STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL010-077	A. BUILDING: _____ B. WING _____	07/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENYA AFL	800 JOSEPH WILLETTS DRIVE SE WINNABOW, NC 28479

(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 07/27/21. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Alternative Family Living.	V 000	DHSR - Mental Health AUG 11 2021 Lic. & Cert. Section	
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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Meriah O'Brien Meriah O'Brien — TITLE: Administrator — (X6) DATE: 8/6/21

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V 108	Continued From page 1 clients. This Rule is not met as evidenced by: Based on interviews, observation, and record reviews, the facility failed to provide training to meet client specific needs affecting 2 of 2 paraprofessional staff audited (Staff #1, #2). The findings are: Review on 7/27/21 of Staff #1's file revealed: -Hire date: 1/28/21 -Position: Direct Support Associate, paraprofessional. -Client specific training documented 12/27/20, provided by the Licensee/Registered nurse (L/RN): Feeding tube, hoyer, catheter care, wheelchair, shower chair, handicapped van. -Training specific client #3's potential need for Narcan or recognition of symptoms of retinal detachment were not documented. Interview on 7/23/21 Staff #1 stated she was a paraprofessional direct care staff. Review on 7/27/21 of Staff #2's file revealed: -Hire date: 2/13/20 -Position: Direct Support Associate, paraprofessional. -No documentation of training to meet specific client needs. Unable to reach Staff #2 for interview on 7/27/21. Review on 7/23/21 of client #1's record revealed: -22 year old male admitted July 2018.	V 108	**Plan of Correction** **V108 27G.0202 F-I** **Personnel Requirements- 3** #3 Rule is not met as evidenced by : Based on interviews, observation, and record Reviews, the facility failed to provide training to Meet client specific needs affecting 2 of 2 Paraprofessional staff. staff #1 Did not have training specific to client #3's potential need for Narcan or recognition of symptoms of retinal detachment were not documented. Staff #2 did not have any documentation of training to meet specific client needs of client #1 and #3. **Plan of Correction** RHA AFL provider/QP will ensure all direct support staff have been trained and it is documented ,In all areas of client specific needs i.e. Feeding tube and venting after each feeding, Hoyer, catheter care, wheelchair, shower chair, handicapped van, use of Narcan, recognition of symptoms of retinal detachment, etc. prior to working with consumers. Monitoring of this process will be the responsibility of RHA QP/Administrator and will take place at least quarterly/as needed. Completion date 9/25/21	

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V 108	Continued From page 2 -Diagnoses included intellectual developmental disabilities; cerebral palsy; adjustment disorder; seizure disorder; scoliosis; chronic GERD (gastroesophageal reflux disease); flexion contractures; constipation by delayed colonic transit. -Non-ambulatory; wheelchair. -Gastrostomy feeding tube (G-tube). -Treatment plan documented client #1 required "venting" after each feeding using his G-tube to remove gas and air from his stomach. Review on 7/23/21 of client #3's record revealed: -39 year old male admitted 12/3/20. -Diagnoses included Autism Spectrum disorder; Major depressive, moderate; attention deficit hyperactive disorder, inattentive type. -Non-ambulatory; wheelchair. -Suprapubic catheter. -Treatment plan documented client #3 was legally blind and had a history of retinal detachment; a significant/sudden change in vision would indicate an emergency and staff were to notify the Licensee and guardian immediately in order for treatment to be provided as soon as possible. -Treatment plan dated 7/1/21 documented client #3 used an inhaler daily and as needed, but he may not realize he needs it. Staff needed to monitor him for shortness of breath, retrieve the inhaler and assist him to use it if needed. -Risk assessment, "Narcan is in place in event he would need it due to overdose. All staff should be trained in how to monitor for if this is needed." -Medication Administration Records for May, June and July 2021 transcribed order for Narcan, "Naloxone 4 mg (milligrams)/actuation nasal spray, 1 spray by nasal route as needed." -Treatment plan dated 7/1/21 documented the Narcan was to be administered as needed for drug overdose by administering 1 spray in each	V 108		

