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V 000	INITIAL COMMENTS A limited follow up survey for the Type A1 rule violation was completed on October 21, 2019. This was a limited follow up survey, only 10A NCAC 27G .0209 MEDICATION REQUIREMENTS, VTag 118(c) (1) (4); VTag 119(d) and VTag 120(e) were reviewed for compliance. 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.	V 110		

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V 110	Continued From page 1 (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility management failed to assure 2 of 2 audited staff (#1 & #2) 1) demonstrate the technical knowledge required by the population served and 2) failed to initiate an individualized supervision plan. The findings are: During interview on 10/18/19, a request was made for staff personnel files. The Licensee: - provided a copy of a certificate for Staff #1 and Staff #1 documenting they received training in diabetes care on 9/26/19. - said he understood the surveyor to only need proof of staff training in diabetes for the survey. Consequently he did not have the staff personnel files present. - The staff supervision plan was developed and provided by the facility's Qualified Professional and should be available. - However, he would provide the required staff documents for the survey. During interview on 10/16/19, Staff #1, the current staff on duty: - Reported he is the Licensee's son and has been working to "help out" in the facility for approximately 2 or 3 months. - Said he works 24 hours a day for three days at a	V 110		

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V 110	Continued From page 2 time. - He was unable to locate current medication administration records for clients and referred me to make the request of the staff who would be working the next day. - He was unable to clarify physician's orders for management of Client #1's diabetes resulting in the client's medication and blood sugar levels not being managed according to the physician's instructions Interview on 10/17/19 with Staff #2, the current staff on duty, revealed the following: - He has been working in the facility approximately one month and works 24 hours a day for three days at a time. - He was unable to clarify physician's orders for management of Client #1's diabetes resulting in the client's medication and blood sugar levels not being managed according to the physician's instructions - He followed instructions given to him from the previous House Manager and did not demonstrate a clear understanding between administering client medications according to physician's orders and documentation of the administration of medication. See Tag V118 for more details on the management and administration of client's medications by Staff #1 and Staff #2, No additional information related to personnel requirements for staff was received prior to the close of the survey.	V 110		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION	V 118		

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V 118	Continued From page 3 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. This Rule is not met as evidenced by: Based on record reviews, observation and interviews facility staff failed to assure: 1) physician's orders were available for all medications being administered; 2) MARs were kept current and 3) physician's orders were	V 118		

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V 118	Continued From page 4 followed for administering medication and managing medical procedures for 1 of 3 audited clients (#1) The findings are: Review on 10/17/19 of Client #1's record revealed: - Admission date of 12/16/16. - Diagnoses of Schizophrenia, Diabetes Type II; Chronic Kidney Disease - Stage 4; Hyperlipidemia; Nicotine Addiction Additional review on 10/17/19 of Client #1's record revealed: - FL-2 dated 4/29/19 was found with medications ordered by the client's physician as follows: 1. Labetalol Hcl 100 milligrams (mg) One tablet two times each day - 8AM & 8PM 2. Metoprolol Succinate ER 25mg, One tablet every day - 8AM 3. Vitamin D2 1.25mg 50,000 Units, One capsule every 6 weeks 4. Fluticasone Prop 50 micrograms (mcg,) 2 sprays into each nostril every day as needed 5. DOK Soft Gel 100mg, One capsule twice daily as needed (PRN) 6. Melatonin 1mg, One tablet at bedtime 7. Amlodipine Besylate 10mg, One tablet every day 8. Olanzapine 15mg, One tablet at bedtime 9. Glimepiride 2 mg, One tablet two times each day 10. Lantus Insulin 100 Units/milliliter (ml) Vial, Inject 10 Units Subcutaneously at bedtime 11. True Metrix Blood Glucose - Use three (3) times a day as instructed to check blood sugar level (BSL) - No other current signed physician's orders were available for medications the client was being administered.	V 118		

