STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-812	A. BUILDING: _____ B. WING _____	R 03/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINBOW OF SUNSHINE 2	307 CEDARWOOD STREET SPRING LAKE, NC 28390

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V 000	INITIAL COMMENTS An annual and follow up survey was completed on March 20, 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 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 111	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to complete an assessment prior to admission affecting one of three audited clients (#3). The findings are: Review on 03/13/2020 of client #3's record revealed: -22 year-old male. -Moved into the facility from a sister facility on 12/10/19. -Diagnoses included intellectual developmental disability (mild), social (pragmatic)communication disorder, cyclothymic disorder; mild neurocognitive disorder probably due to Parkinson's disease with behavioral disturbance. -No initial assessment completed prior to client #3's admission to the facility from a sister facility. Interview on 3/13/2020 the Licensee stated: -Client #3 was previously a resident in a sister facility and was transferred to the current facility owned/operated by the Licensee on 12/10/19. -She was not aware any client moved from one sister facility to another had to be discharged from one and admitted as a new admission to the receiving facility. -She would make sure these procedures were followed for any future clients moved from one sister facility to another.	V 111		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION	V 118		

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	MHL026-812	A. BUILDING: _____ B. WING _____	R 03/20/2020

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V 118	Continued From page 2 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 and interviews, the facility failed to administer medications on the written order of a physician and maintain a current MAR affecting 3 of 3 clients audited (clients #1, #2, #3). The findings are:	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-812	A. BUILDING: _____ B. WING _____	R 03/20/2020

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V 118	Continued From page 3 Finding #1: Review on 3/13/2020 of client #1's record revealed: -38 year old female admitted 1/14/13. -diagnoses included moderate mental retardation, Down syndrome, and depressive disorder, not otherwise specified. -Order dated 12/2/19 for Bactrim DS 800-160 mg (milligrams) , 1 tablet twice daily for 5 days. (Antibiotic) Review on 3/13/2020 of client #1's MAR revealed Bactrim DS 800-160 mg was documented twice daily for 6 days, beginning 12/3/19 and ending 12/8/19. Finding #2: Review on 3/13/2020 of client #2's record revealed: -54 year old male admitted 5/13/17. -Diagnoses included mild mental retardation; schizophrenia, paranoid type; intermittent explosive disorder; depressive disorder; polysubstance dependence, gastroesophageal reflux disease; hyperlipidemia. -Order dated 1/30/2020 for Vitamin D 50,000 units weekly. (Supplement) -Order dated 1/30/2020 for finger stick blood sugar testing daily. No physician's order or physician approved guidelines for actions needed if blood sugar results were lower than a specified result or higher than a specified result. Review on 3/13/2020 of client #2's MARs from 12/1/19 - 3/13/2020 revealed: -Vitamin D 50,000 units documented weekly. No times documented when the medication had been administered.	V 118		

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	MHL026-812	A. BUILDING: _____ B. WING _____	R 03/20/2020

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RAINBOW OF SUNSHINE 2	307 CEDARWOOD STREET SPRING LAKE, NC 28390

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V 118	Continued From page 4 Finding #3: Review on 03/13/2020 of client #3's record revealed: -22 year-old male. -Moved into the facility from a sister facility on 12/10/19. -Diagnoses included intellectual developmental disability (mild), social (pragmatic)communication disorder, cyclothymic disorder; mild neurocognitive disorder probably due to Parkinson's disease with behavioral disturbance. -Order dated 12/9/19 to taper down Benztropine 1 mg, 2 tablets at bedtime, to 1 tablet at bedtime for 6 days, then 1 tablet every other night for 6 days, then stop. (Used to treat Parkinson's disease or involuntary movements due to the side effects of certain psychiatric drugs.) -Order dated 12/9/19 for Eveko 10 mg daily. (Used to treat attention deficit hyperactivity disorder - ADHD.) -Order dated 2/10/2020 for Escitalopram 20 mg daily. (Used to treat depression and anxiety.) -Order dated 3/10/2020 for Famotidine 20 mg twice daily. (Used to prevent ulcers in the stomach and intestine.) -Order dated 2/10/2020 for Haloperidol 10 mg twice daily. (Used to treat mental/mood disorders, i.e. schizophrenia, schizoaffective disorders.) -Order dated 2/10/2020 for Lamotrigine 100 mg twice daily. (Used to prevent and control seizures; help prevent the extreme mood swings of bipolar disorder.) -Order dated 3/10/2020 for Levetiracetam 500 mg twice daily. (Used to treat and prevent seizures.) Review on 3/13/2020 of client #3's MARs from 12/10/19 - 3/13/2020 revealed: -Benztropine taper order was not started until 12/12/19. -Eveko 10 mg daily was not started until 12/16/19.	V 118		

