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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 7/11/19. The complaints were substantiated (intake #NC00152870, NC00153189 and NC00153511). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision	V 110		

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V 110	Continued From page 1 plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record reviews and interviews one of seven audited staff (staff #1) failed to demonstrate the knowledge, skills and abilities required for the population served. The findings are: Review on 7/10/19 of client #1's record revealed: -Admission date of 3/4/19. -Diagnoses of Schizoaffective Disorder, Anemia, High Cholesterol, Incontinence, Fatigue, Tobacco Use and Overweight. -Physician's order dated 5/30/19 for Xanax 1 mg, one tablet three times daily. -There was an order change on 6/5/19 for the Xanax 1 mg. The order changed to Xanax 0.25 mg, one tablet by mouth twice a day. Review of the facility's personnel records on 7/11/19 revealed: -Staff #1 had a hire date of 11/15/16. -Staff #1 was hired as a Residential Supports Worker. Review of facility records on 7/10/19 revealed: -An internal investigation dated 6/18/19 had the following information-Staff were questioned about a missing medication for client #1. "[Staff #2] reported she knew nothing about a missing medication or the medication not being returned to the pharmacy. [Staff #2] stated she was not working when the medication was returned to the	V 110		

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V 110	Continued From page 2	V 110		

pharmacy." [Staff #1] reported that the medication was put in the D/C (discontinuation) box to be returned to the pharmacy on 5/30/19. The pharmacy deliveryman arrived to drop off the new batch of medications for the group home on 5/30/19 at around 11:00 p.m. [Staff #1] attempted to have the deliveryman take the Xanax; however, the deliveryman would not accept the discontinued medication because a return controlled form was not available.....[Staff #1] said she put the medication back in D/C (discontinued) return box. On the night of 6/1/19 the deliveryman came with the D/C return form. [Staff #1] went back into the locked closet to retrieve the medication and fill out the form. The medication was gone. When [Staff #1] was questioned why she did not notify the Director of the missing medication she stated, "I thought someone just flushed the medication." [Staff #3] was a fill in staff on 6/1/19. [Staff #3-] was questioned and stated he had not one into the D/C (discontinued) closet and was not aware that a medication was in the box to be returned. After questioning the staff that worked shifts during the time the medication went missing and after questioning [The Group Home Director], the medication was missing and not reported to [The Group Home Director] and he was unaware of the missing medication until MCO (Managed Care Organization) visited on 6/18/19.

Interview with staff #1 on 7/10/19 revealed:
-Client #1 had an incident with missing Xanax medication in June 2019.
-Client #1 had a change with her Xanax medication.
-She had to send the packet of Xanax back to the pharmacy.
-They were required to put discontinued medication in a locked box and keep it in the

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V 110	Continued From page 3	V 110		

hallway closet.
-A pharmacy person came to the home to get the medication.
-The pharmacy person refused to take the Xanax and told her she needed a controlled medication form.
-She put the medication back in the locked box, however she did not put it in the locked hallway closet.
-She put the medication box on the top of the refrigerator in staff office area.
-The pharmacy person came out the next night to pick up the Xanax.
-When she looked in the locked box the Xanax was missing.
-She was not sure what happened to the medication.
-She thought other staff possibly stole the medication.

Interview with the Group Home Director on 7/10/19 and 7/11/19 revealed:
-On 6/18/19 they had a visit form the local Managed Care Organization (MCO).
-The staff from the MCO informed them there was a complaint related to some missing medication.
-He was informed there was a complaint in reference to client #1 missing some Xanax tablets.
-Client #1 was prescribed Xanax tablets at the beginning of June 2019.
-Staff felt like the milligrams of Xanax was possibly too much for client #1.
-The Xanax was making client #1 "loopy and sleepy."
-The physician was contacted and agreed to decrease the dosage.
-The Xanax pills were supposed to be returned to the pharmacy that same night.

