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	MHL098-168	A. BUILDING: _____ B. WING _____	R 05/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON COUNTY GROUP HOME #3	1300 GOLD STREET WILSON, NC 27893

(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 complaint survey was completed on May 28, 2021. The complaint was substantiated (intake #NC00175913). 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	Person Centered Planning retraining will be provided for the group home manager focusing on the whole person needs of each individuals. This training will be focused training/coaching as she works with the team to develop the next PCP due for a resident in this home. Specific strategies will be developed as part of short term goals to address phealth concerns, behavioral issues, or needed skill development for each individual. The group home manager will provide staff training/coaching and supervision around the specific interventions for each resident. Responsible staff: Group Home Manager/Program Director/QM Director RECEIVED JUN 20 2021 DHSR-MH Licensure Sect	

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to develop and implement strategies based on assessment affecting two of three clients (#4 and FC #5). The findings are: Review on 5/20/21 of client #4's record revealed: - 56 year old female. - Admission date of 4/23/15. - Diagnoses of: Post Traumatic Stress Disorder; Major Depressive With Psychotic Features; Intellectual Development Disability-Moderate. -Physicians order dated 2/12/21 for Jobst Knee-Hi (hose), put on in the morning and remove at bedtime. Observations at the facility from 5/18/21 - 5/28/21 did not reveal Client #4 wearing the Knee-Hi's at anytime. Observations at the 5/20/21 at approximately 11:00am of Client #4's medications revealed: - An un-opened pair of Jobst Knee-Hi's. -Client #5 had a used pair of the Jobst Knee-Hi's in her bedroom that were retrieved by the Qualified Professional. Review on 5/20/21 of client #4's Individual Support plan (ISP) dated 6/10/20 did not reveal any goals or strategies to support client #4's need of having to wear the Jobst Knee-Hi as prescribed.	V 112		

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V 112	Continued From page 2 Review on 5/19/21 of FC #5's record revealed: - 56 year old female. - Admission date of 8/11/11. - Diagnoses of: Intellectual Disabilities-Unspecified; Adjustment Disorder w/Depressed Mood; Major Depressive Disorder; Hyperthyroidism; Urinary Incontinence; Unsteadiness on feet; Dysphagia. - Person Centered Plan (PCP) dated 11/2/20 did not reveal any revised goals or strategies to support Client #5's decline since December 2020. -PCP dated 11/2/20 did not reveal any goals or strategies to support Client #5's use of walker ordered by physician, no goals or strategies to address Client #5's falling on purpose, refusing to eat or bathe, and refusal of staff's assistance. -Crisis Plan did not reveal any strategies to address Client #5's accidental or self-inflicted falls. - Client #5's Unsupervised Time Assessment dated 3/29/21 revealed Client #5 "will fall on purpose when she wants to go to the hospital," Client #5 "knows how to use appliances but haven't since not being able to walk," "is not compliant when staff tries to assist her during bathroom," "is not always community with staff when she needs to get up which results in falling," "due to [Client #5] constant falling on purpose, group home manager and staff have agreed she should no longer be left alone in the home just encase she falls." Client #5's Physician Orders dated 12/8/20-5/8/21 revealed: - A Computed Tomography (CT) Scan ordered of Client #5's head and spine due to a fall. -A walker was ordered. - She was seen for nasal trauma resulting from fall.	V 112		

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V 112	Continued From page 3 - She was seen for general weakness. - She had a referral for physical therapy completed. - Her lumbar spine view report revealed degenerative changes in the lumbar spine. Review of facility documents on 5/20/21 revealed staff meeting agenda dated 3/31/21 about Client #5 with topics including bathroom issues, dementia, training on Client #5's behaviors of falling on purpose and refusing to eat and bathe. Interview on 5/19/21 Staff #1 stated: - She had worked at the facility for 6 years. - Client #5 had refused baths and assistance from staff. - Client #5 changed when her father passed and when the pandemic lockdown occurred. Interview on 5/27/21 Staff #3 stated: - She had worked at the facility almost 2 years. - Client #5 had required assistance with bathing, feeding and toileting since November 2020. - Client #5 had a walker and a portable toilet in her bedroom. - Client #5 refused help from staff. - Everyone did the best they could with Client #5. Interview on 5/20/21 5/28/21 the Qualified Professional Stated: - She had worked at the facility since February 2020. - Client #4 would probably have behaviors since surveyor asked about the Jobst Knee-Hi. - Client #4 would not wear the Jobst Knee-Hi's everyday. - They could not make Client #4 wear the Jobst Knee-Hi's. - She had been responsible for Client #5's treatment plan.	V 112		