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V 118	Continued From page 5 -Escitalopram 20 mg daily was not documented for the 7 am scheduled dose on 3/13/2020. -Famotidine 20 mg, Haloperidol 10 mg, Lamotrigine 100 mg, and Levetiracetam 500 mg were not documented for the 7 pm scheduled doses on 3/12/2020, or the 7 am scheduled doses on 3/13/2020. Interview on 3/13/2020 the Group Home Manager stated: -Benztropine order dated 12/9/19 was not implemented for 3 days waiting on the pharmacy to send the medication with the new order printed on the label. -Eveko 10mg daily was not started until 12/16/19 waiting on the pharmacy to fill the prescription. Interview on 3/13/2020 the Licensee stated she would follow up with the physician on guidelines for responding to blood sugar results. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity.	V 291		

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V 291	Continued From page 6 (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to coordinate care between the facility and the qualified professionals who are responsible for treatment/habilitation affecting 1 of 4 clients audited (client #4). The findings are: Review on 3/13/2020 of client #4's record revealed: -32 year old female admitted 2/3/08. -Diagnoses included mild mental retardation, bipolar disorder, and diabetes. Review on 3/13/2020 of client #4's level 1 incident	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 291	Continued From page 7 reports dated 2/4/2020 and 2/7/2020 revealed: -On 2/4/20 at 6:18 am client #4 went to take her morning shower, slipped as she went to sit on the toilet, and injured her foot. Client #4 Informed the staff she twisted her foot as she fell. Staff applied ice and told her to stay off her foot. Staff notified the Group Home Manager. The incident report was signed and dated by staff #6. -On 2/7/20 at 3:15 pm client #4 twisted and "re-hurt" her foot as she went to step up on the curb while out shopping. The Group Home Manager and Qualified Professional (QP) were notified. Staff #2 was documented as a witness to the incident. Review on 3/17/2020 of client #4's orthopedic office visit summary dated 2/10/2020 revealed: -History of present illness: Client #4 reported she slipped trying to get out of her shower and "rolled her ankle." She had been walking on her ankle since. Client #4 rated her pain as severe, with a score of "10/10." Client #4 described her symptoms as sharp, throbbing, and constant. Client #4 reported since the "onset" her symptoms had been unchanged. Symptoms were made worse when with walking, bending, standing, and lifting. Client #4 reported she was experiencing swelling, numbness, stiffness, limping and tingling. -Physician's physical examination findings: There was an inversion deformity noted along the lateral aspect of the ankle. Swelling, tenderness, ecchymosis (bruising) noted about the lateral ankle and malleolus. -Physician's diagnosis: Non-displaced closed fracture of the lateral malleolus of the left fibula. -A short leg cast was applied. -Treatment plan: Client #4 was to be non-weight bearing on her left lower extremity. Rest and elevation was advised. She was to return in 1-2	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINBOW OF SUNSHINE 2	307 CEDARWOOD STREET SPRING LAKE, NC 28390

