Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-972	A. BUILDING: _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D JONES HOME	1224 ROBINSON AVENUE RALEIGH, NC 27610

(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 Survey was completed 03/12/20. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living	V 000		
V 108	27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction. (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and	V 108	V 108 – Seizure Protocol, Celiac Disease – The RN (Jean Ellis) will provide training on administration of oxygen per his seizure protocol and Celiac Disease no later than 3/30/20. These trainings will also be included with the staff's regularly scheduled annual med admin training. The staff's med admin training, Celiac Training, and the Administration of Oxygen per his Seizure Protocol will be tracked through ESUCPs online training system - RELIAS V113 – A master file is kept at the ESUCP office. Not all the information was in the shadow file where the individual resides. All information obtained during doctor visits are to be kept with the shadow file as well as the master. The Program Manager will review file monthly to ensure proper filing and information sharing. This will be documented in the AFL Monthly Checklist V118 – MAR – All new medications orders will be communicated to the RN. RN will review the MAR weekly. The Program Manger will compare Medical Orders with the MAR and with what is located in the individual's Medication Cabinet monthly. This will be documented in the AFL Monthly Checklist	4/25/20 4/25/20 4/25/20

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-972	A. BUILDING: _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D JONES HOME	1224 ROBINSON AVENUE RALEIGH, NC 27610

(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 108	Continued From page 1 clients. This Rule is not met as evidenced by: Based on observation, record review and interview the governing body failed to assure one of one staff (#1) had been trained in the seizure protocol and celiac disease. The findings are: Review on 03/06/20 of the facility's public file maintained by Division of Health Service Regulation revealed: -Mental Health License issued 08/20/19 for 5600F Supervised Living/Family Alternative Living (AFL) -Corporation name listed as the Licensee -Staff #1 listed as the AFL Service Provider Review on 03/09/20 of staff #1's record record: -No training in client #2's seizure protocol or Celiac Disease Review on 03/06/20 of client #2's record at the group home revealed: -Admitted: September 2019 -Diagnoses: Severe Intellectual Developmental Disability, Mood Disorder, Seizure Disorder and Celiac Disorder (autoimmune disease that occurs in genetically predisposed people where the ingestion of gluten leads to damage in the small intestine. -January - March 2020 Medication Administration Records listed Oxygen (O2) 2 liter (L) administered as needed via nasal canula. Instructions: In the event of a seizure, if the O2 saturation is 90 or below administer 2L of O2.	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-972	A. BUILDING: _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D JONES HOME	1224 ROBINSON AVENUE RALEIGH, NC 27610

(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 108	Continued From page 2 -No seizure response plan by the facility or letter by the neurologist A. Seizure Protocol Review on 03/09/20 of client #2's records maintained at the corporate office revealed: -Letter signed by the Neurologist but not dated indicated: ..."seizure protocol: 1) If the patient appears to be having a seizure check O2 saturation. 2) O2 saturation also to be checked with respiratory illness 3) In the event of a seizure, if O2 sat is 90 or below administer 2L O2 via nasal canula 4) If Diastat is used, call 911" -Seizure Response protocol developed by the facility not dated "If [client #2] is having a seizure, follow each of the steps below: Make sure that [client #2] is in a safe place and position to avoid any additional injuries. Observe his breathing pattern as his breathing may begin to slow down and he may be taking fewer breaths. Check [client #2's] O2 (oxygen) levels (which should be above 90). If [client #2's] Oxygen level is at 90 or below, instruct him to begin taking deep breaths. If [Client #2's] oxygen level does not begin to increase and go up, then administer oxygen as directed (2L). Continue to monitor his oxygen level as needed. Call 911 if [client #2's] oxygen level continues to decrease or will not go up after administering the 2L of oxygen. Call [client #2's] mother..." Observation on 03/06/20 at 2:45 PM and 03/09/20 at 11:50 AM revealed a pulse Oximeter (device used to measure the saturation of oxygen carried in red blood cells), nasal canula and portable cylinder tank with oxygen were located between the living room and the medication closet.	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-972	A. BUILDING: _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D JONES HOME	1224 ROBINSON AVENUE RALEIGH, NC 27610

