STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL074-239	A. BUILDING: _____ B. WING _____	R 02/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWBROOK	1111 MEADOWBROOK DRIVE GREENVILLE, NC 27834

(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 An annual and follow-up survey was completed on February 21, 2019. 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	RECEIVED By DHSR - Mental Health Lic. & Cert. Section at 10:13 am, Mar 08, 2019	
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered, and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the physician or pharmacist of medication errors and document refusals affecting one of two audited clients (#1). The findings are: Review on 02/19/19 and 02/20/19 of client #1's record revealed: - 49 year old female. - Admission date of 03/12/14. - Diagnoses of Cerebral Palsy-Not Otherwise Specified, Moderate Intellectual Developmental Disability, Generalized Anxiety Disorder and Seizure Disorder.	V 123	**V123**: QP/RD to provide in-service to all staff on Incident Reporting with main focus on medication errors refusals/Level 1(s). DCP staff will receive additional training on how to complete these reports in EHR – Therap. Policy on medication errors will also be reviewed with staff. All Level 1 incident reports will be completed in EHR-Therap. Inservice provided to QPs and RDs in staff meeting. QPs will address above issues with DCP in monthly supervision in Therap throughout POC (March and April). RD/QP will review medication refusals on weekly basis on MAR and ensure that the Level 1 report is completed by DCP. Appropriate steps will be followed as noted in in-service.	4-22-19 3-5-19

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V 123	Continued From page 1 Review on 02/19/19 of client #1's signed physician orders dated 11/08/18 revealed: - Norvasc (treats high blood pressure) 10 milligrams (mg) - take one tablet daily. - Abilify (antipsychotic) 10mg - one tablet daily. - Aspirin (treats aches) 81mg - take one tablet daily. - Lexapro (antidepressant) 10mg - take one tablet daily. - Flonase (treats allergies) - 2 sprays daily. - Folic Acid (vitamin) 1 mg - one tablet daily. - Zyrtec (treats allergies) 10mg - one tablet daily. - Multivitamin (treats vitamin deficiency) - take one tablet daily. - Tegretol (treats seizures) 200mg - take one tablet three times daily. - Voltaren Gel (treats pain) apply three times daily. - Lipitor (treats high cholesterol) 20mg - take one tablet daily. - Sinequan (treats anxiety) 50mg - take one capsule daily. - Ditropan (treats urinary incontinence) 5mg - take one tablet daily. - Saline Mist (treats nasal issues) - one spray in each nostril at bedtime. Review on 02/19/19 of client #1's February 2019 MAR revealed the following dates and times of staff initials circled to indicate client's refusal of medications and no documentation a physician or pharmacist was immediately notified of refusals: - Norvasc - 02/17/19 at 8am. - Aspirin - 02/17/19 at 8am. - Lexapro - 02/17/19 at 8am. - Flonase - 02/17/19 at 8am. - Folic Acid - 02/17/19 at 8am. - Zyrtec - 02/15/19 thru 02/17/19 at 5pm. - Multivitamin - 02/15/19 thru 02/17/19 at 5pm. - Tegretol - 02/05/19 at 8pm, 02/14/19 thru 02/16	V 123		

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V 123	Continued From page 2 at 8pm and 02/17/19 at 8am and 12pm. - Voltaren Gel - 02/14/19 thru 02/16/19 at 4pm and 8pm and 02/17 at 8am and 12pm. - Lipitor - 02/05/19 and 02/14/19 thru 02/16/19 at 8pm. - Sinequan - 02/05/19 and 02/14/19 thru 02/16/19 at 8pm. - Ditropan - 02/05/19 and 02/14/19 thru 02/16/19 at 8pm. - Saline Mist - 02/14/19 thru 02/16/19 at 8pm. Interview on 02/20/19 client #1 stated: - She lived at the facility for several years. - She had been refusing some medications but was unable to state the reason. Interview on 02/19/19 the Residential Director stated: - Client #1 had been refusing medications. - Staff documented medication refusals on the MAR. - She did not have any incident reports for missed medications. Interview on 02/19/19 the Qualified Professional stated: - Staff should document on the MAR when medications were missed or refused. - If clients refused medications multiple times then the facility nurse would be notified, and the physician would be made aware.	V 123		
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	V 366		