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V 110	Continued From page 4 -He thought staff had returned the medication towards the beginning on June 2019. -He did not know there was an issue until the MCO staff brought it to his attention. -Therapeutic Alternatives did an investigation once the issue was brought to their attention. -Staff #1 informed them she was in the process of returning the Xanax to the pharmacy. -Staff #1 said a pharmacy person came to the home, however the person would not take the Xanax. -Staff #1 told them the pharmacy person refused to take the medication because she did not have the correct form. -Staff #1 was told she was supposed to have a controlled drug form for the Xanax. -Staff #1 told them she put the medication back into discontinued box and in the locked hallway closet. -Staff #1 told them a pharmacy person came out the next night. -The pharmacy person brought the controlled drug form for the Xanax. -Staff #1 told them she went into the discontinued box to get the Xanax. -Staff #1 told them the Xanax was no longer in the discontinued box. -She told them she did not bring it to anyone's attention because she thought other staff sent medication back. -The Pharmacy confirmed the Xanax for client #1 was never returned to the pharmacy. -Staff #1 never informed them that she left the discontinued box with Xanax on the top of the refrigerator in staff office area. Interview with the Chief Operations Officer on 7/11/19 revealed: -She was aware of the incident with the missing Xanax for client #1.	V 110		

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V 110	Continued From page 5 -She received a call from the local MCO about the medication issue in June 2019. -Prior to the local MCO coming out, they were not aware the Xanax medication was missing for client #1. -Staff #1 informed them she attempted to return the Xanax medication. -Staff #1 told them the pharmacy person refused to take the medication. -Staff #1 told them she was supposed to have a controlled medication form attached to the medication. -Staff #1 informed them she put the locked medication box which contained the Xanax into the locked hallway closet. -Staff #1 informed them the pharmacy person returned to the home the next night to get the medication. -Staff #1 informed them she went into the locked medication box, however the Xanax was missing. -Staff #1 informed them she never said anything about the medication missing because she thought someone threw it away. -Staff #1 never informed them that she left the discontinued box with Xanax on the top of the refrigerator in staff office area.	V 110		
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	V 114		

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V 114	Continued From page 6 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 reviews and interviews, the facility failed to conduct fire and disaster drills under conditions that simulate emergencies. The findings are: Review on 7/11/19 of the facility's fire drill log revealed the following: -7/1/19-2nd shift -6/11/19-1st shift -5/8/19-1st shift -4/11/19-2nd shift -3/25/19-3rd shift -2/3/19-2nd shift -1/22/19-1st shift -12/31/18-3rd shift -There were no fire drills conducted during 3rd shift for the 2nd quarter of 2019. Review on 7/11/19 of the facility's disaster drill log revealed the following: -7/3/19-2nd shift -6/19/19-1st shift -5/21/19-2nd shift -4/30/19-2nd shift -3/26/19-1st shift -2/11/19-1st shift -1/28/19-3rd shift -12/22/18-2nd shift -There were no disaster drills conducted during 3rd shift for the 2nd quarter of 2019.	V 114		

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V 114	Continued From page 7 -There were no disaster drills conducted during 2nd shift for the 1st quarter of 2019. Interview with client #2 on 7/10/19 revealed: -Staff conducted fire and disaster drills with them. -She was not sure how often the drills were being conducted. Interview with client #3 on 7/10/19 revealed: -Staff did fire and disaster drills with them -She thought the fire and disaster drills were done monthly. Interview with the Group Home Director on 7/11/19 revealed: -The group home had three separate shifts. -He was a little confused about the way the drills were supposed to be conducted. -He confirmed staff failed to conduct fire and disaster drills under conditions that simulate emergencies. Interview with the Chief Operating Officer on 7/11/19 confirmed: -Staff failed to conduct fire and disaster drills under conditions that simulate emergencies.	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.	V 118		

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V 118	Continued From page 8 (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 review and interviews, the facility failed to follow the physician's orders and failed to keep the MAR current for one of three clients (#1). The findings are: 1. The following is evidence the facility failed to follow the physician's orders. Review on 7/10/19 of client #1's record revealed: -Admission date of 3/4/19. -Diagnoses of Schizoaffective Disorder, Anemia, High Cholesterol, Incontinence, Fatigue, Tobacco Use and Overweight. -Physician's order dated 12/31/18 for Fluoxetine	V 118		

