STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL097-044	A. BUILDING: _____ B. WING _____	R 03/10/2020

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MULBERRY GROUP HOME	1904 WINDY RIDGE ROAD NORTH WILKESBORO, NC 28659

(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 and follow up survey was completed on March 10, 2020. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	V 112		

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to develop treatment plans which include specific strategies and interventions to address client treatment needs for 1 of 3 audited clients (#2). The findings are: Record review on 3/2/20 for Client #2 revealed: -Admitted on 4/1/03 with diagnoses of Unspecified Depressive Disorder, Mild Intellectual Disability, acid reflux, hypertension, pancreatitis and allergies. -Physician's order dated 9/9/19 to " ...Monitor BP (blood pressure) once a day. Bring log to visit on 9/18/19. Keep food diary ..." Review on 3/2/20 and 3/4/20 of the medical notes for Client #2 revealed: -" ...September 18, 2019. The following issues were addressed: Hypertension ...fatigue ..." -" ...December 9, 2019. The following issues were addressed: Hypertension ...hyperlipidemia ...other chronic pancreatitis" -Visit to the emergency room on 2/15/20 " ...Emergency ...reason for visit: headache ...Diagnosis: Hypertension ...Blood pressure 150/98 ..." -Visit to the emergency room on 2/19/20 " ...Presenting complaint: Patient states: reports high blood pressure ...complains of pain in head ...Vital signs: 149/91 ...The patient has elevated blood pressure ...Patient was doing her usual activities at the group home and her pressure was found to be elevated ...At its worst the blood pressure was moderate ...The patient has experienced similar episodes in the past ...She states that she has had multiple episodes of labile blood pressure ...She does have a family history of hypertension ...repeat blood pressure at	V 112		

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V 112	Continued From page 2	V 112		

disposition is 136/90. She is encouraged follow closely with her primary care physician..."

Review on 3/2/20 of the Treatment Plan for Client #2 revealed:
-" ...[Client #2] has high blood pressure which needs to be monitored. She often does not feel well and fails to tell someone ..."
-Goals included " ...Due to [Client #2] having some health concerns it is important that she alert staff when she is not feeling well ...([Client #2] has a tendency not to tell people about who has upset her and that she is feeling bad. She has high blood pressure and pancreatitis) ...". Strategies for this goal included staff to monitor for signs of pain or distress, encourage her to express feelings, staff to listen to complaints/symptoms, and to consult with the doctor as needed.
-There was no goal or strategies to specifically address her chronic high blood pressure or diet.

Interviews on 3/2/20 and 3/5/20 with Staff #1 revealed:
-Client #2 monitored her blood pressures three times per day.
-The sodium intake for Client #2 was monitored. She did not eat certain foods and the use of salt had been reduced for her food preparation.
-Client #2 was routinely seen by her primary care physician for her hypertension.

Interview on 3/4/20 with the Qualified Professional revealed:
-She wrote the goals included in the treatment plans.
-At one time blood pressures were a part of her treatment plan but were not currently included.

Interview on 3/5/20 with the Executive Director

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V 112	Continued From page 3 revealed: -The Qualified Professional was responsible for completing the treatment plan. -Treatment plans should be revised and changed as needs change. -Treatment plans should be reviewed quarterly for progress. -The treatment plan for Client #2 had not been updated to reflect current medical issues.	V 112		
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	V 118		

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V 118	Continued From page 4 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 review and interview the facility failed to follow written orders by the physician for 1 of 3 audited clients (#2). The findings are: Record review on 3/2/20 for Client #2 revealed: -Admitted on 4/1/03 with diagnoses of Unspecified Depressive Disorder, Mild Intellectual Disability, acid reflux, hypertension, pancreatitis and allergies. -Physician's order dated 9/9/19 to " ...Monitor BP (blood pressure) once a day. Bring log to visit on 9/18/19. Keep food diary ..." Review on 3/2/20 and 3/4/20 of the medical notes for Client #2 revealed: -" ...September 18, 2019. The following issues were addressed: Hypertension ...fatigue ..." -" ...December 9, 2019. The following issues were addressed: Hypertension ...hyperlipidemia ...other chronic pancreatitis" -Visit to the emergency room on 2/15/20 " ...Emergency ...reason for visit: headache ...Diagnosis: Hypertension ...Blood pressure 150/98 ..." -Visit to the emergency room on 2/19/20 " ...Presenting complaint: Patient states: reports high blood pressure ...complains of pain in head ...Vital signs: 149/91 ...The patient has elevated blood pressure ...Patient was doing her usual activities at the group home and her pressure was found to be elevated ...At its worst the blood	V 118		