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V 366	Continued From page 3 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; (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	V 366		

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V 366	Continued From page 4 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; (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;	V 366		

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V 366	Continued From page 5 (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. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to document their response to level I incidents. The findings are: See Tag V123 for specifics. Review on 02/19/19 and 02/20/19 of facility records revealed no incident reports documented for client #1's medication refusals in February 2019. Interview on 02/21/19 the Administrative Staff stated they were aware incident reports were required for medication errors or medication refusals.	V 366	**V366**: QP/RD to provide in-service to all staff on Incident Reporting with main focus on medication errors refusals/Level 1(s). DCP staff will receive additional training on how to complete these reports in EHR – Therap. Policy on medication errors will also be reviewed with staff. All Level 1 incident reports will be completed in EHR-Therap. Inservice provided to QPs and RDs in staff meeting. QPs will address above issues in monthly supervision in Therap (EMR)) throughout POC. RD/QP will review medication refusals on weekly basis and ensure that the Level 1 report is completed by DCP. Appropriate steps will be followed as noted in in-service.	4-22-19 3-5-19

WEEKLY MOORE STREET WATER TEMPERATURE CHECK SHEET

3-3-19 THROUGH 3-24-19

WEEK OF	TIME	WATER TEMPERATURE KITCHEN	WATER TEMPERATURE DOWNSTAIRS BATHROOM	WATER TEMPERATURE UPSTAIRS	RESIDENTIAL DIRECTOR'S SIGNATURE
3-3-19					
3-10-19					
3-17-19					
3-24-19					

Submission to: _____ on (date) _____

Handy Man Service
4737 Old Tar Road
Winterville, NC 25890

Date	Activity	Rate	Total
2-22-19	Adjusted Hot Water Heater		$45.00
			45.00

Signature: _Gregory Taft_____ Date: 2-22-19

STAFF INSERVICE TRAINING LOG

NAME OF INSERVICE	Creating New GER/Level 1(s)/Policy on Medication Errors and Incident Reporting
LOCATION OF TRAINING	Greenville, NC
PRESENTER(S)	Signature of Trainer
DATE	3/5/19

DESCRIPTION OF TRAINING (attach additional information)

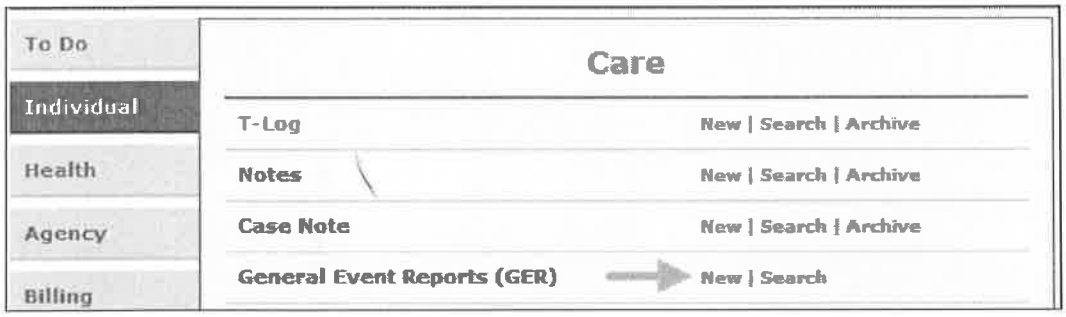
	SIGNATURE	TITLE	DATE
1		CFO	3-5-19
2		RD	3-5-19
3	Mattie Platt	QP	3/5/19
4	Pauline Clayton	QP	3/5/19
5		QP	3/5/19
6		RD	3/5/19
7		QP	3/5/19
8		RD	3/5/19
9		QP	3/5/19
10		RD	3/5/19
11		RD	3/5/19
12		QP	3/5/19
13		QP	3/5/19
14		RD	3-5-19
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			