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V 108	Continued From page 3 nostril every 2-3 minutes until EMS (emergency medical services) arrived. Observation on 7/27/21 between 11:30 am and 12:00 pm revealed Narcan on hand had no instructions on the label; box was sealed. Interview on 7/27/21 the L/RN stated: -Staff #2 had not signed the documentation for her client specific training. -She had discussed with staff if client #3 became "somnolent" they were to administer the Narcan.	V 108		
V 116	27G .0209 (A) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (a) Medication dispensing: (1) Medications shall be dispensed only on the written order of a physician or other practitioner licensed to prescribe. (2) Dispensing shall be restricted to registered pharmacists, physicians, or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy. If a permit to operate a pharmacy is Not required, a nurse or other designated person may assist a physician or other health care practitioner with dispensing so long as the final label, Container, and its contents are physically checked and approved by the authorized person prior to dispensing. (3) Methadone For take-home purposes may be supplied to a client of a methadone treatment service in a properly labeled container by a registered nurse employed by the service, pursuant to the requirements of 10 NCAC 45G .0306 SUPPLYING OF METHADONE IN TREATMENT PROGRAMS BY RN. Supplying of	V 116		

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V 116	Continued From page 4 methadone is not considered dispensing. (4) Other than for emergency use, facilities shall not possess a stock of prescription legend drugs for the purpose of dispensing without hiring a pharmacist and obtaining a permit from the NC Board of Pharmacy. Physicians may keep a small locked supply of prescription drug samples. Samples shall be dispensed, packaged, and labeled in accordance with state law and this Rule. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to ensure dispensing of medications was restricted to registered pharmacists, physicians or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy affecting 3 of 3 clients audited (Clients #1, #2, #3). The findings are: Finding #1: Review on 7/23/21 of client #1's record revealed: -22 year old male admitted July 2018. -Diagnoses included intellectual developmental disabilities; cerebral palsy; adjustment disorder; seizure disorder; scoliosis; chronic GERD (gastroesophageal reflux disease); flexion contractures; constipation by delayed colonic transit. -Orders dated 7/22/21 for Erythromycin Ethysuccinate 200 mg/5ml (milligrams/milliliters) suspension reconstituted (antibiotic), 4 ml (milliliters) 3 times daily and Baclofen 20 mg (milligrams), 1.5 tablets 3 times daily (spasticity).	V 116	**V116 27G. 0209 (A)** **Medication requirements 2-** This rule is not met as evidenced by: Based on record reviews, observations, and Interviews, the facility failed to ensure dispensing of medications was restricted to registered pharmacists, physicians or and other h heath care practitioners authorized by law and registered with the NC Board of pharmacy. If a permit to operate a pharmacy is not required, a nurse or other designated person may assist a physician or other health care practitioner with dispensing so long as the final label, container, and its contents are physically checked and approved by the authorized person before dispensing, affecting 3 of 3 clients audited. **Plan of Correction** RHA AFL provider/Direct Support Associate, will ensure the final label, container and its contents are checked and dispensed against the Medication Administration record/physicians order. AFL Provider/ Direct Support associate who administers the medication will then record immediately, on the medication administration record. Monitoring of this process will be the responsibility of RHA AFL provider/QP and will take place at least monthly / as needed. Completion Date 9/25/21	

