STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G058	A. BUILDING _____ B. WING _____	10/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD FARM ROAD	409 OLD FARM ROAD RAEFORD, NC 28376

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W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure staff were sufficiently trained to perform their duties. The finding is: The medication technician (MT) was not effectively trained to perform required duties during medication administration. a. During observations of medication administration in the home on 10/23/19 from 8:18am - 9:23am, the MT left the medication room on eight separate occasions. As the MT left the room, the closet containing medications and the door to the medication room were unlocked and/or open. Interview on 10/23/19 with the MT revealed they had been trained to ensure the door to the medication room was "closed" when administering medications. Review on 10/23/19 of the facility's medication pass observations sheet (last modified 6/23/16) revealed the medication closet should be "locked when unattended". Interview on 10/23/19 with the facility's nurse confirmed staff have been trained to ensure medications are kept locked if the MT needs to	W 189		

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

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W 189	Continued From page 1 leave the area during medication administration. b. During observations of medication administration in the home on 10/23/19 at 8:51am and 9:07am, the MT obtained the client's medication pill cards, punched the pills into a medication cup and immediately signed the Medication Administration Record (MAR). Afterwards, the clients ingested the medications with water and/or pudding. Interview on 10/23/19 with the MT indicated they routinely sign the MAR before giving clients their medications. Additional interview indicated they had been trained to sign the MAR and then give clients their medications. Review on 10/23/19 of the facility's medication pass observations sheet (last modified 6/23/16) revealed the MT "makes sure meds are ingested prior to documenting on MAR". Interview on 10/23/19 with the facility's nurse confirmed staff have been trained to ensure clients ingest their medications before the MAR is signed.	W 189		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #6's Individual Program Plan (IPP) included	W 240		

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W 240	Continued From page 2	W 240		

information to support his independence. This affected 1 of 3 audit clients. The finding is:

Client #6's IPP did not include information regarding the use of his eye glasses.

During intermittent observations at the day program on 10/22/19 from 10:45am - 12:50pm, client #6 was not observed wearing eye glasses. Throughout the observations, the client sat at a table looking at videos on a small tablet.

During observations at the home on 10/22/19 from 3:15pm - 6:15pm, client #6 wore eye glasses for approximately one hour before removing them. When the client was not wearing the eye glasses, they were located on a mantel over the fire place. On 10/23/19, in the home, client #6 put on his glasses shortly before leaving the home.

Interview on 10/23/19 with Staff C revealed client #6 wears his eye glasses "all the time" but will sometimes take them off when viewing things on his tablet.

Review on 10/23/19 of client #6's IPP dated 7/18/19 revealed, "No order for glasses at this time." Additional review of the record revealed he had an eye exam on 4/25/19. The exam report noted, "Hyperopia and astigmatism...new glasses Rx provided attempt glasses wear. New glasses may help patient with near work (like tablet use)." Further review of the IPP did not include any specific information regarding the use of client #6's eye glasses.

Interview on 10/23/19 with the Qualified Intellectual Disabilities Professional (QIDP)

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W 240	Continued From page 3 confirmed there was no information regarding client #6's eye glasses in his IPP.	W 240		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure all medications were administered without error. This affected 4 of 4 clients (#1, #3, #4, #5) observed receiving medications. Clients did not receive their medications as ordered. a. During observations of medication administration in the home on 10/23/19 at 8:28am, client #1 ingested Robinol and Depakote. The client did not receive any other medications during this time. Review on 10/23/19 of client #1's physician's orders dated 9/1/19 - 12/1/19 revealed an order for Isopt atrop sol 1%, use as directed sublingually twice a day at 8:00am and 8:00pm. Interview on 10/23/19 with the medication technician (MT) indicated they thought the client still receives the solution; however, they did not recall seeing it in his basket during the med pass. b. During observations of medication administration in the home on 10/23/19 at	W 369		

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W 369	Continued From page 4 8:40am, client #3 ingested Abilify and Aspirin. The client did not receive any other medications during this time. Review on 10/23/19 of client #3's physician's orders dated 9/1/19 - 12/1/19 revealed orders for Alphagen sol 1%, instill 1 drop in each eye twice a day at 8:00am and 8:00pm and Gavilax powder, dissolve 17gm (1 capful to the line) in 8 oz of liquid and drink by mouth twice a day at 8:00am and 8:00pm. Interview on 10/23/19 with the MT revealed they thought the client's eye drops were discontinued and his Gavilax was only given at night. c. During observations of medication administration in the home on 10/23/19 at 8:51am, client #4 ingested Vitamin D3, Dulcolax, Cal Cit, Zantac and Singular. The client did not receive any other medications during this time. Review on 10/23/19 of client #4's physician's orders dated 9/1/19 - 12/1/19 revealed orders for Albuterol Neb .083%, inhale 3ml (the contents of one vial) per nebulizer by mouth every morning at 8:00am. The orders also indicated the client should receive 8 oz of prune juice "with medications daily" at 8:00am. Interview on 10/23/19 with the MT indicated they thought client #4's nebulizer treatments had been discontinued but they were not sure. Additional interview revealed client #4 gets the prune juice at breakfast. d. During observations of medication administration in the home on 10/23/19 at 9:07am, client #5 ingested Vimpat, Klonopin,	W 369		

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W 369	Continued From page 5 Neurotin, Singular, Oxtellar XR, Vitamin D3, Thermotabs, Docusate Sodium, Coestid and Carnitor. The client did not receive any other medications during this time. Review on 10/23/19 of client #5's physician's orders dated 8/5/19 revealed orders for the following: Systane eye drops, instill one drop in each eye three times a day at 8:00am, 4:00pm and 8:00pm Flonase spray, instill two sprays in each nostril daily at 8:00am Lactulose, give 15cc by mouth twice a day at 9:00am and 9:00pm. Interview on 10/23/19 with the MT revealed if client #5 wears his glasses, he does not receive his eye drops. Additional interview indicated they were not sure but the nasal spray and Lactulose may have been discontinued. Interview on 10/23/19 with the facility's nurse confirmed all medications and treatments omitted by the MT during morning medication administration on 10/23/19 for clients #1, #3, #4 and #5 remain current and should have been given as ordered.	W 369		
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.	W 382		

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W 382	Continued From page 6 This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure all medications remained locked except when being administered. This potentially affected all clients in the home. The finding is: Medications were not kept locked. During observations of medication administration in the home on 10/23/19 from 8:18am - 9:23am, the medication technician (MT) left the medication room on eight separate occasions. As the MT left the room, the closet containing medications and the door to the medication room were unlocked and/or open. Interview on 10/23/19 with the MT revealed they had been trained to ensure the door to the medication room "was closed" when administering medications. Review on 10/23/19 of the facility's medication pass observations sheet (last modified 6/23/16) revealed the medication closet should be "locked when unattended". Interview on 10/23/19 with the facility's nurse confirmed medications should be kept locked if the MT needs to leave the area during medication administration.	W 382		