Create New GER

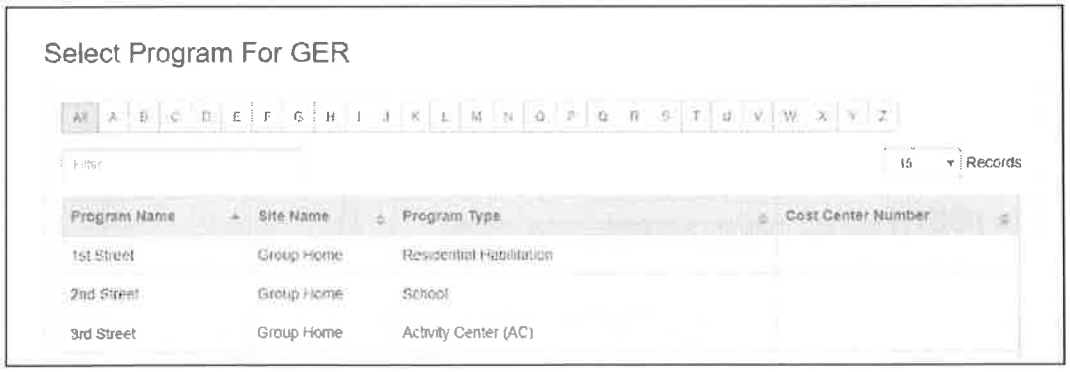
Published 04/24/2017 02:22 AM | Updated 03/13/2018 01:21 AM

Users with the **GER *Submit*** role can create new incident reports, save, and submit them for approval. Please follow the steps below to create a new **GER**:

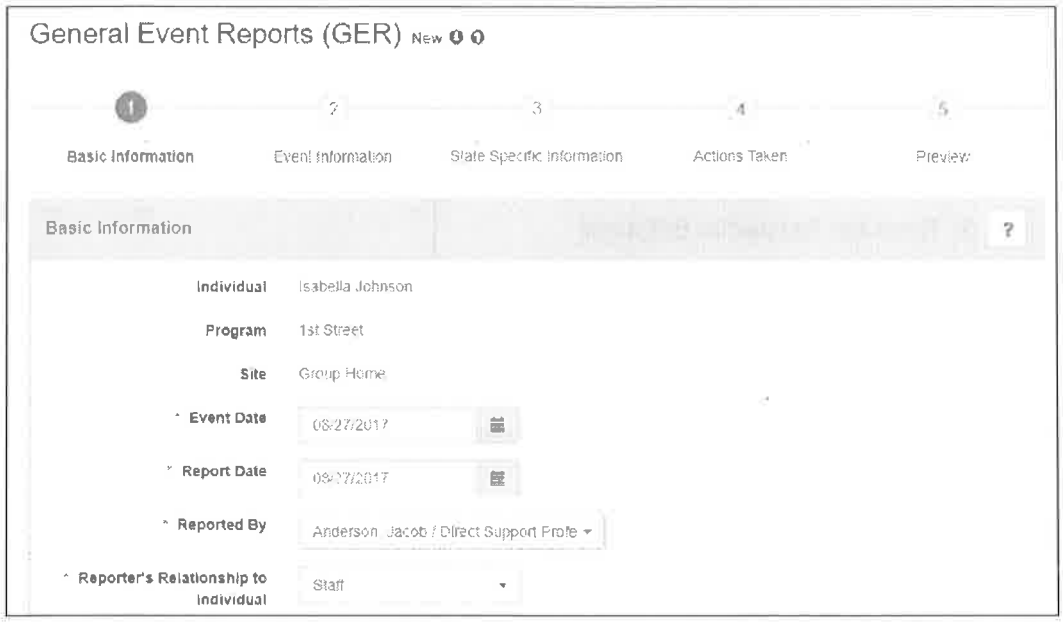
1. Click on the **New** link beside the **General Event Reports (GER)** option on the Individual tab.