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V 118	Continued From page 5 pressure was moderate ...The patient has experienced similar episodes in the past ...She states that she has had multiple episodes of labile blood pressure ...She does have a family history of hypertension ...repeat blood pressure at disposition is 136/90. She is encouraged follow closely with her primary care physician..." Review on 3/4/20 of the blood pressure and food diary documentation for Client #2 revealed: -Blood pressures that were recorded since 9/9/19 indicated high readings almost daily. Range of blood pressures documented were noted to be anywhere from 139/93 to as high as 156/110. -Documented by Client #2 not a staff member. -Daily blood pressures were not documented on 9/24/19, 9/27/19, 10/2/19, 10/3/19, 10/5/19, 10/6/19, 10/8/19-10/29/19 and from 10/31/19 to 2/14/20. Daily blood pressures were also not documented on 2/23/20, 2/24/20 and 2/29/20. -There was no documentation of a food diary. Interview on 3/5/20 with Client #2 revealed: -She stated that she had always had high blood pressure and that it ran in her family. -She was told by the doctor to write down what she was eating. -She indicated that Staff #2 had tried to help her with that in the beginning, but she was not writing down what she ate. She stated that she didn't have time to do that. -She was taking her blood pressure in the morning, at lunch and before bed. -She had not always written it down and the staff did not write it down. Interview on 3/6/20 with the Guardian of Client #2 revealed: -Client #2's blood pressures had been problematic for 8-9 months.	V 118		

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V 118	Continued From page 6 -Client #2 had received the proper attention for her blood pressure problem. She had seen the physician multiple times and was now scheduled to see a Cardiologist. -Client #2 had an electric blood pressure monitor and monitored her own blood pressure at the facility and at the day program. Staff #1 made sure that her blood pressure was checked. -She stated that Client #2's Nurse Practitioner (primary care physician) wanted the food diary kept temporarily but not ongoing. She wasn't sure that a food diary was ever kept and could not recall seeing one. -She indicated that blood pressures were monitored daily for Client #2 even if not consistently documented. Interviews on 3/4/20 and 3/5/20 with Staff #1 revealed: -Client #2's blood pressures were checked three times per day. -Client #2 took her own blood pressure multiple times daily with staff present. Client #2 would show the result to her and then Client #2 would write it down in a notebook that she kept in her possession. -Staff did not take or record blood pressures for Client #2. -If Client #2's blood pressures got too high she was taken to the emergency room. She had been told by a nurse at the hospital not to worry unless the diastolic number was greater than 115. -Client #2 started a food diary and kept for a while. She didn't know if Client #2 still kept a food diary. Interview on 3/9/20 with the Nurse Practitioner for Client #2 revealed: -When Client #2 was seen on 9/18/19 the facility failed to bring in a log of blood pressure readings	V 118		

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V 118	Continued From page 7 or a food diary. -She indicated that Client #2 monitored her own blood pressure and had been compliant in limiting her sodium intake. -She stated that facility staff told her that they did not monitor her blood pressure at the facility but that blood pressures were monitored when Client #2 was at her day program. -Client #2's blood pressure was volatile and has never been well controlled. -She did not feel that the facility would be compliant with tracking blood pressures or food intake. Interview on 3/5/20 with the Executive Director revealed: -Client #2's blood pressures fluctuated daily, and staff were very sensitive to this issue. Client #2 had seen medical providers on multiple occasions and was scheduled to see a Cardiologist. She had been told on 2/19/20 while at the emergency room with Client #2 that if her blood pressure gets to 165/115, stays at that level and does not come down following rest then she should be taken to the hospital. -She indicated that blood pressure was checked daily for Client #2 both at the facility and at the day program. -She thought that staff had documented blood pressures daily. She had not monitored to ensure those readings had been documented. -She had not been aware that the doctor wanted a food diary documented. She had not seen a food diary. -There was no system of oversight in place to monitor blood pressures for Client #2. Review on 3/6/20 of the Plan of Protection completed and signed by the Executive Director on 3/6/20 revealed:	V 118		