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V 291	Continued From page 8 weeks for follow up. Review on 3/16/2020 of client #4's follow up orthopedic office visit summary dated 2/26/2020 revealed: -History of present illness: Client #4 reported there had been no significant changes in her symptoms. Pain was severe with a rating, "10/10." Client #4 presented ambulating on her short leg cast. She was present with a "nurse" who stated the group home had been having client #4 walk on her cast. "She (unclear if this was client #4 or the nurse) notes ... she told the staff there that she is not supposed to be walking; however, they were having her walk. She is experiencing severe pain at this time." -Left ankle examination documented no tenderness or ecchymosis noted about the lateral ankle and malleolus. -X-rays demonstrated a healing, non-displaced lateral malleolus fracture -Treatment plan: Client #4 was placed back in short leg cast (had been removed for x-rays). She was to be non-weight bearing on her left leg. Observations on 3/13/2020 between 8:45 am and 9 am revealed: -Client #4 was standing in her bedroom, dressed and ready to leave for her Day Program. The client did not have her walker with her. -Client #4 did not have a shoe on her left foot. When asked about this, she showed the surveyor her bright pink short leg cast. A sock had been placed over her left foot. -At Approximately 9 am client #4 ambulated with a walker from her bedroom, out the front door, and down the ramp adjacent to the front porch steps. Interview on 3/13/2020 client #4 stated:	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RAINBOW OF SUNSHINE 2	307 CEDARWOOD STREET SPRING LAKE, NC 28390

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V 291	Continued From page 9	V 291		

-She had a cast on her left foot.
-She had fallen in her shower and broken her foot.
-She was waiting to go to her Day Program.

Telephone interview on 3/18/2020 Staff #6 stated:
-She was not working the night client #4 hurt her ankle in the bathroom. She worked the next night.
-Client #4 had complained that her ankle hurt "a little bit." Staff told her to stay off her foot. Her foot was not swollen at first, but later on it did swell and she was taken to the doctor.
-Staff were told to apply ice and elevate her leg and to stay off of it as much as possible.
-Client #4 was very independent and staff had to remind her to stay off the leg.

Telephone interview on 3/18/2020 Staff #2 stated:
-He worked the day shift and was not working when client #4 twisted her ankle in the bathroom.
-When client #4 hurt her ankle out shopping she was with her "1 on 1" day worker from the Day Program. Client #4 told them she hurt her ankle and they wrapped it. Client #4 did complain of pain, but this was typical for her to complain of pain.
-They did not realize it was that "bad off" before she went to the doctor. When she went to the doctor he gave her a walker because she was not able to use the crutches.
-They tried to get her to elevate her foot, but they had to redirect her as she would not keep it elevated.

Telephone interview on 3/18/2020 Staff #7 stated:
-On 2/10/2020 she went with the Group Home Manager to take client #4 to the doctor. After the doctor took X-rays, she took client #4 to the orthopedic doctor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINBOW OF SUNSHINE 2	307 CEDARWOOD STREET SPRING LAKE, NC 28390

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V 291	Continued From page 10	V 291		

-The orthopedic doctor put a cast on client #4's leg.
-The physician's staff tried to teach her how to walk on crutches but her balance was such that she was not able to do this, so they gave her a walker instead. They told her to not put weight on her foot.
-She took client #4 to the follow up orthopedic appointment, too. Client #4 was told not to walk on the foot.
-Her ankle was swollen on the first visit to the MD.

Interview on 3/13/2020 and 3/18/2020 the Group Home Manager stated:
-Client #4 had a slight limp after she re-injured her ankle on 2/7/2020 when she twisted her foot stepping up on a curb. It was not a "terrible" limp and when asked what was wrong she said she had twisted her ankle on a curb. Staff applied ice to her ankle. He did not see any swelling or bruising.
-On 2/10/2020 he took client #4 to her primary care physician appointment for medication refills.
-Client #4 had a slight limp and the physician asked her why she was limping.
-The primary care physician did an X-ray in his office and put the x-ray on a disc. He sent client #4 to an orthopedic physician that same day.
-The orthopedic physician put her in a cast and provided her with a walker.
-The staff who went with the client said the orthopedic physician diagnosed a "hair line fracture."
-He had no instructions from the orthopedic physician as far as client #4's fracture.