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V 118	Continued From page 9 20 mg, one capsule daily and Quetiapine 100 mg, one tablet at bedtime. -There was a discontinuation of medication order dated 5/30/19 for Fluoxetine 20 mg and Quetiapine 100 mg. Review of facility records on 710/19 revealed: -Incident reports for client #1 revealed the following: (1). 6/18/19-"[Staff #3] administered 1 tab (tablet) Prozac 20mg during 8am med (medication) pass on 6/18/19. This medication was discontinued on 5/30/19." (2). 6/17/19-[Former staff #7] administered 1 tab (tablet) Seoquel 100mg during 8pm med (medication) pass on 6/17/19. This medication was discontinued on 5/30/19. [Former staff #7] initials were written on back of med (medication) pack with date of 6/17/19 and the tablet was missing from pack." Interview with the Chief Operations Officer on 7/11/19 revealed: -She was aware of the medication errors made by staff #3 and FS #7. -The Group Home Director was responsible for reviewing the MAR's, orders and medications. -The Group Home Director should review the MAR's, orders and medications to ensure there were no errors. -A discontinued medication must immediately be placed in the discontinued box and returned to the pharmacy. -She confirmed staff #3 and FS #7 failed to follow the physician's orders for client #1. 2. The following is evidence the facility failed to keep the MAR current. Review on 7/10/19 of client #1's record revealed: -Physician's order dated 3/18/19 for Benztropine	V 118		

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V 118	Continued From page 10 Mesylate 1 mg, one tablet two times daily; Clozapine 100 mg, four tablets at bedtime; Atorvastatin 20 mg, one tablet at bedtime and Divalproex 500 mg, three tablets at bedtime. -The July 2019 MAR had a blank box on 7/8/19 for Clozapine 100 mg. -The May 2019 MAR had blank boxes on 5/31 for Benztropine Mesylate 1 mg, Clozapine 100 mg, Atorvastatin 20 mg and Divalproex 500 mg. Interview with the Group Home Director on 7/10/19 revealed: -He thought staff possibly forgot to sign the May and July MAR's to indicate medication was administered. -There were no issues with clients getting their prescribed medications. -He confirmed staff failed to keep the MAR current for client #1. Interview with the Chief Operations Officer on 7/11/19 confirmed: -Staff failed to keep the MAR current for client #1.	V 118		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client;	V 120		

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V 120	Continued From page 11 (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure medications were in a securely locked cabinet affecting one of three current clients (#1). The findings are: Review on 7/10/19 of client #1's record revealed: -Admission date of 3/4/19. -Diagnoses of Schizoaffective Disorder, Anemia, High Cholesterol, Incontinence, Fatigue, Tobacco Use and Overweight. -Physician's order dated 5/30/19 for Xanax 1 mg, one tablet three times daily. -There was an order change on 6/5/19 for the Xanax 1 mg. The order changed to Xanax 0.25 mg, one tablet by mouth twice a day. Review of facility records on 7/10/19 revealed: -An internal investigation dated 6/18/19 had the following information-Staff were questioned about a missing medication for client #1. "[Staff #2] reported she knew nothing about a missing medication or the medication not being returned to the pharmacy. [Staff #2] stated she was not working when the medication was returned to the pharmacy." [Staff #1] reported that the medication was put in the D/C (discontinuation) box to be returned to the pharmacy on 5/30/19. The pharmacy deliveryman arrived to drop off the new	V 120		

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V 120	Continued From page 12 batch of medications for the group home on 5/30/19 at around 11:00 p.m. [Staff #1] attempted to have the deliveryman take the Xanax; however, the deliveryman would not accept the discontinued medication because a return controlled form was not available.....[Staff #1] said she put the medication back in D/C (discontinued) return box. On the night of 6/1/19 the deliveryman came with the D/C return form. [Staff #1] went back into the locked closet to retrieve the medication and fill out the form. The medication was gone. When [Staff #1] was questioned why she did not notify the Director of the missing medication she stated, "I thought someone just flushed the medication." [Staff #3] was a fill in staff on 6/1/19. [Staff #3-] was questioned and stated he had not one into the D/C (discontinued) closet and was not aware that a medication was in the box to be returned. After questioning the staff that worked shifts during the time the medication went missing and after questioning [The Group Home Director], the medication was missing and not reported to [The Group Home Director] and he was unaware of the missing medication until MCO (Managed Care Organization) visited on 6/18/19. Interview with staff #1 on 7/10/19 revealed: -Client #1 had an incident with missing Xanax medication in June 2019. -Client #1 had a change with her Xanax medication. -She had to send the packet of Xanax back to the pharmacy. -They were required to put discontinued medication in a locked box and keep it in the hallway closet. -A pharmacy person came to the home to get the medication. -The pharmacy person refused to take the Xanax	V 120		