2. Select the appropriate program from the list.



3. Select the individual from the list.

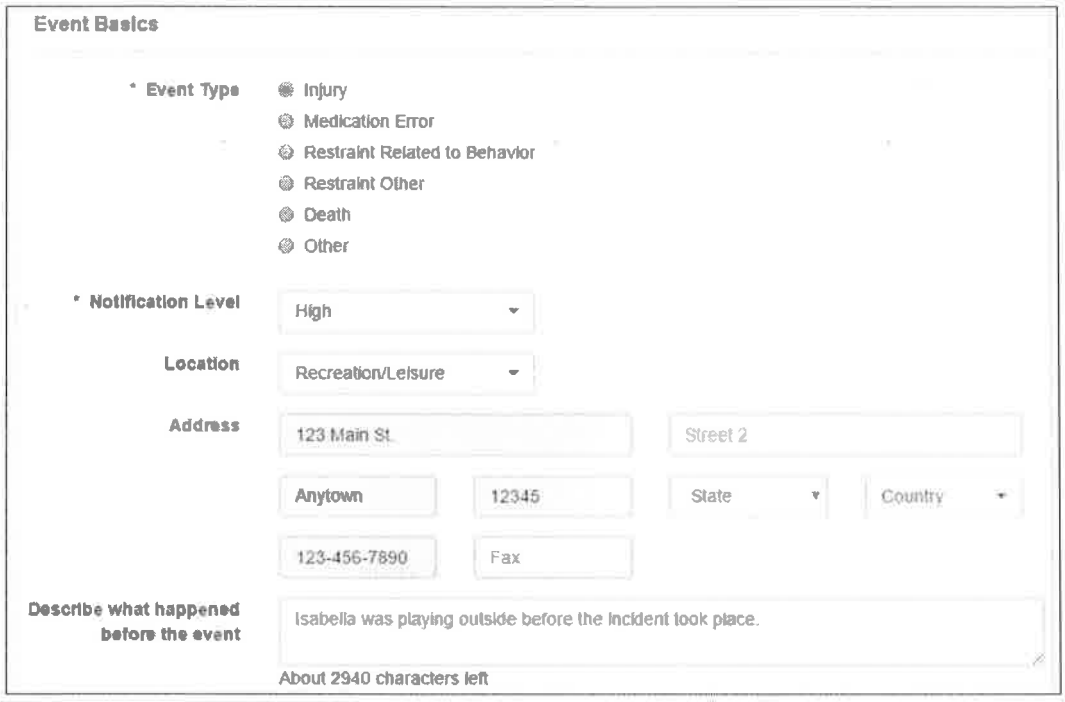


Release 2017.2.0: In the Basic Information section, on the Reporter's Relationship to Individual drop down list:

1. The item **Self** has been renamed as **Individual**.
2. The item **Contractor** has been added.

Release 2017.3.0::From this release onwards, the Country field will automatically populate on the **GER** form and will be pulled from the Provider information.

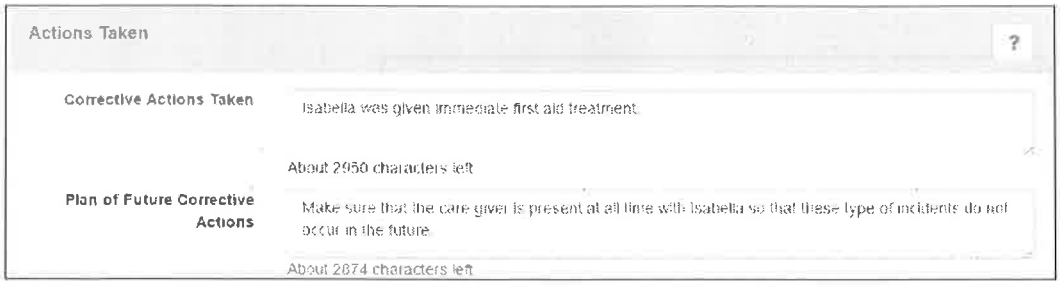
3. Under the Event Basics section, choose the appropriate Event Type from the following:
    - Injury
    - Medication Error
    - Restraint Related to Behavior
    - Restraint Other
    - Death
    - Other



8. Add necessary information in the Abuse/ Neglect/ Exploitation section. If the option **Yes** is selected for Abuse Suspected?, Neglect Suspected?, and Exploitation Suspected?, then it is required to select an option from the dropdown for the respective Type fields, which will auto-populate accordingly once **Yes** option is selected.