Interview on 3/13/2020 and 3/18/2020 the Licensee stated:
-The staff notified the Group Home Manager

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-812	A. BUILDING: _____ B. WING _____	R 03/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINBOW OF SUNSHINE 2	307 CEDARWOOD STREET SPRING LAKE, NC 28390

(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 291	Continued From page 11	V 291		

when she slipped in the shower, and he notified the Licensee. Swelling developed and the Group Home Manager told her he would have her doctor check it at her upcoming doctor appointment. She did not recall seeing client #4 limping.
-On 2/7/2020 client #4 hurt her ankle while shopping. The staff put ice on her ankle and had her to elevate her leg.
-Client #4 continued to attend the Day Program during this time.
-Staff #7 took client #4 to the orthopedic physician appointment. Client #4 was given a walker.
-The facility got no instructions from the orthopedic physician to include instructions for weight bearing.
-On 3/13/2020 the Licensee stated she would call the orthopedic physician and get a copy of the office visit notes and send to the surveyor on Monday via facsimile. (See above record reviews for office notes received via facsimile on 3/16/2020 and 3/17/2020.)

Review on March 20, 2020 of the Plan of Protection signed by the Licensee dated March 3/19/2020 revealed:
- "What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? Effective immediately Rainbow of Sunshine will implement a policy to Insure staffing reports to the QP any and all loss of balances sustained by a consumer which causes them to strike a wall, furniture or flooring as a result of loss of balance irregardless of them showing any signs of injury. To protect from further injury, staff will obtain written medical documentation outlining the necessary procedures and precautions to protect the consumers injury from further harm. Staff will do everything within their power to insure the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-812	A. BUILDING: _____ B. WING _____	R 03/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINBOW OF SUNSHINE 2	307 CEDARWOOD STREET SPRING LAKE, NC 28390

(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 291	Continued From page 12	V 291		

consumers adhere to all physicians order's."
- "Describe your plans to make sure the above happens. Rainbow of Sunshine leadership will review the state requirements for filing an iris Report and evaluate any incident and immediately report any incident that meets the states minimum requirement for filing an Iris Report or is questionable. Any incident which results in an Injury the QP will document the Rainbow of Sunshine's procedures for protecting the Consumer and submit the report to the Human Rights Committee for review."

Client #4 was a 32 year old female admitted 2/3/08 with diagnoses to include mild developmental disabilities, bipolar disorder, and diabetes. Client #4 injured her left ankle on 2/4/2020 when she fell in the bathroom, and re-injured the same ankle on 2/7/2020 while in the community. The direct care staff reported these injuries to the Group Home Manager and Licensee, and applied first aid. Staff stated the client did have pain, swelling, and a limp. Facility staff and management did not recognize the seriousness of the injury. Client #4 continued to participate in her day program and walking on the injured leg. No medical attention was sought for Client #4. During a routine appointment with her primary physician on 2/10/2020 he noted Client #4 limping and ordered an x-ray. The x-ray showed client #4 had a fracture. Client #4 was referred to an orthopedic specialist and seen that same day. On physical exam the orthopedic physician documented client #4 reported her pain was severe, sharp, throbbing, constant, and unchanged from "onset." He diagnosed a non-displaced fracture of the left lateral malleolus, applied a short leg cast, and instructed the client to be non-weight bearing. On 2/26/2020 client #4 saw the orthopedic physician for follow

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-812	A. BUILDING: _____ B. WING _____	R 03/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 291	Continued From page 13 up. The physician documented client #4 presented ambulating on her short leg cast. It was reported to the physician that the group home had been having her walk on her cast. The physician gave instructions to continue non-weight bearing on her left leg. On 3/13/2020 client #4 was observed in her room standing by her bed, without a walker. The Group Home Manager and Licensee stated there were no care instructions from the orthopedic physician. Neither (Group Home Manager or Licensee) knew what the physician had recommended. The facility failed to ensure timely treatment for client #4's broken leg and also failed to follow the orthopedic specialist's directions for care following the injury. These failures resulted in increased pain and delayed medical treatment for client #4 constituting serious neglect. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 291		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-812	A. BUILDING: _____ B. WING _____	R 03/20/2020

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V 366	Continued From page 14	V 366		

measures according to provider specified timeframes not to exceed 45 days;
(4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days;
(5) assigning person(s) to be responsible for implementation of the corrections and preventive measures;
(6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and
(7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule.
(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.
(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:
(1) immediately securing the client record by:
(A) obtaining the client record;
(B) making a photocopy;
(C) certifying the copy's completeness; and
(D) transferring the copy to an internal review team;
(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or

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V 366	Continued From page 15 with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;	V 366		

