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V 000	INITIAL COMMENTS A follow up survey was completed on 8/13/19. 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 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (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.	V 118		

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This Rule is not met as evidenced by:
Based on record reviews, observations, and interviews, the facility failed to ensure medications were administered as ordered by the physician effecting 3 of 3 clients audited (#1, #3, #4). The findings are:

Finding #1:
Cross reference tag (V123). 10A NCAC 27G .0209 Medication Requirements-Medication Errors. Based on record reviews and interviews the facility failed to notify the physician or pharmacist of medication errors for 1 of 3 current clients audited (client #3).

Finding #2:
Review on 8/8/19 of client 3's record revealed:
-44 year old female admitted 7/18/10.
-Diagnoses included Schizoaffective Disorder, Unspecified; Mild Mental Retardation; Hypertension; Type 2 Diabetes Without Complications; Depressive Disorder, Not Otherwise Specified; Substance Abuse.
-Order Dated 7/5/19 (Friday) to discontinue Viibyrd 40 mg (milligrams) every morning and to decrease Viibyrd dosage to 20 mg every morning. (Antidepressant)

Review on 8/8/19 of client #3's July 2019 MAR revealed:
-Last dose of Viibyrd 40 mg was documented on 7/5/19.
-Viibyrd 20 mg was transcribed to be administered at 8 pm.
-First Dose of Viibyrd 20 mg was documented at

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V 118	Continued From page 2 8 pm on 7/12/19. Finding #3: Review on 8/8/19 of client 4's record revealed: -36 year old female admitted 10/10/14. -Diagnoses included Schizophrenia, Unspecified; Intellectual Disability; Anemia. -Order dated 6/28/19 to decrease Seroquel 25 mg twice daily to once daily for 1 week, then to discontinue. (Anti-psychotic drug used to treat certain mental/mood conditions, i.e. schizophrenia) -Order dated 6/28/19 to increase Vistaril 25 mg to twice daily. (Used to treat anxiety and tension.) Review on 8/8/19 of client #4's July and August 2019 MARs revealed: -Seroquel 25 mg had been documented as administered once daily from 7/1/19 -7/7/19 and from 8/1/19 - 8/8/19. (Should have been discontinued 7/5/19.) -Vistaril 25 mg had been transcribed to the August 2019 MARs by generic names, Hydroxyzine HCL 25 mg twice daily at 8 am and 8 pm; and Hydroxyzine Pamoate 25 mg twice daily at 8 am and 8 pm. Both Hydroxyzine HCL 25 mg and Hydroxyzine Pamoate had been documented as administered twice daily from 8/1/19 through the 8 am dose on 8/8/19. The dosage documented equaled 50 mg of Vistaril twice daily. Observations on 8/8/19 at approximately 4:00 pm revealed there was no Seroquel 25 mg on hand labeled for client #4. Finding #4: Review on 8/8/19 of client 1's record revealed: -51 year old female admitted 4/17/19. -Diagnoses included Schizoaffective Disorder. -Order dated 7/5/19 (Friday) for Fluoxetine HCL	V 118		

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V 118	Continued From page 3 10 mg at bedtime. (Antidepressant) Review on 8/8/19 of client #1's July 2019 MAR revealed the first dose of Fluoxetine was documented as given on 7/8/19. During interview on 8/8/19 staff #1 stated: -She did not have any more Viibyrd 40 mg on hand when client #3 was seen by her physician on 7/5/19. -The pharmacy did not deliver medications over the week end; therefore, client #3's Viibyrd 20 mg could not be started until it was received the following week. -She was sure she documented in error on client #4's August 2019 MAR that she received Seroquel daily and Hydroxyzine twice at 8 am and 8 pm. During interview on 8/8/19 the Licensee stated: -Facility clients requested to have physician appointments scheduled on Fridays so they did not miss their Day Program attended Monday - Thursday. -The physicians sent medication orders to the pharmacy electronically. Sometimes the physician would wait until the end of his work day to send all of the orders at one time. -Prescriptions sent electronically on a Friday would not be delivered before the following Monday at the earliest. The medications may be sent later than the following Monday if the doctor sent the prescriptions in at the end of the day. -She had not seen this as a problem for psychiatric medications and the physician had not been made aware of the delays in filling prescriptions. -There was no Viibyrd 40 mg on hand following the 7/5/19 doctor's visit. She knew this because if there had been it would have been listed on the	V 118		

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disposal sheet.
-The doctor had not been asked on 7/5/19 for directions, given the Viibyrd would not be delivered until the following week.

