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	34G113	A. BUILDING _____ B. WING _____	C 04/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN RIDGE GROUP HOME	810 KING ARTHUR DRIVE GASTONIA, NC 28054

(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) COMPLETION DATE
W 124	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(2) The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the legal guardian was informed timely of the change in medical condition for 1 of 6 clients (#3). The finding is: On 4/15/19 a review of facility incident reports from 2/2019-present revealed medication error reports for client #3 on 3/28/19 and 3/29/19. Review of the medication errors on 3/28/19 and 3/29/19 revealed client #3 was not given Vimpat and Clonazepam medications as ordered because medications had run out. Further review of the 3/29/19 medication error report revealed client #3 was unable to get his Vimpat medication due to medication not coming in, staff reported seizures to Program Director and Nursing as client had four seizures in the group home. Additional review of the 3/29/19 medication error revealed staff to report client #3's guardian picked up the client on 3/29/19 and the guardian contacted staff to report the client had two seizures while with the guardian. Subsequent review of the medication error reports for 3/28-29/19 revealed no notification of the guardian regarding the medication errors or the client's seizures in the group home.	W 124		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 124	Continued From page 1 Interview with the facility qualified intellectual disabilities professional (QIDP) on 4/15/19 revealed client #3 ran out of Vimpat and Clonazepam medications on 3/28/19 due to delivery issues with the pharmacy. Further interview with the QIDP revealed she did not contact the guardian regarding the medication errors and the client's seizures that occurred on 3/29/19. Interview with nursing staff on 4/15/19 revealed she had not contacted the guardian regarding client #3's medication issues or change in medical status with four seizures in the group home on 3/29/19, as the group home manager or QIDP calls the guardian. Interview with the group home manager on 4/15/19 revealed she was on vacation during the time of the medication errors.	W 124		
W 253	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(2) The facility must document significant events that are related to the client's individual program plan and assessments. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to document an interdisciplinary team meeting for 1 of 6 clients (#1) relative to medication errors that resulted in a change in the client's medical status. The finding is: On 4/15/19 a review of facility incident reports from 2/2019-present revealed medication error reports for client #3 on 3/28/19 and 3/29/19. Review of the medication errors on 3/28/19 and 3/29/19 revealed client #3 was not given Vimpat and Clonazepam medications as ordered because medications had run out. Further review	W 253		

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W 253	Continued From page 2 of the 3/29/19 medication error report revealed client #3 was unable to get his Vimpat medication due to medication not coming in, staff reported seizures to the Program Director and Nursing as client had four seizures in the group home. Review of client #3's record on 4/15/19 revealed no documentation of prevention measures relative to the incident. Interview with the qualified intellectual disabilities professional (QIDP) on 4/15/19 verified client #3 was not given medications as prescribed for Vimpat and Clonazepam on 3/28-3/29/19. Interview with the QIDP further revealed the medications were not delivered from the pharmacy as expected on 3/25/19 due to an issue with the prescription expiration. The QIDP additionally revealed the pharmacy tried to deliver the medications after 3/25/19 and there was no response at the door of the group home. The QIDP verified on 4/2/19 a new delivery protocol was established with the pharmacy to include the use of a specific group home door for deliveries and phone numbers for administrative staff if there is no response at the group home. Further interview with the QIDP revealed a team meeting was held on 4/10/19 with the executive director, client #3's mother, the QIDP and the home manager to address the medication errors, effects of medication errors on the client and a new protocol for pharmacy deliveries. The QIDP confirmed she did not document the team meeting or have any written documentation from the meeting available.	W 253		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing	W 331		

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W 331	Continued From page 3	W 331		

services in accordance with their needs.

This STANDARD is not met as evidenced by:
Based on observation, record review and interview, the facility failed failed to provide nursing service in accordance with the needs of 1 of 6 clients residing in the home (#3) relative to staff training, reporting medical needs to the physician and documentation of medical issues in the client's record. The findings are:

A. Nursing services failed to assure staff were trained in reporting medication administration errors and changes in medical condition to the nurse in a timely manner for client #3.

Review of the record for client #3, conducted on 4/15/19 revealed physician's orders dated 3/1/19 documenting client #3 should receive Clonazepam 0.5 mg by mouth once daily at 8:00 PM and Vimpat 300 mg. by mouth twice daily at 8:00 AM and 8:00 PM, among others. Review of the facility's medication administration error reports revealed reports dated 3/28/19 and 3/29/19 documenting client #3 had not received his routinely ordered Clonazepam 0.5 mg or Vimpat 300 mg. on 3/28/19 or 3/29/19 due to these medications not being available in the home. Review of seizure records for client #3 revealed client #3 had 4 recorded seizures on 4/29/19, with the most recent seizure prior to 3/29/19 reported on 12/31/18 during a home visit.

Interview conducted with the nurse on 4/15/19 revealed the nurse was not notified of the medication errors for client #3 which occurred on 3/28/19 and 3/29/19 until after client #3 had 4 seizures on 4/29/19, at which time the nurse

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W 331	Continued From page 4	W 331		

advised staff to administer Clonazepam 0.5 mg. as ordered by the physician to be given on an as-needed basis for seizures. This interview with the nurse further revealed the nurse should be notified immediately of any medication errors or changes in medical status for all clients residing in the group home.