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V 116	Continued From page 5 Observation on 7/23/21 at 8:30 am revealed: -A small green medicine container, label read, "travel jar 22 ml" inside the refrigerator. -Inside the "travel jar" was a white semi-liquid with 2 partially dissolved white tablets. Finding #2: Review on 7/23/21 of client #2's record revealed: -30 year old male admitted 4/30/17. -Diagnoses included moderate intellectual developmental disabilities; Autism Spectrum, mild; hypertension; hypothyroidism; hyperlipidemia. Medications scheduled to be administered at 7 am were as follows: -Omega 3 fatty acids 1000mg (supplement) -Paroxetine 10mg (depression) -Levothyroxine 0.125 mg (thyroid hormone replacement) -Guanfacine 4 mg (attention deficit disorder) Interview on 7/23/21 client #2 stated: -He took his meds (medications) in the morning after breakfast. -The Licensee/Registered Nurse (L/RN) or Staff #1 gave him his medications. -If the L/RN was not going to be there in the morning she would put his meds in a cup the night before and place the cup on the window sill. Staff #1 would prepare breakfast and give him his meds. Finding #3: Review on 7/23/21 of client #3's record revealed: -39 year old male admitted 12/3/20. -Diagnoses included Autism Spectrum disorder; Major depressive, moderate; attention deficit disorder, inattentive type. Medications scheduled to be administered at 7 am were as follows:	V 116		

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V 116	Continued From page 6 -Diazepam 5 mg (anxiety) -Quetiapine 200 mg (depression) -Vitamin D3 (supplement) -Coenzyme Q 10 (supplement) -Omeprazole 40 mg (reflux) -Oxycontin 20 mg (pain) -Potassium 10 milliequivalents (supplement) -Levothyroxine 25 micrograms Interview on 7/23/21 client #3's day worker stated: -He worked 7:30 am - 3:30 pm. -When he arrived the L/RN would have put client #3's morning medications in a single plastic cup. -He would give client #3 the medications from the cup. -The L/RN or Staff #1 would sign the medication administration record because he was not providing a daily living service. Interview on 7/23/21 the L/RN stated: -She had poured client #2's Erythromycin and baclofen doses that were due to be given between 2 pm and 3 pm into the "travel jar" and placed the container in the refrigerator. -She was aware medicines should not be pre-poured. Refer to V118 for medication orders and medication administration record documentation for client #2 and #3.	V 116		
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 7 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 as ordered by the physician and maintain an accurate MAR for 3 of 3 clients audited (#1, #2, #3). The findings are: Finding #1:	V 118		

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V 118	Continued From page 8 Review on 7/23/21 of client #1's record revealed: -22 year old male admitted July 2018. -Diagnoses included intellectual developmental disabilities; cerebral palsy; adjustment disorder; seizure disorder; scoliosis; chronic GERD (gastroesophageal reflux disease); flexion contractures; constipation by delayed colonic transit. Review on 7/23/21 of client #1's medication orders and order dates revealed: -5/11/21: Miralax 17 gm (grams) scoop powder, 1/2 capful orally once daily as needed. (constipation) -5/11/21: Tizanidine HCL (hydrochloride) 4 mg (milligrams) as needed once a day. (muscle spasms) -7/14/21: Tizanidine 4 mg order changed to be administer nightly. Review on 7/23/21 of client #1's May, June and July 2021 MARs revealed: -Transcribed order for Tizanidine 4 mg read to administered as a routine medication nightly; Tizanidine 4 mg was documented as given nightly for all of May and June, and from 7/1/21 - 7/14/21. -July 2021 transcribed order for Miralax read to mix 17 grams in 8 ounces of water and administer daily as needed. -No Miralax order transcribed to the May or June 2021 MARs. Finding #2: Review on 7/23/21 of client #2's record revealed: -30 year old male admitted 4/30/17. -Diagnoses included moderate intellectual developmental disabilities; Autism Spectrum, mild; attention deficit hyperactive disorder (ADHD); hypertension; hypothyroidism;	V 118	**V118 27G.0209 (C)** Medication Requirements (C) Medication Administration This rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to administer medications as ordered by the physician and maintain an accurate MAR for 3 of 3 clients. **Plan of Correction** RHA AFL Provider/RHA Direct Support back up staff, will ensure all medications are administered as ordered by the physician. RHA AFL provider/ RHA DSA back up staff, will ensure a written order is obtained for any medications to be administered. RHA AFL provider/RHA DSA back up staff, will ensure a Medication Administration Record (MAR) of all drugs Administered to each client is kept current. Medication Administered shall be recorded immediately after Administration. The MAR will include to the following: A. Client 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 the person administering the drug. RHA AFL provider/RHA DSA Back up staff will ensure PRN medications are documented on MAR. RHA AFL provider/RHA DSA Back staff will ensure PRN medication is available, in the event PRN medication is needed. Monitoring of this process will be the responsibility of RHA QP/ Administrator and will take place at least monthly/as needed. Completion Date 9/25/21.	

