STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL079-132	A. BUILDING: _____ B. WING _____	09/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAYETTEVILLE STREET COMMUNITY LIVING HOMES	855 MORGAN ROAD EDEN, NC 27288

(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 survey was completed on 9/18/2019. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	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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V 118	Continued From page 1	V 118		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure medications were administered as ordered by a qualified person, and administration of medications was documented immediately following administration affecting 2 of 3 clients (#2 & #3). The findings are:

Review on 9/18/2019 of client #2's record revealed:
- Admission date: 5/3/2019
- Diagnoses: Unspecified disruptive impulse control and conduct disorder; Schizoaffective disorder; Bipolar disorder, unspecified; Generalized anxiety disorder; Attention Deficit-Hyperactivity Disorder (ADHD), combined type; Moderate intellectual disabilities; Seizure Disorder; Mild Asthma; Gastroesophageal Reflux Disease (GERD); Type 2 Diabetes; and Combined Hyperlipidemia;
- Physicians orders for the following medications:
    - Dymista nasal spray, 1 spray in each nostril BID (twice daily), dated 5/29/2019;
    - Famotidine (Pepcid) 20 mg (milligrams), 1 tablet BID, dated 5/3/2019;
    - Metformin HCL (hydrochloride) 850 mg, I tablet BID with meals, dated 5/3/2019;
    - Symbicort 160/4.5 mg inhaler, inhale 2 puffs into lungs BID, dated 5/3/2019;
    - Tegretol XR 400 mg, 1 tablet BID, dated 5/3/2019;
    - Quetiapine fumarate (Seroquel) 25 mg, 1 tablet TID (three times daily), dated 5/3/2019;
- A physician's order for blood sugar checks TID,

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V 118	Continued From page 2 dated 5/3/2019. Review on 9/17/2019 of client #2's MARs dated 7/1/2019 to 9/17/2019 revealed: - There was no documentation of administration of Dynamist at 8:00AM during the entire month of July, and on 4 days in September; or at 8:00PM from August 2-11, and from September 1-17; - Blanks were on the MARs for famotidine, Metformin, Symbicort, Tegretol, and quetiapine fumarate on sporadic dates, for a total of 14 missed doses; - Blood sugar checks were not documented consistently on the MAR forms; Further review of client #2's record on 9/18/2019 revealed: - "Blood Sugar/Blood Pressure Sheet" forms were used to document the date, time, and results of blood sugar checks; - The blood sugar records were reviewed for the dates of 7/1/2019 to 7/18/2019; - There was no documentation that client #2's blood sugar was tested on 7 days; - Client #2's blood sugar was only tested once a day instead of TID on 13 days; - Client #2's blood sugar was only tested twice daily instead of TID on 11 days. Review on 9/18/2019 of client #3's record revealed: - Admission date: 6/10/2019; - Diagnoses: ADHD; Unspecified Schizophrenia Spectrum D/O; Anxiety D/O; Autism Spectrum D/O; Mild Intellectual Disabilities; GERD; - Physician's orders for the following medications: - Triamcinolone 24-hour nasal spray, 2 sprays into nostrils QD, dated 5/22/2019; - Metformin HCL 500mg, 1 tablet QD with dinner, dated 5/22/2019;	V 118		

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V 118	Continued From page 3 - Montelukast sodium 10 mg, 1 tablet QD, dated 6/26/2019; - Saline mist 0.65% nasal spray, 2 sprays each nostril QD, dated 5/22/2019; - Guanfacine 2mg, 1 tablet BID, dated 6/26/2019; - Buspirone HCL 10mg, 1 tablet TID, dated 6/28/2019; - Hydroxyzine HCL 25mg, 1 tablet TID, dated 8/22/2019. Review on 9/17/2019 of client #3's MARs dated 7/1/2019 to 9/17/2019 revealed: - Blanks were left on the MARs for triamcinolone nasal spray, montelukast sodium, saline mist nasal spray, guanfacine, buspirone, and hydroxyzine HCL on sporadic dates for a total of 10 missed doses; - Metformin was routinely administered at 5:00PM; - The metformin entry on the September MAR had two lines of staff initials, one with no time listed, which indicated that the metformin was administered twice daily instead of the ordered once daily. Interview on 9/17/2019 with client #2 revealed: - He could name some of his medications; - He thought he was taking his medications correctly every day. Interview on 9/17/2019 with client #3 revealed: - He did not know the names of all of his medications; - He thought that facility staff were administering his medications correctly. Interview on 918/2019 with staff #1 revealed: - Staff #1 only administered medications at 2:00PM because the 3rd shift staff administered	V 118		

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V 118	Continued From page 4 8:00AM medications before they left; - Staff #1 had told other staff that they needed to double check the MARs when staff #1 saw documentation errors; - the House Manager (HM) or the Owner/ Chief Executive Officer (O/CEO) checked the MARs for accuracy. Interviews on 9/17/2019 and 9/18/2019 with the HM revealed: - Client #2's Dymista was denied by Medicaid, therefore, the facility could not get a refill for it until the Pharmacy and client #2's Physician resolved the funding issue; - The Pharmacy had been sending two bottles of Dymista, with one bottle having administration instructions for 8:00AM and the other for 8:00PM; - When client #2 ran out of one bottle, that dose was not administered; - The HM had been inContact with client #2's Physician about the Dymista, but a discontinuation order had not been received; - Client #2 had an upcoming appointment scheduled with his Physician, and the Physician was planning to discontinue the medication at that time; - Client #2 would sometime refuse to use the Symbicort inhaler, but facility staff should have been documenting that instead f leaving blanks on the MARs; - The error with having two lines of staff initials for administration of metformin on client #3's September MAR was probably an error in which the first staff who made the error was going too fast and signed the wrong line; - The continued documentation error for the metformin was probably because other staff saw the initial and continued to sign in the wrong place without looking more closely at the MAR; - Client #3's blood sugar test results were	V 118		

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V 118	Continued From page 5 documented on a different form than the MAR; - There should not have been any missing entries for client #3's blood sugar test results. Interview on 9/18/2019 with the Qualified Professional (QP) revealed: - The facility staff were trained on how to correctly administer and document medication administration; - The O/CEO reviewed MAR with a Licensed Practical Nurse (LPN) and a Registered Nurse (RN) regularly; - The O/CEO was thorough about ensuring medications were administered correctly; If there were issues with client #3's blood sugar, facility staff would contact a nurse or take him to an urgent care center; - The QP was not aware of any negative health outcomes related to medication errors or missed medication doses. Interview on 9/18/2019 with the O/CEO revealed: - The HM was responsible for ensuring that MARs were completed correctly; - The O/CEO was not aware of the documentation errors on clients' #2 and #3's MARs and client #3's blood sugar logs; - The O/CEO would ensure that client #2's Physician was contacted about resolving the issue with Medicaid covering his Dymista nasal spray.	V 118		