for additional Prednisone. - The typed August 2018 MAR from the nurse that she provided was documentation of the administration of the additional order for Prednisone after the client's 8/14/18 doctor's visit. - She was certain the agency's RN completed a typed August 2018 MAR with transcription of the Prednisone 20 mg as ordered on 8/3/18. - However, she was unable to provide an August 2018 MAR with staff documentation they administered each daily dose as ordered. - She was also unable to clarify the handwritten prescription for Remeron dated 10/8/13 with the note "Discontinue Celexa 20 mg." Due to the above confusion in dates on the documents submitted regarding Client #2's Prednisone and Celexa , it was not possible to determine if staff administered the medication as ordered. Review of the Plan of Protection dated 1/8/19 submitted by the Team Leader/Qualified Professional revealed: What will you immediately do to correct the above violations in order to protect clients from further risk or additional harm? "Anson Group Home will provide the following outlines below to protect clients from further risk or additional harm: 1. Staff will follow the orders on all medication given by doctor's or standing orders as it is written.	V 118		

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	MHL004-003	A. BUILDING: _____ B. WING _____	01/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSON GROUP HOME	405 BURNS STREET WADESBORO, NC 28170

(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 118	Continued From page 13 2. Make sure any standing order(s) that are given is written and dated correctly on the MAR. 3. Staff will not give any medication pass the number of days the doctor has prescribe. 4. Staff will seek outside immediate attention, emergency room, urgent care, if primary care doctor is available after medication is prescribed by primary doctor. 5.) Staff will provide clear documentation, transcribe all medication correctly on MAR'S and will seek other outlets for assistance if needed 6.) Staff will document all doctor's appointments made or attempted in the phone log book." Describe your plans to make sure the above happens. "The plans to make sure the above plans happen: By January 10th staff will be retrained by QP and/or RM on how to transcribe standing orders correctly on the MAR'S, document temperatures on the MAR'S when they are sick, and the proper protocol and communication (on-call) when PWS (People We Serve) are sick or not feeling well and seek medical attention as define by standing orders. Residential Manager will also check order's, medication and MAR'S on every Monday. Staff will start documenting every doctor's appointment made or attempted on the calendar and in the phone log book." The facility utilized a standing order form outlining over the counter medications to be used for minor ailments for all their clients. This form included an order for Tussin Expectorant (Guaifenesin) 10 cc - 2 teaspoons (tsp) four times a day for 4 days for cough and congestion. Client #1 had diagnoses which included Down's syndrome and cardiac disease requiring an implanted pacemaker. He first complained of cough and chest congestion on 7/28/18. Client #1 continued to complain of cough, chest congestion,	V 118		

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V 118	Continued From page 14 headache and fatigue through 8/3/18. Facility staff continued to administer the Tussin beyond the four days of the standing order. Client was too ill to attend the day program on 8/1/18, 8/2/18 and 8/3/18. Despite, client #1's compromised respiratory status due to the Downs syndrome and cardiac history the facility did not seek nursing or medical intervention until a physician's appointment was made on 8/4/18. As a result of this physician's visit, Client #1 was immediately admitted to the hospital with diagnoses of bilateral pneumonia, acute respiratory distress, dehydration and kidney failure. The decision to continue the over-the-counter medication and failure to contact the physician when these symptoms persisted delayed treatment of these serious medical conditions constituted serious neglect. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000.00 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		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be	V 291		

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V 291	Continued From page 15 maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility staff failed to maintain coordination of care with the physician affecting 1 of 3 (#1)audited client's physical health. The findings are: Review on 1/3/19 of Client #1's record revealed: - Admission date of 9/15/90 - Diagnoses of Down's Syndrome, Intellectual Disability, Moderate; Disruptive Mood Dysregulation Disorder; Psoriasis, Severe; Cardiac Pacemaker; Hypothyroidism and Allergic Rhinitis. Review on 1/4/19 of staff documentation on Client #1's August 2018 MAR revealed:	V 291		

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V 291	Continued From page 16 - Staff documented they administered Tussin Expectorant DM beginning 7/28/18 to resolve the client's cough and chest congestion. - Staff continued to administer over-the counter medication thru 8/2/18. - Staff documented symptoms he displayed included cough, congestion, sore throat, headache, wheezing, shortness of breath and fatigue. Additional review on 1/4/19 of staff documentation revealed: - No documentation was found of contact with a physician between 7/28/18 and 8/3/18 to obtain information on how to address Client #1's condition in consideration of his medical diagnoses. - Staff did not consult with his physician regarding the symptoms he displayed as they thought the symptoms were signs of a common cold. - Client #1's condition did not improve and staff continued to administer the over-the counter medication. - Staff made management aware of the client's condition when she reported to work on 7/30/18. - The Residential Manager made an appointment with his doctor on 8/3/18, however no documentation was found that staff coordinated with the client's physician to inform his doctor about his presenting symptoms and worsening condition. - The client's doctor immediately hospitalized the client on 8/4/18 after the appointment and he was diagnosed with pneumonia in both lungs. This deficiency is cross referenced into 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (V118) for a Type A1 and must be corrected within 23 days.	V 291		