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V 366	Continued From page 16 (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to implement written policies governing their response to incidents. The findings are: Review on 3/13/2020 of client #4's record revealed: -32 year old female admitted 2/3/08. -Diagnoses included mild mental retardation, bipolar disorder, and diabetes. Review on 3/13/2020 of client #4's level 1 incident reports revealed: -Level 1 incident report: 2/4/2020 at 6:18 pm client #4 informed staff she twisted her foot as she fell in the bathroom. Staff applied ice and told her to stay off her foot. The Group Home Manager was notified. -Level 1 incident report: 2/7/20 at 3:15 pm client #4 twisted her foot when she was walking in a retail store. Staff documented she "re-hurt" her foot as she went to step up on the curb. The Group Home Manager and Qualified Professional (QP) were notified. Review on 3/16/2020 of client #4's orthopedic physician's office summary dated 2/10/2020 revealed:	V 366		

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V 366	Continued From page 17 -Client #4 reported she slipped trying to get out of her shower and "rolled her ankle." She had been walking on her ankle since. Pain was severe, rating "10/10." Symptoms were made worse when with walking, bending, standing, and lifting. -Swelling, tenderness, bruising were documented by the physician. -Physician diagnosed a non-displaced fracture of lateral malleolus of left fibula, closed fracture. -Short leg cast applied. Interview with the Group Home Manager on 3/13/2020 revealed client #4 was not seen by a physician following her ankle injuries until a routine office visit on 2/10/2020 with her primary care physician for medication refills. There were no care instructions from client #4's orthopedic physician. Interview on 3/13/2020 the Licensee stated there had been no level 2 incident reports since the last annual survey.	V 366		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the	V 367		

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V 367	Continued From page 18 Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of	V 367		

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V 367	Continued From page 19 becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all level II incidents to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The findings are: Review on 3/13/2020 of client #4's record revealed:	V 367		

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V 367	Continued From page 20 -32 year old female admitted 2/3/08. -Diagnoses included mild mental retardation, bipolar disorder, and diabetes. Review on 3/16/2020 of client #4's orthopedic physician's office summary dated 2/10/2020 revealed: -Client #4 reported she slipped trying to get out of her shower and "rolled her ankle." She had been walking on her ankle since. -Diagnosed with a non-displaced fracture of lateral malleolus of left fibula, closed fracture. -Short leg cast applied. Interview on 3/18/2020 the Licensee stated: -There was no level 2 incident report made after client #4 was seen by an orthopedic physician on 2/10/2020. -The QP was responsible for submitting level 2 incident reports.	V 367		
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 observations and interview, the facility was not maintained in a safe, clean, attractive and orderly manner, free from offensive odor. The findings are:	V 736		

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V 736	Continued From page 21 Observations on 3/13/2020 between 9 am and 10 am revealed: -Client #3's room: Missing handles on client's dresser, middle drawer. -Client #5's room: Missing bottom drawer in client's dresser; middle drawer off track. Seven broken slats in the window blinds. Accordion closet door off track. Unpainted wall patch by the door approximately 24 by 12 inches in size. No globe over light bulb in ceiling fan. -Hall bath: Black discolorations of calking around the tub. -Client #2's room: Musty odor present. -Hall wall adjacent to client #5's room: Vertical area about 10 inches in height and 2 inches in width with 4 holes the approximate size of a nail or screw; area had not been repaired and painted to match the surrounding wall. -Clients #1 and #4's room: Curtain rod swayed in the middle. Sink faucet knob for sink stop pull missing, exposing the screw where the knob should be attached. Gray ceiling stains above the shower. -Kitchen: Laminate floor planks separated at seams. Insect web under the sink attached to the plumbing. Black debris particles collected inside the sink base cabinet. -Front of home: a wooden ramp had been built attaching the front porch to the ground. Ramp was steep and measured 21 inches high from the ground to the point it attached to the porch, and 8 feet in length from the top edge of the slope to the point of contact with the ground. -Clients #1, #4, and #5 were observed ambulating down the ramp as they left the home. Client #4 was walking with the aid of a walker and had a cast on her left leg. This deficiency constitutes a re-cited deficiency	V 736		

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V 736	Continued From page 22 and must be corrected within 30 days.	V 736		