(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 108	Continued From page 3 During interviews between 03/06/20 and 03/11/20, staff #1 reported: -The oxygen was avalaible for use with client #2. The oxygen had not been used by the facility. - If client #2 struggled with breathing, the oxygen was to be utilized. - The oxygen use could result because of seizure but it is for breathing. - He had not been told the oxygen was related to seizure. -In addition to the oxygen, there was a machine placed on the finger that checked his oxygen levels. He was not aware of what the numbers on the machine meant. -Client #2 had not had a long seizure. He had incidents of starring or shaking which lasted 2-3 seconds. These episodes are considered seizures per client #2's mother/guardian but would not require medication. -A few weeks after admission, client #2's mother/guardian provided some guidance regarding the oxygen. He did not recall all the information provided by the guardian. The Program Manager reported she would have a nurse conduct formal training. He had not received any training by the agency or a nurse regarding the use of the oxygen or the machine. During interview on 03/11/20, the Program Manager reported: -In February 2020, the agency transitioned to limited computer program access for all AFL service providers. The facility continued to have notebooks/client records which should contain the same paperwork as the office client records. She was not aware the seizure protocols located at the office were not in the notebook/client #2's record at the group home. During interview between 03/11/20 and 03/12/20,	V 108		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-972	A. BUILDING: _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D JONES HOME	1224 ROBINSON AVENUE RALEIGH, NC 27610

(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 108	Continued From page 4	V 108		

the nurse at client #2's neurologist's office reported:

-June 22, 2018 the letter was developed for client #2's seizure protocol

-Client #2 was last seen January 2019. During the 2019 visit, "absent seizures- stares, looks off" were discussed. At the time, client #2 averaged two "absent seizures" per week. No changes were made to the seizure protocol. Not aware of any seizures between January 2019 and present date.

During interview on 03/10/20, client #2's mother/guardian reported:

-To her knowledge, client #2 had not had a "full" seizure in over a year. Client #2 had experienced absent seizures. After an absent seizure, client #2 would say "I'm alright."

B. Celiac Disease

During interview on 03/06/20, staff #1 reported:

-Client #2 was on a gluten free diet.

-Client #2 had lost significant weight prior to his September 2019 admission to this group home. It was discovered he required a gluten free diet. In the past few weeks, decision was made to document his weight daily.

During interview on 03/11/20, the Program Manager reported:

-Client #2 had always been Gluten intolerant.

-Around the same time as client #2's admission to the group home in September 2019, he was diagnosed with Celiac Disease.

-Previously, the agency used to utilize an electronic staff training program. The computer based program had training in Celiac Disease. She thought the agency would resume the electronic staff training program. She would have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-972	A. BUILDING: _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D JONES HOME	1224 ROBINSON AVENUE RALEIGH, NC 27610

(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 108	Continued From page 5	V 108		

used the computer based training for Celiac as it was in a three part session.

-Staff #1, client #2's previous residential provider, client #2's mother and herself had a meeting in which the seizure protocol for oxygen usage and Celiac Disease were discussed. The meeting was conducted by client #2's mother. The Program Manager did not have documentation to support the meeting occurred. The Program Manager could not recall the specifics of all that was discussed because they also reviewed client #2's medications.

-She did tell staff #1 a nurse would conduct a training regarding the Oxygen and the Celiac Disease. The training by a nurse had not been conducted. Initially, a nurse from a different region in North Carolina assisted with securing medical information for client #2. Once client #2 was admitted, a new nurse was hired for this region in North Carolina. The new nurse began to assist with client #2's medical information within the past 24 hour period of this interview. The new nurse would not have conducted any trainings on Celiac Disease or the Seizure Protocol for Oxygen. The Program Manager was unsure if the nurse from a different region in North Carolina continued to work for the agency.

Review on 03/11/20 of the facility's plan of protection dated 03/11/20 submitted by the Program Manager revealed:

-"What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? Notify service provider that additional client specific trainings are needed based on the medical needs of the individual. Review with service provider client's seizure response protocol immediately and provide service provider documentation of the seizure response protocol as well as Celiac

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-972	A. BUILDING: _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D JONES HOME	1224 ROBINSON AVENUE RALEIGH, NC 27610

(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 108	Continued From page 6 Disease information. Contact nurse to discuss additional training needs of the service provider. -Describe your plans to make sure the above happens. Program Manager will schedule additional trainings with the service provider and nurse based on the medical needs of the individual. Program Manager will ensure that the trainings are documented and included in the service provider's personnel record. Program Manager will ensure that these trainings are completed annually and document completion of trainings." Admitted to this group home September 2019, client #2 had been diagnosed with Celiac Disease and Seizure Disorder. Although staff was able to indicate client required a gluten free diet, he was not able to provide any information regarding Celiac Disease. A protocol had been developed for seizures. The seizure protocol included oxygen and monitoring of oxygen levels. Staff had not been trained by the company nurse, therefore, unable to detail the seizure protocol and its correlation to the oxygen or oximeter for monitoring. This deficient practice is detrimental to the health, safety and welfare of client #2 and constitutes a 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 108		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes:	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-972	A. BUILDING: _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D JONES HOME	1224 ROBINSON AVENUE RALEIGH, NC 27610