Interview conducted with the qualified intellectual disabilities professional (QIDP) on 4/15/19 revealed client #3's guardian (mother) picked him up from the group home and transported him to the urgent care around 4:00 PM on 3/29/19 related to the increase in seizure activity. Further interviews on 4/15/19 with the QIDP and the program manager, verified by interview with the nurse revealed no staff training related to medication administration or the reporting of medication errors or changes in medical status for clients had occurred following the medication administration errors and increase in seizure activity for client #3.

B. Nursing services failed to assure medication errors and a change in medical status for client #3 was reported to the physician.

Review of the record for client #3, conducted on 4/15/19 revealed physician's orders dated 3/1/19 documenting client #3 should receive Clonazepam 0.5 mg by mouth once daily at 8:00 PM and Vimpat 300 mg. by mouth twice daily at 8:00 AM and 8:00 PM, among others. Review of the facility's medication administration error reports revealed reports dated 3/28/19 and 3/29/19 documenting client #3 had not received his routinely ordered Clonazepam 0.5 mg or Vimpat 300 mg. on 3/28/19 or 3/29/19 due to these medications not being available in the

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home. Continued review of the medication administration error reports revealed no documentation of physician notification. Review of seizure records for client #3 revealed client #3 had 4 recorded seizures on 4/29/19, with the most recent seizure prior to 3/29/19 reported on 12/31/18 during a home visit.

Interview conducted by telephone with the nurse on 4/15/19 revealed the nurse had not notified the physician of the medication administration errors which occurred on 3/28/19 and 3/29/19 or the increase in seizure activity for client #3 following these errors.

C. Nursing services failed to assure documentation was included in the record for client #3 relative to medication administration errors and change in medical status for client #3.

Review of the facility's medication administration error reports, conducted on 4/15/19, revealed reports dated 3/28/19 and 3/29/19 documenting client #3 had not received his routinely ordered Clonazepam 0.5 mg or Vimpat 300 mg. on 3/28/19 or 3/29/19 due to these medications not being available in the home. Continued review of the medication administration error reports revealed no documentation of physician notification. Review of seizure records for client #3 revealed client #3 had 4 recorded seizures on 4/29/19, with the most recent seizure prior to 3/29/19 reported on 12/31/18 during a home visit.

Review of the record for client #3, conducted on 4/15/19 revealed no documentation related to the medication errors which occurred on 3/28/19 and 3/29/19, no documentation of seizure activity on 3/29/19 and no documentation of client #3's visit

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W 331	Continued From page 6 to the urgent care on 3/29/19. Interview conducted with the qualified intellectual disabilities professional (QIDP) on 4/15/19 revealed client #3's guardian (mother) picked him up from the group home and transported him to the urgent care around 4:00 PM on 3/29/19 due to the increase in seizure activity. Interview conducted by telephone with the nurse on 4/15/19 verified the nurse had not placed any documentation in client #3's record related to these changes in medical status for client #3.	W 331		
W 376	DRUG ADMINISTRATION CFR(s): 483.460(k)(8) The system for drug administration must assure that drug administration errors and adverse drug reactions are reported immediately to a physician. This STANDARD is not met as evidenced by: On 4/15/19 a review of facility incident reports from 2/2019-present revealed medication error reports for client #3 on 3/28/19 and 3/29/19. Review of the medication errors on 3/28/19 and 3/29/19 revealed client #3 was not given Vimpat and Clonazepam medications as ordered because medications had run out. Further review of the 3/29/19 medication error report revealed client #3 was unable to get his Vimpat medication due to medication not coming in, staff reported siezures to Program Director and Nursing as client had four siezures in the group home. Subsequent review of the medication error reports for 3/28-29/19 revealed no notification of the physician regarding the medication errors or the client's siezures in the group home.	W 376		

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W 376	Continued From page 7 Interview with the facility qualified intellectual disabilities professional (QIDP) on 4/15/19 verified client #3 ran out of Vimpat and Clonazepam medications on 3/28/19 due to delivery issues with the pharmacy. Interview with nursing staff on 4/15/19 revealed she did not contact the physician regarding client #3's medication issues or change in medical status with four siezures in the group home on 3/29/19, as the group home manager or QIDP calls the physician. Additional interview with the QIDP and the facility home manager verified the physician was not contacted.	W 376		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observation and interviews, the facility failed to assure all medications were appropriately stored and locked for 1 of 6 clients residing in the group home (#3). The finding is: Observations were conducted on 4/15/19 related to the availability and storage condition of medication prescribed for client #3. These observations revealed client #3's routinely prescribed medications, including Clonazepam 0.5 mg. and Vimpat 100 mg. tablets were stored in the locked medication closet located off the living room of the home, with the controlled drugs , including Clonazepam 0.5 mg., located in a locked box inside the locked closet. Further observation of the storage of medications for	W 382		

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W 382	Continued From page 8 client #3 revealed his Clonazepam 0.5 mg. prescribed to be given as needed (PRN) was located in a separate locked closet in the office of the group home. The Clonazepam was observed to be located in a plastic bin inside the closet along with a controlled drug ordered for another client residing in the home. This bin was further observed to contain items of clothing and other items unrelated to the controlled drugs. Interview conducted with the nurse on 4/15/19 revealed all medications, including controlled drugs and medications ordered to be given PRN should be stored in one locked cabinet with controlled drugs under double lock.	W 382		