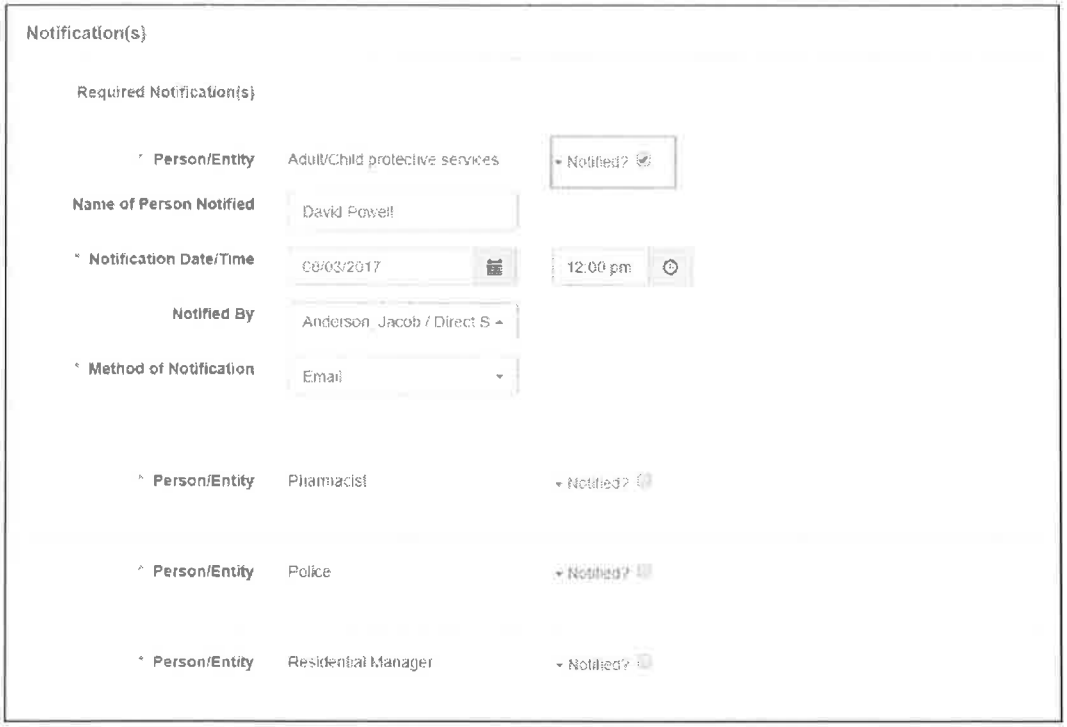
9. Click on the **Next** button to complete the next section.

Event Information



2. Under the Notification(s) section, check the box next to the **Notified?** field. The form will extend to let users enter information on who was notified regarding the incident.

   Release 2017.2.0: Depending on the **Provider Preferences** and **GER Event Category Rule** set for an agency, users will see the list of entities that need to be notified.



3. You may add files in the External Attachment(s) section. Click on the **Add File** button to add a file saved in your computer or click on the **Scan File** button to use your scanner to add a document.

   Refer to the **Document Scanning** User Guide for more information.

Policy 11 Rights and Privacy: Incident Reporting

POLICY: An incident report shall be completed for any event, which is not consistent with the routine operation of a program or the routine care of the person. The incident report is not part of the medical record and shall not be included in person's record, nor should an incident report be mentioned in the person's record. This refers the administrative form entitled "Incident Report Form".

PURPOSE: An incident report is an administrative report to identify areas that may require corrective action and to alert administration to situations that could be adverse and to prevent their recurrence. It will also identify training needs of staff.

PROCEDURES:

1. Within 24 hours of an incident, before leaving the facility at the end of a shift, the person with the best and most complete knowledge must complete the incident report. A significant note regarding the event must also be documented in the person's record, but this note should not make reference to the existence of the incident report, which is an administrative instrument only. The note shall include: description of event, remedial action, and person condition following the event. Opinions and conclusions shall not be included in the record.
2. ALL blanks on the form MUST be filled in. The narrative summary should be complete, including relevant antecedent occurrences, type of incident, actions of all participants in the incident, specific First Aid used, type of therapeutic hold and other relevant facts.
3. The incident should be reported to the immediate supervisor within 24 hours, and the supervisor should investigate the incident as soon as possible. The supervisor should investigate the incident as soon as possible. The supervisor should write up his/her findings regarding the incident on the incident report form, not in the chart. Medication errors, adverse reactions to medications and/or other life threatening situations require immediate notification of supervisor who will contact the person's physician or pharmacist immediately.
4. The incident report should be sent to the BCI's Office.
5. The Qualified Professional should review and sign the report.
6. The original shall be filed within and reviewed by Human Rights Committee or Quality Enhancement Committee and monitored for trends.
7. Each area MCO is sent a copy after review by the Better Connections, Inc. Qualified Professional. A preliminary report can be filed if the investigation of the incident is still ongoing. All incident reporting to the appropriate MCO should be within the agency's prescribed time frames. (Please log on the report date, time, and method of sending it to the Area Mental Health Agencies.)
8. All Level II/III incident reports are now completed in the IRIS system.