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V 118	Continued From page 9 hyperlipidemia. Review on 7/23/21 of client #2's medication orders and order dates revealed: -12/17/19: Omega 3 fatty acids 1000mg, 1 in the morning and 1 in the evening (supplement) -12/17/19: Gabapentin 400 MG at bedtime (anticonvulsant, nerve pain, and off label uses to include ADHD) -12/17/19: Paroxetine 10mg daily (depression) -12/17/19: Latuda 60 mg QD with evening meal (improve function in persons with autism spectrum) -9/23/19: Levothyroxine 0.125 mg daily (thyroid hormone replacement) -9/23/21: Guanfacine 4 mg daily (attention deficit disorder) Review on 7/23/21 of client #2's May, June, and July 2021 MARs revealed all medications had been initialed as given by the Licensee/Registered Nurse (L/RN). Interview on 7/23/21 client #2 stated: -The L/RN or Staff #1 gave him his medications. -If the L/RN was not going to be there in the morning Staff #1 would prepare breakfast and give him his medications. Finding #3: Review on 7/23/21 of client #3's record revealed: -39 year old male admitted 12/3/20. -Diagnoses included Autism Spectrum disorder; Major depressive, moderate; ADHD, inattentive type. -No order for "Sulfamethoxazol TMP (trimethoprim) DS (double strength) take 1 tablet q (every) 12 hrs x 10 days." (antibiotic) Review on 7/27/21 of orders on hospital	V 118		

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V 118	Continued From page 10 discharge summary dated 12/3/20 revealed: -Albuterol 90 mcg (micrograms)/actuation 2 puff inhaler, inhale 2 puffs every 4 hours as needed for wheezing. Use every morning before Breo (routine inhaler, breathing). -Diazepam 5 mg twice daily (anxiety) -Quetiapine 200 mg 3 times daily (psychosis) -Vitamin D3 daily (vitamin D deficiency) -Coenzyme Q 10 twice daily (dietary supplement) -Omeprazole 40 mg daily (reflux) -Oxycontin 20 mg 3 times daily (pain) -Potassium 10 milliequivalents twice daily(low potassium, supplement) -Levothyroxine 25 micrograms daily Review on 7/27/21 of client #3's May, June, and July 2021 MARs revealed: -Diazepam 5 mg had been administered three times daily. -Transcribed order, "Sulfamethoxazol TMP DS (sulfamethoxazole and trimethoprim double strength) take 1 tablet q 12hrs x 10 days," administered twice daily 7/2/21 (8p) - 7/12/21 (8a). No dosage documented. -All medications were documented as given by the L/RN. Interview on 7/23/21 client #3's day worker stated: -He worked 7:30 am - 3:30 pm 1 day a week. -He gave client #3 his medications pre-poured by staff. -The L/RN or Staff #1 would sign the medication administration record because he was not providing a daily living service. Interviews on 7/23/21 and 7/27/21 the L/RN stated: -Client #1's Tizanidine 4 mg had always been given as a routine medication; she had not	V 118		

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V 118	Continued From page 11 realized the order had been written "as needed" on 5/11/21. -Client #3's order for Diazepam had been changed by this psychiatric provider on 2/22/21 according to his mother. She (L/RN) had not received a copy of the order. -Sulfamethoxazol TMP DS had been ordered for client #3 when he had an elevated temperature of 101.3. She (L/RN) never received an order. -Client #3 went out into the community daily with his day worker. He did not take his albuterol inhaler with him in case he needed it for wheezing. He had not had any issues. -She signed all of the MARs. 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		