STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL081-082	A. BUILDING: _____ B. WING _____	R-C 10/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMAL DRIVE	149 THERMAL DRIVE FOREST CITY, NC 28043

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 10/9/19. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Intellectual and Developmental Disabilities.	V 000		
V 116	27G .0209 (A) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (a) Medication dispensing: (1) Medications shall be dispensed only on the written order of a physician or other practitioner licensed to prescribe. (2) Dispensing shall be restricted to registered pharmacists, physicians, or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy. If a permit to operate a pharmacy is Not required, a nurse or other designated person may assist a physician or other health care practitioner with dispensing so long as the final label, Container, and its contents are physically checked and approved by the authorized person prior to dispensing. (3) Methadone For take-home purposes may be supplied to a client of a methadone treatment service in a properly labeled container by a registered nurse employed by the service, pursuant to the requirements of 10 NCAC 45G .0306 SUPPLYING OF METHADONE IN TREATMENT PROGRAMS BY RN. Supplying of methadone is not considered dispensing. (4) Other than for emergency use, facilities shall not possess a stock of prescription legend drugs for the purpose of dispensing without hiring a pharmacist and obtaining a permit from the NC	V 116		

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V 116	Continued From page 1 Board of Pharmacy. Physicians may keep a small locked supply of prescription drug samples. Samples shall be dispensed, packaged, and labeled in accordance with state law and this Rule. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure dispensing of medications was restricted to pharmacists, physicians or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy affecting 1 of 3 clients (Client #1). The findings are: Observation on 10/9/19 at approximately 11:30am revealed of medication box for Client #1 revealed: -Empty plastic pill pack in medication box. Pill pack was approximately 4" tall by 7" wide with 7 days of the week labeled across the top and 4 compartments under each day of the week. Third row down revealed an orange sticker with 2PM written on it. Record review on 10/9/19 for Client #1 revealed: -Admission date of 6/1/09 with diagnoses of Mild Intellectual/Developmental Disabilities, Oppositional Defiant Disorder, Smith-Magennis Syndrome and Selective Mutism. Physician ordered medications included: --Ferrous Sulfate (iron deficiency) 325mg once daily ordered 1/3/19. --Omeprazole (reflux) 20mg once daily ordered 1/3/19. --Vitamin D3 (vitamin deficiency)1000iu once daily ordered 1/3/19.	V 116		

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V 116	Continued From page 2 --Vraylar (bipolar) 6mg once daily ordered 6/18/19. --SF 5000 Plus Cream (floride) -brush with pea size amount three times daily ordered 9/19/18. --Desmopressin (enuresis) 0.2mg 3 tabs at bedtime ordered 10/18/18. --Fluvoxamine (obsessive compulsive disorder) 50mg at bedtime ordered 10/18/18. --Melatonin (sleep)3mg at bedtime ordered 2/14/19. --Lorazepam (anxiety) 1mg at bedtime on Friday, Saturday, Sunday only and 0.5mg in AM and at 2pm ordered 6/18/19. --Abilify (antipsychotic) 2mg at bedtime ordered 7/16/19. Interview on 10/9/19 with the House Manager and the Qualified Professional revealed: -Staff had been sending the medication pill pack for years when Client #1 went home for visits. -There was a brief time, that the entire medication box went home with Client #1. That practice stopped and staff went back to the weekly pill pack. -Client #1 went home frequently for visits sometimes for 1 night and sometimes for 3 nights. -They would figure out the best way to manage Client #1's weekend visits without staff packing and sending the med pack.	V 116		
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	V 123		

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V 123	Continued From page 3 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 review and interview, the facility failed to ensure medication errors were reported immediately to a physician or pharmacist affecting 1 of 3 clients (Client #1). The findings are: Record review on 10/9/19 for Client #1 revealed: -Admission date of 6/1/09 with diagnoses of Mild Intellectual/Developmental Disabilities, Oppositional Defiant Disorder, Smith-Magennis Syndrome and Selective Mutism. Review on 9/27/19 of incident reports from June 1, 2019 - September 27, 2019 revealed: -3 incident reports, 6/30/19 (Client #1 refused medications); 9/7/19 (Client #1 aggressive behavior) and 9/8/19 (Client #1 aggressive behavior). -On 6/30/19 Client #1 refused evening medications but neither pharmacist nor physician were contacted. Review on 9/27/19 of Client #1's behavior log revealed: -On 8/20/19, Client #1 refused meds and went to sleep at 5pm. No documentation of pharmacist or physician contact was available. Review on 9/27/19 of August and September 2019 MARs revealed: -On 8/11/19, 8/20/19 and 9/7/19 Client #1 refused	V 123		

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V 123	Continued From page 4 all 8pm meds. No incident report or documentation of pharmacist or physician contact was available for 8/11/19, 8/20/19 or 9/7/19 when Client #1 refused his 8pm meds. Interview on 10/9/19 with the Qualified Professional (QP) revealed: -She was responsible for writing incident reports and normally completed the report forms the day following an incident. -Staff made frequent calls to the pharmacy and the pharmacist got very annoyed. -8pm meds were sometimes difficult for Client #1 because he liked to go to bed when it got dark.	V 123		
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 failed to be maintained in a clean, attractive and orderly manner. The findings are: Observation of the facility on 9/27/19 and 10/9/19 at 12:50pm revealed: -2 large holes in the drywall in Client #1's bedroom. Several other patches were evident but not painted.	V 736		

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V 736	Continued From page 5 -2 holes in the bathroom wall and the outer paper of the drywall was peeled off covering about a 1' x 2' area. -The deck off the back of the house had 10-12 "soft" boards that flexed when stepped on. Some of these boards were warped or split and in need of replacement. Several nails had popped up and were a trip hazard. Interview on 10/9/19 with the Qualified Professional revealed: -She would make sure the landlord was made aware of the deck issues. -She would have their maintenance person patch the holes in the wall which was a continuous thing. Client #1 often hit the walls in frustration. After punching even a small hole in the wall he often picked at the hole until it was much larger. This was an ongoing issue. This deficiency constitutes a recite deficiency and must be corrected within 30 days.	V 736		