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V 118	Continued From page 5 Review on 10/17/19 of Client #1's September 2019 and October 2019 MARs revealed the following: A. September 2019 MAR, staff documented the following: 1. All of the above medications were administered as ordered on the FL-2 dated 4/29/19 except Amlodipine Besylate. 2. Amlodipine Besylate was documented as administered as 5mg, one tablet every day 9/1/19 thru 9/30/19 - However, the last available physician's order on the FL-2 dated 4/29/16 ordered Amlodipine Besylate to be administered in a 10mg dose, once daily. - No physician's order was found ordering a change in the strength of the medication from 10mg to 5mg. Additionally, interview on 8/18/19 with the Pharmacist's revealed: - Client #1's Amlodipine Besylate was discontinued on 9/23/19 by his physician through a verbal order. 3. Glimepiride 4 mg, One tablet once each day - Staff initialed medication was administered daily from 9/1 thru 9/22 and 9/24 -25. - 9/1 thru 9/31 was blacked out with a black marker and "D/C" (discontinued) written above it. NOTE: An order dated 9/23/19 from the client's physician was found discontinuing the medication. 3. Vitamin D2 1.25mg 50,000 Units, one capsule every 6 weeks - No documentation medication was administered any day from 9/1/19 through 9/30/19 4. DOK Soft Gel 100mg, one capsule twice daily PRN - Staff documented the client was administered a	V 118		

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V 118	Continued From page 6 total of nine (9) capsule from the container of 60 capsules dispensed on 2/14/19 = twice on 9/1 and 9/8; and once each day on 9/12; 9/17; 9/21; 9/24 & 9/26. B. October 2019 MAR - Documentation for administration of the following medications was missing on the dates identified: 1. Labetalol Hcl 100mg at 8PM on 10/1 thru 10/16 and 8AM on 10/14 2. Metoprolol Succinate ER 25mg on 10/12 and 10/13 3. Vitamin D2 1.25mg 50,000 Units, one capsule every 6 weeks - No documentation medication was administered any day from 10/1/19 through 10/17/19 4. Melatonin 1mg, 10/9 and on 10/11 thru 10/15 5. Amlodipine Besylate was not transcribed on the October 2019 MAR. - Consequently, staff did not document the medication was administered in 10mg nor 5mg, one tablet every day. - No physician's order was found discontinuing the medication. C. October 2019 MAR - Staff documented the following medications were administered as ordered on the dates identified: 1. Lantus Insulin 100 Units/ml Vial, Inject 10 Units Subcutaneously at bedtime - Documentation medication was administered each night on 10/1 thru 10/17 2. Fluticasone Prop 50mcg, 2 sprays into each nostril every day as needed (PRN) - Documentation medication was administered once a day 10/1 thru 10/17 - However, documentation was incomplete. Staff did not document time or reason the PRN medication was administered nor whether the client responded to the PRN medication.	V 118		

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V 118	Continued From page 7 3. DOK Soft Gel 100mg, One capsule twice daily PRN - Documentation medication was administered once a day 10/1 thru 10/17 - However, documentation was incomplete. Staff did not document time or reason the PRN medication was administered nor client response. - Additionally, medication count was off as documentation of number of capsules did not correspond with number of tablets remaining in container of medication dispensed on 2/14/19. 4. BSL levels were documented as checked during the following dates and times: - 8:00 AM on 10/1 thru 10/17; 4:00 PM on 10/1 & 10/3 thru 10/6; and at 8:00 PM on all days except 10/2. Observation on 10/17/19 at 2:30 PM of Client #1's medications-on-hand revealed: 1. Pills and capsules dispensed by the pharmacy in a daily dose bubble pack; i.e. all medications were contained in one bubble and identified by time of day for administration. - Names of the medication contained in each bubble was listed next to the bubble. - A list of all the medications was also identified at the top of the bubble pack with the strength and dose to be administered. However, no description of the actual pill/capsule was provided. - Olanzapine 15mg, one tablet at bedtime, was one of the medications included in the combined daily dose bubble pack dispensed on 10/11/19. - Olanzapine 15mg was not transcribed on the client's October MAR as one of the medications he was being administered. 2. Lantus Insulin 100 Units/ml Vial - six (6) 15mL vials stored in a lock box in the refrigerator. - Label instructions to be administered as ordered by physician. - The date the pharmacy dispensed the Insulin	V 118		

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V 118	Continued From page 8	V 118		

could not be identified.
- One vial of Insulin was partially used. However, it could not be determined when staff began administering the medication as there was not an "open date" recorded on the vial as required.
3. Fluticasone Prop 50mcg, 120 sprays - three (3) bottles
- Label instructions to administer two sprays into each nostril every day PRN
- Stored in lock box in refrigerator containing client's Insulin.
- Two bottles were unopened. One bottle had approximately one-fifth of the contents missing.
- Did not have a dispense date however bottle had an expiration date of 4/2021
4. DOK Soft Gel 100mg, one bottle originally dispensed on 2/14/19 with 60 capsules.
- No instructions on label.
- Stored in lock box in refrigerator containing client's Insulin.
- 11 of the capsules were missing with 49 remaining in the container.
- Additionally, 9 capsules were documented as administered in September 2019 from the same bottle dispensed on 2/14/19