Telephone interview on 8/9/19 and 8/13/19 the Qualified Professional (QP) stated:
-She was not aware of the system delays in supplying medications over the weekend.
-She was not aware client #3 had not received her Viibyrd in July 2019 for 6 days.
-She agreed the system problem of medication delivery, especially for medications ordered on a Friday, had to be corrected.
-She instructed the staff on 8/13/19 via telephone to put a process in place to have physicians give an order when to start a new medication or make an order change. If the start date was prior to the next delivery date by the contracted pharmacy, the staff would obtain a hard copy prescription and have it filled by the back up pharmacy.
-She would work with the facility to make sure medications were obtained and administered correctly.

Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician.

This deficiency has been cited 3 times since the original cite on 3/23/18.

Review on 8/13/19 of the Plan of Protection dated 8/13/19 written by the Licensee revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care? The Medical Contact sheet will be revised to require physicians to specify when a medication must be started. In the case of dosage changes

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the contact sheet will also be revised to specify whether the current dosage may be continued until the new medication is made available."
-"Describe your plans to ensure the above happens. Each facility will have a binder of medication changes for licensees and the QP to review to ensure accurate and continued availability of the correct medications."

Client medications were supplied by a pharmacy contracted by the facility to fill and deliver medications to the facility, and provide MARs for all clients. The contracted pharmacy delivered medications during the week, but not on the weekends. Clients #1, #3, and #4 attended a Day Program Monday through Thursday and had requested their doctor appointments be made on Fridays. The clients' physician would send medication orders to their pharmacy electronically, sometimes waiting until the end of his work day. When the appointments were on a Friday, the contracted pharmacy would not deliver the medications until the following Monday, at the earliest. This systematic delay in supplying newly ordered medications had not been seen as an issue by the facility, and the physician had not been made aware. Client #3, diagnosed with Schizoaffective Disorder, saw her physician on a Friday, 7/7/19, and her order for Viibyrd was decreased from 40 mg to 20 mg daily. The physician was not made aware the medication would not be available to continue her medication therapy uninterrupted, and as a result, client #3's antidepressant medication abruptly stopped for 6 days. Similarly, this system delay resulted in client #1, also seen by her physician on Friday, 7/7/19 and diagnosed with Schizoaffective Disorder, was not able to begin a newly ordered antidepressant (Fluoxetine HCL 10 mg) until the following Monday. Client #4, diagnosed with

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V 118	Continued From page 6 Schizophrenia, had duplicate entries printed on her August 2019 for Vistaril 25 mg (ordered twice daily), and a continuation of Seroquel 25 mg daily, a discontinued medication. Client #4's MAR was not corrected by the facility, and Vistaril 25 mg was documented as given twice at each dosing time, and the discontinued Seroquel 25 mg, documented daily. The systematic delays in filling medication orders resulted in a delay for clients to receive the therapeutic effects of their medications. As for client #3, the abrupt ending of an antidepressant medication put her at risk of suffering withdrawal like symptoms and a loss of therapeutic effect. The inaccurate documentation of client #4's medication made it impossible to know for certain if she received medications as ordered. These system delays in providing medications and inaccuracy in medication documentation placed clients in a situation that was detrimental to their health, safety, and welfare. This deficiency constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 30th day.	V 118		
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. .	V 123		

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V 123	Continued From page 7 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 for 1 of 3 current clients audited (client #3). The findings are: Review on 8/8/19 of client 3's record revealed: -44 year old female admitted 7/18/10. -Diagnoses included Schizoaffective Disorder, Unspecified; Mild Mental Retardation; Hypertension; Type 2 Diabetes Without Complications; Depressive Disorder, Not Otherwise Specified; Substance Abuse. -Order Dated 7/5/19 (Friday) to discontinue Viibyrd 40 mg (milligrams) every morning and to decrease Viibyrd dosage to 20 mg every morning. (Antidepressant) -No documentation the physician or pharmacist was notified that client #3 was missing her Viibyrd for 6 consecutive days. Review on 8/8/19 of client #3's July 2019 MAR revealed: -Last dose of Viibyrd 40 mg was documented on 7/5/19. -Viibyrd 20 mg was transcribed to be administered at 8 pm. -First Dose of Viibyrd 20 mg was documented at 8 pm on 7/12/19. Interview on 8/8/19 staff #1 stated: -She did not have any more Viibyrd 40 mg on hand when client #3 was seen by her physician on 7/5/19. -The pharmacy did not deliver medications over the weekend; therefore, client #3's Viibyrd 20 mg could not be started until it was received the	V 123		