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V 120	Continued From page 13 and told her she needed a controlled medication form. -She put the medication back in the locked box, however she did not put it in the locked hallway closet. -She put the medication box on the top of the refrigerator in staff office area. -The pharmacy person came out the next night to pick up the Xanax. -When she looked in the locked box the Xanax was missing. -She was not sure what happened to the medication. -She thought other staff possibly stole the medication. -She confirmed facility staff failed to ensure medications were securely locked in a cabinet. Interview with the Group Home Director on 7/10/19 and 7/11/19 revealed: -On 6/18/19 they had a visit form the local Managed Care Organization (MCO). -The staff from the MCO informed them there was a complaint related to some missing medication. -He was informed there was a complaint in reference to client #1 missing some Xanax tablets. -Client #1 was prescribed Xanax tablets at the beginning of June 2019. -Staff felt like the milligrams of Xanax was possibly too much for client #1. -The Xanax was making client #1 "loopy and sleepy." -The physician was contacted and agreed to decrease the dosage. -The Xanax pills were supposed to be returned to the pharmacy that same night. -He thought staff had returned the medication towards the beginning on June 2019.	V 120		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL063-087	A. BUILDING: _____ B. WING _____	07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YADKIN PLACE	360 YADKIN ROAD SOUTHERN PINES, NC 28387

(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 120	Continued From page 14 -He did not know there was an issue until the MCO staff brought it to his attention. -Therapeutic Alternatives did an investigation once the issue was brought to their attention. -Staff #1 informed them she was in the process of returning the Xanax to the pharmacy. -Staff #1 said a pharmacy person came to the home, however the person would not take the Xanax. -Staff #1 told them the pharmacy person refused to take the medication because she did not have the correct form. -Staff #1 was told she was supposed to have a controlled drug form for the Xanax. -Staff #1 told them she put the medication back into discontinued box and in the locked hallway closet. -Staff #1 told them a pharmacy person came out the next night. -The pharmacy person brought the controlled drug form for the Xanax. -Staff #1 told them she went into the discontinued box to get the Xanax. -Staff #1 told them the Xanax was no longer in the discontinued box. -She told them she did not bring it to anyone's attention because she thought other staff sent medication back. -The Pharmacy confirmed the Xanax for client #1 was never returned to the pharmacy. -Staff #1 never informed them that she left the discontinued box with Xanax on the top of the refrigerator in staff office area. -He confirmed the facility staff failed to ensure medications were securely locked in a cabinet. Interview with the Chief Operations Officer on 7/11/19 revealed: -She was aware of the incident with the missing Xanax for client #1.	V 120		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL063-087	A. BUILDING: _____ B. WING _____	07/11/2019

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V 120	Continued From page 15 -She received a call from the local MCO about the medication issue in June 2019. -Prior to the local MCO coming out, they were not aware the Xanax medication was missing for client #1. -Staff #1 informed them she attempted to return the Xanax medication. -Staff #1 told them the pharmacy person refused to take the medication. -Staff #1 told them she was supposed to have a controlled medication form attached to the medication. -Staff #1 informed them she put the locked medication box which contained the Xanax into the locked hallway closet. -Staff #1 informed them the pharmacy person returned to the home the next night to get the medication. -Staff #1 informed them she went into the locked medication box, however the Xanax was missing. -Staff #1 informed them she never said anything about the medication missing because she thought someone threw it away. -Staff #1 never informed them that she left the discontinued box with Xanax on the top of the refrigerator in staff office area. -She confirmed the facility staff failed to ensure medications were securely locked in a cabinet.	V 120		