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
HOME CARE SOLUTIONS	187 SCOTLAND RIDGE DRIVE WINSTON SALEM, NC 27107

(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 A complaint survey was completed on 9/18/2020. The complaints were substantiated (intake #NC164861, NC164954, NC165099, & NC165232). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.	V 000		
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 checks shall be recorded and kept with the MAR	V 118		

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V 118	Continued From page 1 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 ensure medications were administered as ordered by an authorized person, and administration of medications was documented immediately following administration affecting 2 of 3 clients (#1 & #2). The findings are: Reviews on 5/15/2020, 5/18/2020 and 5/29/2020 of client #1's record revealed: - Admission date: 3/5/2019 - Diagnoses: Mood Disorder Not Otherwise Specified (NOS); Attention Deficit-Hyperactivity Disorder (ADHD); Autism Spectrum Disorder; Moderate Intellectual Disabilities; Vitamin D Deficiency; Dysmenorrhea; Static Encephalopathy; History of abdominal trauma; Status Post colostomy and reversal (6/2016); and Constipation; - Physicians' orders for the following medications: - Tegretol 200 milligrams (mg), take 3 tablets twice daily (BID) for autism and behavioral issues, dated 4/27/2020; - There was no discontinuation order for Tegretol; - Gavilax powder (Miralax) (laxative to stimulate bowel movements), mix 17 grams in 4-8 ounces water and take BID at 7AM and 8PM, dated 9/11/2019. Reviews on 5/18/2020 and 5/21/2020 of client	V 118		

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V 118	Continued From page 2 #1's MARs dated 3/1/2020-4/30/2020 revealed: - Client #1 was on therapeutic leave from 11/22/2019 to 11/26/2019; - Notations were made that Tegretol was not given, "need med" or "not ava" (available), from 11/25/2019 to 11/28/2019; - Notations were made that Gavilax was not given, "need med" or "not available", from 11/1/2019 to 11/30/2019. Review on 5/18/2020 of drugs.com revealed: - Tegretol was an anticonvulsant used to treat seizures. Reviews on 5/15/2020 and 5/18/2020 of client #2's record revealed: - Admission date: 2/1/2018 - Diagnoses: Major Depressive Disorder; Bipolar II Disorder; Moderate IDD; Acid Reflux; Diabetes; Hypertension; Hx of Trach Dependency; Obesity; Sleep Apnea; and Fungal Infections; - Progress notes dated 2/24/2020 that revealed: - Physician's orders for: - Mupirocin (Bactroban) 2% ointment (antibiotic used to treat skin infections), apply to affected area three times daily (TID), dated 6/20/2019; - Clonazepam (Klonopin) 0.5mg (benzodiazepine used to treat seizures and certain types of anxiety disorders), one tablet TID, dated 11/4/2019. Reviews on 5/18/2020 and 5/21/2020 of client #2's MARs dated 3/1/2020 to 4/30/2020 revealed: - Mupirocin was not administered from 4/1/2020 to 4/30/2020 due to the medication not being available; - No documentation of administration of clonazepam at 2:00pm on 3/28/2020 or 3/29/2020.	V 118		

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V 118	Continued From page 3 No interview was completed with client #1 due to her being non-verbal and unable to provide information about her medications. Interviews on 5/20/2020 and 7/6/2020 with client #1's Guardian revealed: - During client #1's home visit over the Thanksgiving 2019 holiday, client #1 had a seizure at the Guardian's home; - When she was evaluated at a local hospital following the seizure, it was discovered that client #1 had not been getting her Tegretol for approximately one week; - The Guardian had shown a Neurologist at the hospital the bubble packs of client #1' medications that the facility had sent home with her, and there was no Tegretol present; - It had appeared as if the last date that client #1 received Tegretol was on 11/17/2019; - Facility staff had told the Guardian that client #1 was out of Tegretol, and her doctor needed to order more. Interview on 6/4/2020 with client #2 revealed: - Client #2 did not know the names of her medications but thought that facility staff gave her the correct ones every day. Interview on 6/2/2020 with the Pharmacist revealed: - The Pharmacy had received a physician's order to fill a 10-day supply of client #1's Tegretol on 11/5/2020; - The Pharmacy did not receive another order for Tegretol until 11/29/2020; - Both Tegretol orders came from client #1's primary care physician's office, but from different prescribers in the same office; - There would not have been an increased risk of seizures for client #1 when she ran out of Tegretol	V 118		