*(Reminder: Incident Reports include Suspected or Actual Abuse, Neglect or Exploitation of Persons being served.)

- Obtaining the person's record;
- Making a photocopy;
- Certifying the copy's completeness; and
- Transferring the copy to a peer review team.

3. The Clinical Services Director will appoint a peer review team to convene with 24 hours of the incident. The peer review team shall:

   a. Review the copy of the person's record;
   b. Gather other information needed;
   c. Issue a report concerning the incident to the Clinical Director and to the person's home area authority/LME to facilitate the monitoring of services as required by G.S 122C-111 and other State statutes; and
   d. Immediately notify the following:
      - The local area authority/LME;
      - The person's legal guardian, as applicable; and
      - Any other authorities required by law.

4. The Clinical Services Director will assure that Level II or Level III incidents are reported to the local area authority/MCO within 72 hours of the incident. The report will be submitted on the DHHS Incident and Death Reporting Form approved by the Secretary of the Department of Health and Human Services (DHHS). The report may be submitted via Mail, in person, facsimile or other electronic means. The report shall include the following information:
   a. Better Connections, Inc. contact person an identification information;
   b. Person's identification information;
   c. Type of incident;
   d. Description of incident;
   e. Status of the effort to determine the cause of the incident; and
   f. Other individuals or authorities notified or responding.

5. Any missing or incomplete information will be explained and by the end of the next business day, the Clinical Director will ensure that staff update the report by:

   a. Notifying the local area authority/LME when it has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; and
   b. Submitting to the local area authority/LME information required on the incident form that was previously unavailable.

6. The Clinical Director will submit, upon request by the local authority/LME other information obtained regarding the incident, including:
   a. Hospital records including confidential information;
   b. Reports by other authorities; and
   c. Better Connections, Inc. staff response to the incident.

Policy 11 Rights and Privacy: Incident Reporting (cont.)

12. Reporting of incidents and unusual occurrences will include:
    a. A description of the event;
    b. Actions taken on behalf of the person (corrective actions taken); and
    c. The person's condition following the event.

13. If the incident involved any suspicion of abuse, neglect or exploitation of a person, the staff witnessing the event or suspecting such must report it to the County Department of Social Services.

14. Incident Reports which include the administrative review must not be referenced or filed in the person record but filed in administrative files. Opinions conclusions or personnel actions relative to the even must not be included in the person's record.

Policy 12 Service Delivery: Medication

Policy: Better Connections, Inc. supports people needing assistance with medication, whenever feasible.

Purpose: To provide guidelines for assisting people with their medication needs.

Procedure:
Staff Training: Better Connections, Inc.'s registered nurses conduct medication training for all direct care service providers and representatives who will be expected to administer medications. Better Connections, Inc. requires direct care representatives to successfully complete medication administration training prior to assisting with medication administration and/or injections. An annual renewal may be obtained from another agency if a registered nurse provides the training and a copy of the training certificate is provided to Better Connections, Inc.

Prior to conducting medication administration training, Better Connections, Inc. RN must have successfully completed the state mandated training on administering medications.

Dispensing Medication: Better Connections, Inc. does not dispense medications. All medications are secured from a licensed pharmacist or physician or other healthcare practitioner authorized by law and registered with the NC Board of Pharmacy. Better Connections, Inc. does not supply, dispense or administer methadone.

Medication Packaging and Labeling: Non-prescription drug containers not dispensed by a pharmacist retain the manufacturer's label with expiration dates clearly visible.
(1) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging to minimize the risk of accidental ingestion. Such packaging includes plastic or glass bottles or vials with tamper-resistant caps, or in the case of unit-of-use packaged medications, a zip-locked bag may be adequate.
(2) The packaging label of each prescription medication must include the following:
- Name of the person receiving services.
- Name of the prescribing physician.
- The current dispensing date.
- Clear directions for administration.
- The name, strength, quantity and expiration of the medication.
- The name, address and phone number of the pharmacy or dispensing location.
- The name of the dispensing practitioner.