(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 113	Continued From page 7 (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician; (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143.	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-972	A. BUILDING: _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D JONES HOME	1224 ROBINSON AVENUE RALEIGH, NC 27610

(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 113	Continued From page 8 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to maintain documentation of services provided for two of two clients (#1 and #2). The findings are: a. Review on 03/06/20 & 03/09/20 of client #1's records revealed: -Admitted: Prior to 08/20/19 -Diagnoses: Impulsive Control Disorder, Pedophilia and Moderate Intellectual Developmental Disability -No evidence of physician's visits between 08/20/19 and 03/09/20. No documentation of discontinued medications During interview on 03/09/20, client #1 reported: -He visited the doctor annually. In 2019, he went to visit his Primary Care Physician -Over the past year, he had lost weight and was off all medication except Vitamin D. He was on medication for blood pressure until his weight loss in the past 6 months. During interview on 03/09/19, staff #1 reported: -Client #1's 2019 primary care physician visit was in August 2019. -He was previously on Lisipinol HCTZ 25 milligrams (used to treat high blood pressure). It was discontinued due to his weight loss -He could not locate documentation of the August 2019 visit with the primary care physician b. Review on 03/06/20 and 03/09/20, client #2's records revealed: -Admitted: September 2019 -Diagnoses: Severe Intellectual Developmental Disability, Mood disorder, Seizure	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-972	A. BUILDING: _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D JONES HOME	1224 ROBINSON AVENUE RALEIGH, NC 27610

(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 113	Continued From page 9 Disorder and Celiac Disorder -No evidence of physicians visits During interview on 03/10/20, client #2's mother/guardian reported: -She assumed responsibility for all client #2's medical appointments -The physicians did not provide documentation of services at the end of the appointment -Was recently informed by the agency she needed to obtain medical information after each doctor's visit During interview on 03/11/20, the Program Manager: -The agency used consultation forms for the clients' physicians to complete. -She had asked client #2's mother/guardian and staff #1 to have physician's complete the forms and place in clients' records	V 113		
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.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-972	A. BUILDING: _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D JONES HOME	1224 ROBINSON AVENUE RALEIGH, NC 27610

(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 118	Continued From page 10 (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 observation, record review and interview, the facility failed to assure medications were administered on the written order a physician for one of two clients (#2). The findings are: Observation on 03/06/20 between 1:00 - 2:50 PM and 03/09/20 between 11:30 AM - 12 Noon revealed the following medications for client #2: -Trilipetal 300 milligrams (mg) two tablets twice daily (used for treatment of seizures) -Celexa 20 mg one tablet twice daily (used for treatment of depression) -Lisinopirl 20 mg one tablet daily (used for treatment of high blood pressure) -Atenolol 50 mg one daily (used for treatment of high blood pressure) -Gabitril 4 mg one tablet twice daily (used to treat seizures)	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-972	A. BUILDING: _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D JONES HOME	1224 ROBINSON AVENUE RALEIGH, NC 27610

(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 118	Continued From page 11 -Vimpat 50 mg two tablets twice daily (used to treat partial seizures) -Lorazepam 1 mg one tablet three times a day as needed (used to treat anxiety and depression) -Montelukast 10 mg one tablet daily (used to treat seasonal allergies) -Levocetirizine 5 mg one tablet (used to treat seasonal allergies) Review on 03/06/20 of client #2's record at the group home revealed: -Admitted: September 2019 -Diagnoses: Severe Intellectual Developmental Disability, Mood Disorder, Seizure Disorder and Celiac Disorder -Physician's orders dated 06/22/18 for Celexa 40 mg one tablet twice a day, Gabitril, Lorazepam, Levocetirizine and Vimpat -Physician's orders dated 08/01/18 for Trilipetal, Lisiniprol, Atenolol and Montelukast -January - March 2020 MARs initialed as administered for the above medications During interviews on 03/09/20 and 03/11/20, the Program Manager reported: -She was aware client #2 had not had updated physician's orders since 2018. -During client #2's admission process, she initiated assistance from a nurse from a different region to obtain his medical orders. The 2018 medical orders were obtained. -In February 2020, she faxed medical consent forms and requested current medical information and physician's orders from all physicians affiliated with client #2. She had not received feedback.	V 118		