During interview on 10/16/19, Staff #1, the current staff on duty reported he:
- is the Licensee's son and has been working to "help out" in the facility for approximately 2 or 3 months.
- works 24 hours a day for three days at a time.
- received training in medication administration.
- could not locate Client #1's October MAR, however could provide the medications he administered the client for the survey.
- administered Client #1's medication based on pharmacy-printed instructions on the medication label
- initialed all boxes for medications identified on

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V 118	Continued From page 9 Client #1's MAR as he was instructed to do by the facility's previous House Manager. - did not administer Client #1 his 10 units of Lantus Insulin at bedtime each night as identified on the client's MAR. - administers the client 10 Units of Lantus Insulin from the 15mL vial only "when he needs it;" i.e. when the client's blood sugar level (BSL) is "high" or "low." - used the glucometer to help the client take his BSL, however he has not recorded the information in a log. - received instructions from the facility's previous House Manager on when to administer Client #1's Lantus Insulin. - did not have written instructions from the client's physician on when to administer the Lantus Insulin. - did not have written instructions from the client's physician on when to consider the client's blood sugar levels as high or low. - thought Staff #2, who would be working the following day, had more information and could also locate the client's MARs. Interview on 10/17/19 with Staff #2, the current staff on duty, revealed the following: - He has been working in the facility approximately one month and works 24 hours a day for three days at a time. - A nurse trained him in how to take blood sugar levels with a glucometer and how to use insulin pens to administer insulin. - He used the pharmacy-printed instructions on the medication label to guide him when he administered Client #1's medications. - He was instructed by the facility's previous House Manager to initial all boxes for medications identified on Client #1's MARs and "do not leave any boxes blank."	V 118		

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V 118	Continued From page 10 - He was unable to explain the lack of documentation on the dates identified above for: Labetalol Hcl 100mg; Metoprolol Succinate ER 25mg; Melatonin 1mg. and Vitamin D2 1.25mg 50,000 Units. - He said Vitamin D2 1.25mg 50,000 Units needed to be ordered so it could be administered. He was unable to locate documentation of when Client #1 last received the Vitamin D2. - He acknowledged the October 2019 MAR shows documentation he administered Client #1 Fluticasone Prop 50mcg once daily when he was on duty. However, he said he believes he actually may have administered the medication "One time when he (Client #1) asked for it." - He also acknowledged the October 2019 MAR shows documentation he administered DOK Soft Gel 100mg, once daily when he was on duty. However, he said he has never given the client a dose of the DOK medication. - He further said he did not administer Client #1 Lantus Insulin 10 units at bedtime each night as he documented on the client's October 2019 MAR. - He thinks he has administered approximately 10 Units of Lantus Insulin to Client #1 during the one month he has been working in the facility. However, he was unable to confirm the date he gave the client the insulin. - He will administer 10 Units of Lantus Insulin to the client in the AM or PM if the client's blood sugar level is "high" or "low." - He described a "low" blood sugar level = "When his blood sugar is under 100, I give him a shot." - He said a "high" blood sugar level = is "about 150 or 160." - He was not aware if there were written instructions from the client's physician on when to consider the client's BSL as "high" or "low." - He did not have written instructions from the	V 118		

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V 118	Continued From page 11 client's physician on when to administer the Lantus Insulin. - "I was here when he (Client #1) went to the doctor on 9/23. [Licensee] took him. He gave me the discontinued med (medication) paper (for Glimepiride) only." - The facility's previous House Manager told him to record Client #1's BSL in a small calendar notebook. Review on 10/17/19 of the calendar notebook provided by Staff #2 as documentation of Client #1's BSL's revealed: - Various numbers ranging from 90 to 170 at different places on the calendar. - Numbers were placed sporadically under different days on the October calendar. - However, no specific dates or times were noted on the calendar to identify when Client #1's BSL was taken/recorded. During interview on 10/21/19, the Licensee said: - The above problems began when the facility switched to a different pharmacy sometime in July or August 2019. - The new pharmacy did not receive all the correct information from the former pharmacy provider. - The physician communicated information and changes regarding Client #1's insulin and BSL's verbally to the pharmacy and the former House Manager. - Additionally, the House Manager was sick and left suddenly without obtaining written instructions from the client's doctor and clearly communicating the physician's instructions which placed the facility in a difficult position. - He would immediately contact Client #1's physician and the pharmacy to obtain correct medical instructions and signed copies of all	V 118		