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V 118	Continued From page 4 because of how long it would take for Tegretol to be out of client #1's system; - Based on the Pharmacy's records, client #1 was only out of 3-4 days' doses of Tegretol; - Client #1's gavilax was only sent to the facility when facility staff notified the Pharmacy that they were about to run out. Interview on 6/4/2020 with staff #1 revealed: - Staff #1 worked on 3rd shift and only administered morning medications; - Client #1 had run out of Tegretol once and the facility had to wait for a new prescription to be written before they could get more; - When a client was down to about five doses worth of medications, facility staff were supposed to contact the Residential Manager (RM) to inform them; - Clients were not usually out of medications from more than one day at a time; - If there were blanks left on MARs, that probably meant that the staff who administered the medication forgot to initial the MAR; - The RM would review the MARs and have staff go back and initial the blocks that they forgot to sign. Interview on 6/3/2020 with staff #2 revealed: - Staff #2 knew that Client #1 ran out of Tegretol at one point, but she did not recall when that was; - When a client ran out of medication, facility staff were supposed to notify the RM. Interview on 6/18/2020 with the RM revealed: - The RM thought that the client #1 ran out of Tegretol when she went on a home visit over the Thanksgiving 2019 holiday; - The RM was not notified that client #1 was out of Tegretol.	V 118		

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V 118	Continued From page 5 Interviews from 5/14/2020 to 9/18/2020 with the Qualified Professional (QP) revealed: - Client #1 was only given a 10-day supply of Tegretol in November of 2019 because she had a behavioral episode while at the doctor's office and the doctor would not see client #1 face-to-face; - The pharmacy sent out a 10-day supply to last until we got the script ... There was a delay because the pharmacy didn't send it out immediately ... - Client #1 only missed her doses of Tegretol over the Thanksgiving Holiday; - The QP did not realize that client #2's MAR had blanks during March 2020 or that client #2 had run out of muciprion in April 2020; - The RM usually contacted the pharmacy to ensure medications did not run out.	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. (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	V 291		

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V 291	Continued From page 6 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 record reviews and interviews, the facility failed to maintain coordination of services with qualified professionals who were responsible for treatment, and provide opportunities for participation of the legal guardian affecting 2 of 3 Clients (#1 & #2). The findings are: Finding #1: Reviews on 5/15/2020, 5/18/2020 and 5/29/2020 of Client #1's record revealed: - Admission date: 3/5/2019 - Diagnoses: Mood Disorder Not Otherwise Specified (NOS); Attention Deficit-Hyperactivity Disorder (ADHD); Autism Spectrum Disorder; Moderate Intellectual Disabilities; Vitamin D Deficiency; Dysmenorrhea; Static Encephalopathy; History of abdominal trauma; Status Post colostomy and reversal (6/2016); Constipation - A treatment plan dated 12/12/2019 that revealed: - Client #1 was non-verbal, but seemed to understand verbal communication fairly well; - A history of self-injurious behavior,	V 291		

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V 291	Continued From page 7	V 291		

head-banging, biting, hitting, kicking, pulling hair, scratching, property destruction, and tantrums;
- An Individual Behavior Support Plan dated 4/2/2020 addressed target behaviors of physical aggression towards others, self-injurious behaviors, aggression to property/objects, and loud or disruptive behaviors;
- " ... She requires a highly structured environment with specially trained staff to prevent or manage behaviors that are expected to cause serious harm to self or others ... She requires supports in all activity areas and locations ...She works best with 1:1 attention ... [Client #1] needs close visual monitoring at all times with the exception of when she is in the bathroom or her bedroom ... When she is in her bedroom/bathroom, give her privacy while completing 15-minute checks (stand outside the door and listen for any noises that indicates she may need assistance and knock on the door if in doubt that she may need assistance)..."
- A progress note completed by staff #1 and dated "4-24-20 3rd (shift)" that revealed: " [Client #1] had a good night. She slept well. All am goals were complete and needs met."
- A Progress note completed by staff #3 and dated "4-24-20 1st/2nd (shifts)" that revealed: "Therapeutic Leave";
- There were no progress notes present describing an incident on 4/24/2020 in which Client #1 required hospital care due to cutting her head on her broken bedroom window.
- A progress noted completed by staff #1 and dated "4-25-20 3rd (shift)" that revealed: "[Client #1] came last night late. She watch television until she was tired. [Client #1] also use the restroom on herself and was cleaned up this morning. [Client #1] had a good morning no behaviors."
- Documentation of treatment for headache and staple removal at a local hospital emergency