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V 112	Continued From page 4 - Client #5 had fallen on on purpose. - Client #5 had no revisions to her treatment plan to address falling on purpose, refusing assistance, refusing to eat and bathe. - She made other team members aware of Client #5's issues. -Client #5 had been discharged to a nursing facility on 5/11/21 due to her decline. Interviews between 5/19/21 and 5/28/21 the Regional Director stated: - Client #5 would request to go to the hospital when nothing was wrong with her. - Client #5 wanted to be waited on by others. - A meeting was held with staff and guardian to discuss Client #5's decline. - Client #5 fell to get out of doing things. - Client #5 began falling on purpose, yelling, waking up other clients' banging on walls and self-injurious behaviors in March 2021. - Client #5 had not previously required psych medications. - She tried to determine if Client #5's issues could be resolved medically. - Client #5 had not had a behavior plan. - Client #5's crisis plan had not included strategies for Client #5's falls or behaviors. - No strategies had been added to Client #5's treatment plan to address the use of a walker and portable toilet, her falling on purpose or her refusals.	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	V 118		

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V 118	Continued From page 5 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 interview the facility failed to administer medications as ordered by a physician and failed to keep an accurate MAR affecting one of three clients (#4). The findings are: Finding #1:	V 118	The The Health and Wellness team nurse will complete a review of medication administration records for residents by 7/30/21. This will include a reveiw of Physician Orders and medication error reports. Retraining for staff will be provided as needed by the RN	

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V 118	Continued From page 6 Review on 5/20/21 of client #4's record revealed: - 56 year old female. - Admission date of 4/23/15. - Diagnoses of: Post Traumatic Stress Disorder; Major Depressive Disorder With Psychotic Features; Intellectual Development Disability-Moderate, Asthma, Hyperlipidemia, Venous insufficiency and Recurrent Falls. -Physicians order dated 2/12/21 for Jobst Knee-Hi (hose), put on in the morning and remove at bedtime. Review on 5/20/21 of client #4's of physician orders dated 2/12/21 revealed: -Docusate 100 milligrams (mg) (stool softner), 1 capsule (cap) twice daily as needed. -Nyamyc Powder, (treats fungal infections) apply twice daily as needed. Review on 5/20/21 of client #4's physician orders dated 5/11/21 revealed: -Verapamil ER 240 mg (treats high blood pressure), 1 tablet (tab) at bedtime. Review on 5/20/21 of client #4's May 2021 MARs revealed the following blanks: -Docusate 100mg - 1 cap twice daily on 5/12/21 at 8:00pm. -Verapamil ER 240 mg- 1 tab at bedtime 5/11/21-5/12/21 at 8:00pm -Nyamyc Powder- apply twice daily, 5/12/21 3:00pm -10:59pm. Review on 5/20/21 of client #4's May 2021 MARs revealed the following: -Docusate 100mg- 1 cap- not transcribed to be administered as needed. -Nyamyc Powder- apply twice daily- not transcribed to be administered as needed.	V 118		

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V 118	Continued From page 7 Review on 5/20/21 of client #4's physician signed FL2 revealed the following orders: -Torsemide (treats edema) 20mg with morning dose of Torsemide for 3 days for weight gain of more than 3 pounds (lbs) in one day. -Torsemide 20mg with morning dose by mouth for 3 days for weight gain of more that 5 lbs in one week. Review on 5/20/21 of client #4's February 2021 - May 2021 revealed the following: February 2021 -Torsemide 20mg 2 tabs for weight gain of more than 3 pounds in one day or 5 pounds in one week 3 days as needed blank. -Torsemide 20mg for weight gain of more than 3 pounds in one day documented as administered daily at 8:00am. -Torsemide 20mg for weight gain of more than 5 pounds in one week documented as administered weekly at 8:00am. March 2021 -Torsemide 20mg 2 tabs for weight gain of more than 3 pounds in one day or 5 pounds in one week 3 days as needed blank. -Torsemide 20mg for weight gain of more than 3 pounds in one day documented as administered daily at 8:00am. -Torsemide 20mg for weight gain of more than 5 pounds in one week documented as administered weekly at 8:00am. April 2021 -Torsemide 20mg 2 tabs for weight gain of more than 3 pounds in one day or 5 pounds in one week 3 days as needed blank. -Torsemide 20mg for weight gain of more than 3 pounds in one day documented as administered daily at 8:00am. -Torsemide 20mg for weight gain of more than 5 pounds in one week documented as administered	V 118		

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V 118	Continued From page 8 weekly at 8:00am. May 2021 -Torsemide 20mg 2 tabs for weight gain of more than 3 pounds in one day or 5 pounds in one week 3 days as needed blank. -Torsemide 20mg for weight gain of more than 3 pounds in one day documented as administered daily at 8:00am. -Torsemide 20mg for weight gain of more than 5 pounds in one week documented as administered weekly at 8:00am. Review on 5/20/21 of client #4's weight on February 2021 - May 2021 MARs revealed the following: -No daily 3 pound weight gain or 5 pound weekly weight gain during February 2021. -No daily 3 pound weight gain or 5 pound weekly weight gain during March 2021. -No daily 3 pound weight gain or 5 pound weekly weight gain during April 2021. -No daily 3 pound weight gain or 5 pound weekly weight gain during May 2021. Interview on 5/20/21 client #4 indicated she received her medications daily. Interview on 5/20/21 staff #4 stated: -She had only administered the Torsemide to client #4 if she gained the weight as the MAR states. Interview on 5/20/21 the Qualified Professional stated: -Client #4 had only been administered the Torsemide medication as it was ordered. Interview on 5/20/21 the Regional Director stated: -Client #4 had only been administered the Torsemide medication if she gained the weight as	V 118		