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V 123	Continued From page 8 following week. -She had not notified the physician or pharmacist that client #3 was missing her medication for 6 days. Interview on 8/8/19 the Licensee stated: -She was aware medications would not be delivered over the weekend and had not seen this as a problem for psychiatric medications. -They had not notified the physician or pharmacist that client #3 had missed her Viibyrd medication for 6 days. [This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type B and must be corrected within 30 days.]	V 123		
V 366	27G .0603 Incident Response Requirments 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 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;	V 366		

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V 366	Continued From page 9 (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 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;	V 366		

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V 366	Continued From page 10 (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; (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.	V 366		

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V 366	Continued From page 11 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement written policies governing their documentation and response to Level I incidents. The findings are: Review on 8/8/19 of client 3's record revealed: -44 year old female admitted 7/18/10. -Diagnoses included Schizoaffective Disorder, Unspecified; Mild Mental Retardation; Hypertension; Type 2 Diabetes Without Complications; Depressive Disorder, Not Otherwise Specified; Substance Abuse. -Order Dated 7/5/19 (Friday) to discontinue Viibyrd 40 mg (milligrams) every morning and to decrease Viibyrd dosage to 20 mg every morning. (Antidepressant) -No incident report documented for client #3 not receiving her Viibyrd for 6 consecutive days. Review on 8/8/19 of client #3's July 2019 MAR revealed: -Last dose of Viibyrd 40 mg was documented on 7/5/19. -Viibyrd 20 mg was transcribed to be administered at 8 pm. -First Dose of Viibyrd 20 mg was documented at 8 pm on 7/12/19. Interview on 8/8/19 the Licensee stated: -Prescriptions sent to the pharmacy electronically on a Friday would not be delivered before the following Monday, at the earliest. The medications may be sent later than the following Monday if the doctor sent the prescriptions to the pharmacy at the end of the day. -She had not seen this as a problem for	V 366		

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V 366	Continued From page 12 psychiatric medications. -They had not documented an incident report for the client #3 missing her Viibyrd medication for 6 consecutive days.	V 366		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observations on 8/8/19 between 10:00am and 10:30am revealed: -Kitchen: Debris particles inside kitchen drawers; dust/dirt accumulation behind chest freezer; light brown particle on window ledge; rust colored areas on file cabinet and drawer handles detached on one side. -Hall bathroom: stains on back or toilet; walls smudged; dust/dirt build up on horizontal surfaces of vanity, toilet base, and baseboards. The lid on the toilet tank did not fit and would not sit securely over the tank (moved freely). -Client #1 and #4's room: Client #4 dresser drawers off track and would not close; desk chair with split seat covering exposing foam filling. -Cat litter pan in hall with litter scattered on the floor. Two flies circling the pan; lumps of litter	V 736		

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BTW HOME CARE SERVICES III	781 HAGGERTY TRAIL ROCKY MOUNT, NC 27803

(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 736	Continued From page 13 present. -Client #2's curtain sagging on rod. -Client #3 and #5's room: Door smudged with gray stains. -Air return vent in hall covered in thick dust buildup. -Rolling chair in living room with top layer of vinyl coating completely worn away and frayed. -Back storm door would not close; closure mechanism bent; screen mesh ripped away from frame and hanging loosely by the bottom edge. -Bucket filled with soiled water sitting by the back door on exterior walk out. Interview on 8/8/19 Staff #1 stated: -The cat litter had been changed the prior day. -She did not know when the air filter had last been changed. She would follow up. Interview on 8/8/19 the Licensee stated: -The owner of the home had replaced the back of the toilet tank with one that did not fit. She would follow up to get one that would fit. -She would remove and replace the broken furniture. This deficiency has been cited 3 times since the original cite on 3/23/18 and must be corrected within 30 days.	V 736		