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V 291	Continued From page 8 department (ED) on 5/1/2020. Review on 5/14/2020 of the Incident Response Improvement System (IRIS) revealed: - An incident report dated 4/24/2020 noted that Client #1 had become upset after the facility staff working had ordered a pizza and did not give Client #1 any; - Client #1 had hit her head on the window in her bedroom, breaking the glass, and injuring her head; - Client #1 was transported by Emergency Medical Services (EMS) to a local hospital for treatment in the Emergency Department (ED). Reviews on 7/6/2020 and 7/16/2020 of Client #1's record from the local hospital revealed: - Client #1 arrived at the ED at 3:48pm on 4/24/2020; - Client #1 was treated for a facial laceration; - Client #1's history was provided by EMS, and limited by Client #1 being nonverbal; - Portions of the medical examination in the ED was not possible due to Client #1 being nonverbal; - No facility staff were present with Client #1 at the ED; - ED staff notes on 4/24/2020 revealed: - 6:31PM: " ... Pt's (patient) (Client #1's) [Guardian] called for a ride home. [Guardian] will call facility for a ride home." - 7:34PM: " ... We are having difficulty contacting her (Client #1's) group home as there is nothing in her chart as to where she lives and there are no emergency contacts ..." - 8:17PM: Client #1 was discharged to "Home or Self Care." No interview was completed with Client #1 due to her being non-verbal and unable to provide	V 291		

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V 291	Continued From page 9 information Interview on 5/20/2020 & 7/6/2020 with Client #1's Guardian revealed: - Client #1 was non-verbal and could only communicate with minimal sign language (10-15 signs); - Client #1 needed specially trained staff to work with her; - On 4/24/2020, Client #1 had busted the glass in her bedroom window and injured herself requiring treatment at the local hospital ED; - The Guardian received a call from the hospital informing the Guardian that no facility staff were with Client #1; - When the Guardian called the Qualified Professional (QP), the QP did not know that there was not a facility staff with Client #1 at the hospital; - Because of Covid-19 visitation restrictions, the Guardian could not visit Client #1; - The Guardian had requested that the QP and Residential Manager (RM) go to the facility to check on Client #1 and send photos of Client #1's injuries; - The facility did not send the Guardian photos of Client #1's injuries until three days after the incident occurred. Interview on 6/3/2020 with staff #2 revealed: - On 4/24/2020, staff #2 had worked on 3rd shift following Client #1's incident; - Client #1 was returned to the facility by EMS following discharge from the local hospital ED. Interview on 6/18/2020 the RM revealed: - Client #1 was non-verbal and unable to express if something was wrong; - On 4/24/2020, Client #1 had been taken to the local hospital ED by EMS due to a behavior in	V 291		

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V 291	Continued From page 10 which she broke a window with her head; - The RM did not know why no facility staff were with Client #1 while she was at the hospital. Interviews from 5/14/2020 to 6/3/2020 with the QP revealed: - Client #1 was non-verbal; - Facility staff usually accompanied Client #1 to all medical visits; - The RM or QP usually made arrangements for facility staff to attend Client #1's medical appointments or go to hospital with her; - The QP did not know why no staff went to the hospital with Client #1 on 4/24/2020; - Following the hospital visit, Client #1's Guardian sent text messages to the RM asking to have a video call with client #1; - The RM was unable to coordinate the call at the time because the RM was working at a sister facility; - The QP did not think that it took about a day for the video call to be coordinated. Finding #2: Reviews on 5/15/2020 and 5/18/2020 of Client #2's record revealed: - Admission date: 2/1/2018 - Diagnoses: Major Depressive Disorder; Bipolar II Disorder; Moderate IDD; Acid Reflux; Diabetes; Hypertension; Hx of Trach Dependency; Obesity; Sleep Apnea; and Fungal Infections - A treatment plan dated 1/1/2020 that revealed: - " ... [Client #2] has significant behavioral support needs. These behaviors include: physical and verbal aggression, elopement, stealing, property destruction, and inappropriate sexual behaviors. Elopement has included putting herself in unsafe situations including having unsafe sex, taking the	V 291		