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V 118	Continued From page 8 What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? -"Beginning immediately today 3-6-20 all doctor's orders will be followed as written. Blood pressure will be checked and a food diary and BP (blood pressure) will be maintained daily as per doctor's order until there is a written order to discontinue from the doctor, by Group Home Managers. Should she show symptoms outside of her norm, she will be taken to ER (emergency room) or 911 will be called to transport." Describe your plans to make sure the above happens. -"Executive Director will monitor the process and documentation a minimum of three days per week, up to five days per week until there is an order from the doctor to discontinue, beginning 3-6-20." Client #2 has a diagnosis of hypertension and struggles daily with chronic, uncontrolled blood pressures that ranged anywhere from 139/93 to as high as 156/110. In September her physician ordered daily blood pressure checks and wanted the facility to document what Client #2 was eating. The facility left that responsibility up to Client #2 with no assessment nto determine her capability to understand and perform those tasks. Facility staff did not document either daily blood pressures or food intake. No food diary was kept and shared with the physician. Blood pressures were not documented for 138 days since September. The facility failed to follow the physicians orders for treatment and had no checks and balances in place to ensure this information was monitored, documented and communicated with the physician which is considered detrimental to the health, safety and welfare of Client #2. This deficiency constitutes a	V 118		

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V 118	Continued From page 9 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 45th day.	V 118		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff	V 290		

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V 290	Continued From page 10 need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to assess, annually review and document that a client was capable of being unsupervised in the community effecting 2 of 3 audited clients (#2, #3). The findings are: Client #2: Record review on 3/2/20 for Client #2 revealed: -Admitted on 4/1/03 with diagnoses of Unspecified Depressive Disorder, Mild Intellectual Disability, acid reflux, hypertension, pancreatitis and allergies. -There was no documentation to indicate that Client #2 had been assessed regarding her capability to be unsupervised for periods of time in the community. -Treatment plan dated 1/10/20 indicated " ...Short range goal ...[Client #2] enjoys being seen as independent as possible, therefore she and a peer, if she chooses to have a peer with her, will be allowed to go into a business to make an independent purchase of her choice, at least	V 290		

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V 290	Continued From page 11 once a month ..." Review on 3/2/20 of Client #2's progress notes for the month of January 2020 revealed: -"[Client #2] will go in store and make a purchase of item of her choice at least once monthly ...Staff honors [Client #2's] request to go in store alone to purchase personal items. Staff waits outside with the others while she does her shopping ..." Interview on 3/2/20 with Client #2 revealed: -She went into stores to make personal purchases and staff were present in the stores. Client #3: Record review on 3/2/20 for Client #3 revealed: -Admitted on 10/22/04 with diagnoses of Mild Mental Retardation, Other Specified attention-deficit hyperactivity disorder, borderline obesity and season allergies. -Treatment plan did not include goals or strategies to address unsupervised time in the community for Client #3. -There was no documentation to indicate that Client #3 had been assessed regarding her capability to be unsupervised for periods of time in the community. Review on 3/2/20 of Client #3's progress notes for the month of January 2020 revealed: -"[Client #3] will go in store by herself and make personal purchases with staff permission ...Staff lets [Client #3] go in a store by herself to make personal purchases ..." Interview on 3/5/20 with Client #3 revealed: -She indicated that she went to local stores and could be in store alone or with a staff member also in the store at the time.	V 290		

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V 290	Continued From page 12 Interviews on 3/2/20 and 3/5/20 with Staff #1 revealed: -Some clients had goals to go into stores and make purchases on their own. -Staff stayed outside the store in the vehicle but had eyesight on the door to the store. -She indicated that Client #2 and Client #3 went into stores without a staff member. She felt that they were safe. Interview on 3/5/20 with the Executive Director revealed: -Clients who went into stores unsupervised should have had a goal in their treatment plan. -Staff were always monitoring near the door of the store. -For each client the treatment team made the decision for clients to be unsupervised based on what the client wants to do and what the treatment team thinks should happen. -Unsupervised time is for specific periods of time and would only be in a safe environment. -She was not aware of identified criteria to meet for a client to be deemed capable of unsupervised time. -There was no documented evaluation of capability for Client #2 or Client #3. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 290		