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V 118	Continued From page 9 ordered. -Staff had documented the medication as administered incorrectly. -Client #4's MAR was not accurate because staff should have documented the Torsemide as administered in the as needed section of the MAR if client #4 gained the required weight. -She would discuss with staff and the pharmacy about MAR changes for the Torsemide medication. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician.	V 118	D	
V 363	G.S. 122C-61 Treatment rights in 24-hour facilities. § 122C-61. Treatment rights in 24-hour facilities. In addition to the rights set forth in G.S. 122C-57, each client who is receiving services at a 24-hour facility has the following rights: (1) The right to receive necessary treatment for and prevention of physical ailments based upon the client's condition and projected length of stay. The facility may seek to collect appropriate reimbursement for its costs in providing the treatment and prevention; and (2) The right to have, as soon as practical during treatment or habilitation but not later than the time of discharge, an individualized written discharge plan containing recommendations for further services designed to enable the client to live as normally as possible. A discharge plan may not be required when it is not feasible because of an unanticipated discontinuation of a client's treatment. With the consent of the client or his legally responsible person, the	V 363	Discharge planning documentation training will be provided to group home managers. In this situation efforts were made to coordinate with appropriate stakeholders, however documentation of those efforts was limited. Training on the use of our coordination of care logs within our electronic health record will provide increased documentation on these events.	

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V 363	Continued From page 10 professionals responsible for the plans shall contact appropriate agencies at the client's destination or in his home community before formulating the recommendations. A copy of the plan shall be furnished to the client or to his legally responsible person and, with the consent of the client, to the client's next of kin. (1973, c. 475, s. 1; c. 1436, ss. 6, 7; 1981, c. 328, ss. 1, 2; 1985, c. 589, s. 2.) This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement an individualized written discharge plan as soon as practical, containing recommendations for further services designed to enable the client to live as normally as possible affecting 1 of 4 (FC#5). The findings are: Review on 5/19/21 through 5/28/21 of FC #5's record revealed: -56 year old female. -Admission date of 8/11/11. -Diagnoses of: Intellectual Disabilities-Unspecified; Adjustment Disorder w/Depressed Mood; Major Depressive Disorder. Review on 5/28/21 of the Discharge Notice for FC #5 revealed: -FC #5's identifying information and diagnosis. -FC #5's reason for discharge was to transfer to another agency. -Summary of FC #5's reasons for admission to a new facility. -FC #5 was discharged on 5/11/21 to a nursing facility. -No indication of who completed the discharge	V 363		

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V 363	Continued From page 11 summary or what date it was completed. -Recommendations section on page 3 of FC 5's discharge summary had been left blank. -Signature and date section on page 3 of FC #5's discharge summary had been left blank. Interview on 5/14/21 the managed care organization (MCO) representative stated: -FC #5 had been non-ambulatory since December 2020. -FC #5 had started declining last year. -The facility had started coordinating a discharge for FC #5. Interview on 5/28/21 the Qualified Professional (QP) stated: -She searched and called potential facilities for FC #5. -She had notified the department of social services of the plan to discharge FC #5. -She sent FC #5's discharge paperwork to the local advocacy agency. -She had a conversation with someone at a prospective agency to discharge FC #5 to. -There was no written discharge notice or plan. Interviews between 5/19/21 - 5/28/21 the Regional Director stated: -She had discussed FC #5's status and her decline with the guardian and the MCO representative. -She, the guardian and the MCO representative had decided that FC #5 required a higher level of care. -FC #5's guardian was aware for months of the plan to discharge FC #5. -A discharge summary had been completed for FC#5 and would be provided to surveyor for review.	V 363		

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V 736	Continued From page 12	V 736		
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 interviews the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observations on 5/19/21 at approximately 12:30pm revealed: -Rust spots inside the top of the microwave. -Portable fan in Client #4's bedroom covered in heavy dust. -Hallway vent register covered in heavy dust. -Handicap bathroom sink had rust in the drain. -Mildew or Mold in between tile in the shower. -Window sill in living room had dust. -Dead bugs on the floor behind the sofa. -Paint scraped off the wall behind 2 chairs in the living room. -Two 3 bulb ceiling light fixtures in the dining area both had 1 bulb blown. -Blind on door in the dining area hanging slanted and broke. During interview on 5/28/21 the Regional Director stated she was aware the facility had to be maintained in a safe, clean, and attractive and orderly manner.	V 736		

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