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V 291	Continued From page 11 bus to a Winston-Salem where she has an extensive history of getting into legal trouble... She will often pit one service provider against another ... The team would like to add that there are continued struggles with behavioral challenges. [Client #2] has either eloped or threatened to elope multiple times a week for the last few months. She has demonstrated an increase in aggression and frustration and has required therapeutic holds several times this year. She has successfully run away a handful of times this year, once going to a shelter where she met a man that she slept with in the woods ..." - An individual Behavior Support Plan dated 1/1/2020 and created by a Licensed Psychologist revealed: " ... [Client #2] requires close supervision and monitoring in order to prevent her engaging in unsafe behaviors and placing herself in dangerous situations. One to one staff supervision is recommended in order to ensure that she is safe. Close staff supervision is necessary while she is in the community and during activities such as volunteer work. Constant visual monitoring and staying in close proximity - within arm's length - while in the community is important to prevent unsafe behaviors such as elopement ..." Review on 6/29/2020 of [Client #2]'s local hospital emergency department (ED) records dated 5/7/2020 revealed: - Client #2 was transported to the ED by law enforcement officers (LEO) at 9:20pm on 5/7/2020 after running away from the facility when she was not allowed to talk to her sister; - There was no documentation of facility staff being present with Client #2 while she was at the ED; - Client #2 was cleared for discharge at 10:59pm on 5/7/2020;	V 291		

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V 291	Continued From page 12 - Beginning at 10:59pm on 5/7/2020, the hospital made multiple attempts to contact facility staff to arrange for Client #2 to be picked up and returned to the facility; - Client #2's Guardian also attempted to reach facility staff to coordinate transportation from the hospital back to the facility; - Facility staff did not coordinate with the hospital to pick Client #2 up; - Client #2 was not picked up from the hospital ED until 5:35am on 5/8/2020. Interview on 6/4/2020 with Client #2 revealed: - On 5/7/2020, Client #2 was taken to the local hospital ED after she had walked away from the facility; - When she was ready for discharge from the ED, the hospital staff attempted to call staff from the facility to pick her up; - Facility staff did not answer the hospital's calls; - Client #2's Guardian had to pick her up to transport her back to the facility. Interview on 6/22/2020 with Client #2's Guardian revealed: - Client #2 had a history of running away when she did not get her way; - Client #2 was not allowed to contact her sister because the sister was involved with Child Protective Services (CPS) and had tried to get Client #2 to take the blame for the sister's actions; - On 5/7/2020, Client #2 ran away from the facility and was taken to the local hospital ED by LEO; - Client #2 was assessed by the ED's behavioral health staff and was to be discharged; - The hospital attempted to contact facility staff to pick Client #2 up, but no one from the facility would return the hospital's calls; - The hospital ED staff called the Guardian to pick	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
HOME CARE SOLUTIONS	187 SCOTLAND RIDGE DRIVE WINSTON SALEM, NC 27107

(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	V 291		

up Client #2 when they were unsuccessful in reaching facility staff;
- The facility only had one staff working on each shift;
- The Guardian thought that the facility should have had a staff person go to the ED with Client #2;
- The Guardian eventually had to pick Client #2 up at approximately 6:00am on 5/8/2020 because the facility never responded to calls from the hospital.

Interview on 6/4/2020 with staff #1 revealed:
- On 5/7/2020, Client #2's sister called her, which precipitated Client #2 having a behavioral incident;
- Client #2 was not supposed to have contact with her sister without Guardian approval;
- Client #2 was transported to the local hospital ED due to the severity of her aggressive behaviors during the incident;
- Staff #1 remained at the facility with the other Clients throughout the rest of her shift;
- Client #2 went to the hospital ED without staff accompanying her because the other Clients were sleeping and there was no other staff available.

Interview on 6/18/2020 with the RM revealed:
- Facility staff were supposed to dial phone numbers for Client #2, but Client #2 would hang up and redial a different number before staff were aware of it;
- Client #2 was not supposed to have contact with her sister without Guardian consent;
- On 5/7/2020, Client #2 had called her sister before facility staff could intervene, which precipitated a behavioral incident;
- Client #2 also wanted to go to the hospital at times because she could sneak away from the

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V 291	Continued From page 14 hospital to go somewhere else; - Sometimes facility staff went with Client #2 to the hospital, and sometimes they did not; - The hospital sometimes called the RM when she was ready to be picked up, or the hospital would call whoever's phone number that Client #2 gave them; - There had not been any facility staff available to go to the hospital with Client #2 on 5/7/2020. Interviews from 5/14/2020 to 6/3/2020 with the QP revealed: - Client #2 had a habit of saying she was suicidal in order to go the local hospital ED; - The ED usually discharged Client #2 within 1 ½ hours of her arrival; - On 5/7/2020, Client #2 had a behavioral incident in which the local LEO was contacted, and Client #2 waited until the LEO was present before making threats to harm herself; - Client #2 was transported to the ED; - Facility staff were usually with Client #2 at the ED; - No facility staff went to the ED with Client #2 that night, possibly because they thought that Client #2 was going to be admitted to the hospital; - The ED called the facility to pick Client #2 up around 3:00AM; - The QP did not know why Client	V 291		