Medication Administration
(1) Prescription and non-prescription medications are administered on the written order of a person authorized by law to prescribe medications.
(2) Medications must be administered within one hour of the scheduled time. Exception to this rule must be approved by a doctor, registered nurse or pharmacist and recorded on an Incident Report.
(3) Medications can only be self-administered by the person when authorized in writing by the person's physician.

(4) Better Connections, Inc. direct care staff is permitted to administer medications according to the order of a physician after receiving Medication Administration training and when in possession of the written order of the physician. Only Better Connections, Inc. direct care staff trained by a registered nurse, pharmacist, or other legally qualified person may inject medications to people receiving services from Better Connections, Inc.

(5) Staff may not exceed the recommended dosage of any medication, administer medications past the expiration date, change the schedule of administration, or make an independent judgment of when to administer or how much medication to administer.

(6) Each time medication is administered it must be immediately recorded on a Medication Administration Record (MAR) form. All of the following information must be recorded on the form:

- Person's name.
- Name, strength and quantity of the medication.
- Instructions for administration of the medication.
- Date and time the medication is administered.
- Full name and initials of the person administering the medication.

Note: White-out is not permitted to correct a recording error.

(7) Staff must wash their hands with soap and water before and after dispensing medication. In addition to hand washing, staff should wear gloves when administering medication if there is any opportunity for exposure to blood. Gloves should only be used for one person and then discarded and another set used.

(7) Only a physician may change or stop a medication ordered.

(8) Medication change requests made by the person being served or their guardian will be recorded and the next level Better Connections, Inc. representative notified of the change request. This will be followed up with an appointment or consultation with a physician.

(9) Better Connections, Inc. does not administer Opioid or Methadone treatments.

Medication Disposal: Better Connections, Inc. does not dispose of prescription or non-prescription medications unless the following methods are used:

- Medications must be returned to the legally responsible person or the pharmacist when a medication is unusable or left in the care of a Better Connections, Inc.
- Incineration
- Flush down the toilet

  If the above three methods are used, the QP shall keep a record of medication disposed of. The record shall include the following: person's name, name and strength of medication, drug store name and prescription number (if applicable), quantity to be disposed, method of disposal, date of disposal, signature of employee disposing of the medication and signature of employee witnessing the disposal.
- Controlled substances shall be disposed of in accordance with NC Controlled Substances Act GS 90, Article 5, including any subsequent amendments.
- Upon discharge of a person, the remainder of his or her drug supply shall be disposed of immediately unless it is reasonably expected that the person shall return to the facility and in

such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge.

Medication Storage: Medications will be stored:

- In a securely locked, clean, well lit cabinet in a ventilated room between 59 and 86 degrees F.
- In a refrigerator, if required, between 36 and 46 degrees F. If the same refrigerator is used for food items, medications will be in a separate, locked compartment or container.
- Separately by person served or supported.
- Separately for external or internal administration.
- In a secure manner if approved by a physician for a person to self-administer.

Controlled Substances: Better Connections, Inc. does not maintain a stock of controlled substances.

Medication Review: Better Connections, Inc. schedules and coordinates a medication review by a physician or pharmacist at least every 6 months for psychotropic medications or as indicated by the person's plan. The findings of the medication review will be noted by the Better Connections, Inc. representative in the person's record and shared with all appropriate direct care providers.

As best practices, Better Connections, Inc. may invite people being supported to attend the medication administration training provided to employees.

Medication Error or Refusal: All drug administration errors are considered a Major Incident.

Better Connections, Inc. staff must follow Incident Reporting procedures for Major incidents regardless of the effect or seeming lack of adverse effect on the person served. The Better Connections, Inc. direct care provider must call a physician or pharmacist, Better Connections, Inc. Representative and legally responsible person according to the Better Connections, Inc. Incident Reporting procedure.

The medication error and any adverse effect must be recorded on the MAR form and the incident report form. Then the Better Connections, Inc. direct care provider must provide the Incident Report form to the appropriate Better Connections, Inc. representative within twenty-four (24) hours of the medication error.

Medication errors include any incidents when the medication schedule is not kept. This includes, but is not limited to: inability to administer the medication because the parent or guardian failed to provide the medication; dropping or spilling a medication so it is not available for administration; expired medication; refusal or inability to take a medication.