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V 118	Continued From page 12 current medications the client's physician ordered. A Plan of Protection (POP) was requested at the survey exit. The Licensee said he would have the facility Qualified Professional complete and immediately fax the information. However, a POP was not received. Additional contact was made to discuss the POP requirements with the Licensee and he requested another copy of the POP form be sent by email. The second copy of the form was emailed to the Licensee on 9/6/19. A notification from North Carolina Department of Health and Human Services Secure Email Message Expiration Notification was received on 11/5/19 that the recipient "failed to pickup the message." Client #1 had diagnoses of Schizophrenia, Diabetes Type II and Chronic Kidney Disease-Stage 4. Staff did not a) did not administer the client's Lantus Insulin (a long acting insulin) once nightly as ordered by his doctor; b) take and document blood sugars (BSL) daily for the client; c) did not have knowledge of medically desired BSL ranges for Client #1 and c) did not coordinate with his physician in the proper management of his medical conditions. Additionally, staff admitted they did not actually administer the insulin daily. However they inaccurately documented they administered the insulin medication each day. Consequently, staff were unable to confirm the actual dates the client received his insulin medication. Further, staff received instructions from a former staff on how to manage and care for Client #1's diabetic condition. The staff, former House Manager, was not a medically trained professional and provided incorrect and misleading instructions to the staff on managing Client #1's diabetes. These areas	V 118		

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V 118	Continued From page 13 constituted serious neglect which subjected Client #1 to conditions that could further complicate his medical conditions and subjected him to serious risk of harm. This deficiency constitutes a Failure to Correct the Type A1 rule violation originally cited for serious neglect. An administrative penalty of $500.00 per day is imposed for failure to correct within 23 days.	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; (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:	V 120		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-237	A. BUILDING: _____ B. WING _____	R 10/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOMES II	801 N MEBANE STREET BURLINGTON, NC 27217

(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 Based on record reviews, observation and interviews, the facility staff failed to assure medication for 3 of 3 audited clients (#1; #2 & #3) was stored separately for each client in a clean, well-lighted, ventilated area. The findings are: Review on 10/17/19 of Client #1's record revealed: - Admission date of 12/16/16. - Diagnoses of Schizophrenia, Diabetes Type II; Chronic Kidney Disease - Stage 4; Hyperlipidemia; Nicotine Addiction Observation on 10/17/19 at 2:30 PM of Client #1's medications-on-hand revealed: 1. Atorvastatin 20mg 2. Cinacalcet Hcl 30mg (Sensipar) 3. Finasteride 5mg 4. Folic Acide 1000mg 5. Labetalol Hcl 100mg 6. Lisinopril 5mg 7. Melatonin 1mg 8. Metoprolol Succinate ER 25mg, 9. Olanzapine 15mg Review on 10/17/19 of Client #2's record revealed: - Admission date of 2/3/16. - Diagnoses of Schizophrenia, Bipolar I Disorder; Hyperlipidemia; Vitamin D Deficiency; Osteoarthritis and Abdominal Bruit Observation on 10/17/19 at 3:30 PM of Client #2's medications-on-hand revealed: 1. Vitamin D3 1000 2. Claritin 10mg 3. Aspirin EC 81mg 4. Tylenol Arthritis ER 650 5. Pravachol 40mg 6. Trazodone 100mg	V 120		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-237	A. BUILDING: _____ B. WING _____	R 10/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HOMES II	801 N MEBANE STREET BURLINGTON, NC 27217

(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 15 Review on 10/17/19 of Client #3's record revealed: - Admission date of 12/2/15. - Diagnoses of Schizophrenia, Alzheimer's Disease; Advanced Dementia; Chronic Atrial Fibrillation; Seizure Disorder; Hypertension; Hyperlipidemia; Vitamin B12 Deficiency Observation on 10/17/19 at 3:45 PM of Client #3's medications-on-hand revealed: 1. Amlodipine Besylate 10mg 2. Vitamin B-12 1000mg 3. Memantine Hcl 5mg 4. Lamotrigine 150mg 5. Tylenol Arthritis ER 650 6. Atorvastatin 10mg 7. Olanzapine 10mg Further observation on 10/17/19 between 2:30PM and 4:00 PM revealed: - All of the above client medications were stored together in large brown paper bags. - Bags of medications were then stored in a locked hall closet. - Client medications were not stored separately for each client.	V 120		