STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL096-271	A. BUILDING: _____ B. WING _____	R 09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINSTON	1606 SALEM CHURCH ROAD GOLDSBORO, NC 27530

(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 follow up survey was completed on 09/07/21. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	{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 file followed up by appointment or consultation with a physician.	{V 118}		

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{V 118}	Continued From page 1 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 a physician and MARs current affecting 3 of 3 former clients (FC) audited (FC#1, FC#2, FC#3). The findings are: Finding #1: Review on 9/7/21 of FC# 1's record revealed: -21 year old male admitted 1/5/18 and discharged 6/14/21. -Diagnoses: Attention Deficit Hyperactive Disorder (ADHD), Moderate Intellectual Developmental Disorder (IDD), Expressive language disorder; Oppositional Defiant Disorder (ODD), Bilateral hearing loss and Cerebral Palsy. -Order dated 5/3/21 for Concerta ER (extended release) 36 mg (milligrams) in the morning. (ADHD) -Order dated 3/23/21 for Temazepam 7.5 mg at bedtime. (Insomnia) Review on 9/7/21 of FC# 1's MARs, 4/1/21 - 6/14/21 revealed: -Concerta ER 36 mg (8 am scheduled dose) was not administered on 6/7/21. Staff documented the medication was not available. -Temazepam 7.5 mg (8 pm dose) was not administered 4/8/21, 6/1/21, 6/22/21, and 6/23/21. Staff documented the medication was not available for each dose not administered. On 4/8/21 staff documented, "reorder made through pharmacy;" on 6/1/21 staff documented, "med	{V 118}		

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{V 118}	Continued From page 2 was out called pharmacy he had no more refills left." Finding #2: Review on 9/7/21 of FC# 2's record revealed: -36 year old male admitted 1/12/21 and discharged 6/14/21. -Diagnoses: Paranoid Schizophrenia, Moderate IDD, ADHD, Seizure Disorder, Mild Cognitive Impairment; Delusional Disorder, Intermittent Explosive Disorder. -Order dated 5/10/21 for Clonazepam 0.5 mg 3 times daily. (Seizure control) -Order dated 8/12/20 for Listerine Cool Mint mouthwash, use as directed daily. (Oral hygiene) -Order dated 3/4/21 for Olanzapine 10 mg 1/2 tab (5mg) at noon and 5 pm. -Order dated 4/1/21 on physician consult form to discontinue Olanzapine 10 mg 1/2 tab (5mg) at noon and 5 pm. -New order dated 4/1/21 on physician consult form to administer Olanzapine 10 mg at noon. (Schizophrenia) Review on 9/7/21 of FC# 2's MARs 4/1/21 - 6/14/21 revealed: -Clonazepam 0.5 mg 2 pm dose was not documented as administered on 6/14/21 (blank on MAR). No explanation documented on the "Exceptions" section of the June 2021 MAR. -Listerine mouthwash was not administered on 4/11/21, 4/17/21, 4/18/21, or 4/24/21. Staff documented, "Med not available." -April 2021 printed MAR with hand written initials documenting medications administered did not include a transcribed entry to discontinue the 3/4/21 Olanzapine order. -April 2021 printed MAR with hand written initials did not include a transcribed entry for the new order dated 4/1/21 to administer Olanzapine 10	{V 118}		

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{V 118}	Continued From page 3	{V 118}		

mg at noon.
-April 2021 MAR with hand written initials documented Olanzapine 10 mg, 1/2 tab at noon: 4/1/21 - 4/9/21; 4/11/21 - 4/15/21; 4/17/21 - 7/30/21.
-April 2021 MAR with hand written initials documented Olanzapine 10 mg, 1/2 tab at 5 pm: 4/1/21 - 4/4/21, 4/17/21, 4/18/21, 4/24/21, 4/25/21.
-April 2021 MAR printed for surveyor on 9/7/21 documented the 4/1/21 Olanzapine order (10 mg at noon) with electronically entered staff initials from 4/3/21 - 4/30/21.

Finding #3:
Review on 9/7/21 of FC# 3's record revealed:
-22 year old male admitted 3/15/21 and discharged 6/14/21.
-Diagnoses: Schizoaffective Disorder; bipolar type; Post Traumatic Stress Disorder (PTSD); Mild IDD; Hypothyroidism; Hyperlipidemia.
-Orders dated 3/16/21 as follows:
-Atorvastatin 20 mg at bedtime. (Lower Cholesterol)
-Benztropine 1 mg at bedtime. (Involuntary movement)
-Depakote 500 mg twice daily. (Schizoaffective Disorder; bipolar type)
-Hydroxyzine 100 mg at bedtime. (Anxiety, sleep)
-Levothyroxine 25 mcg (micrograms) daily. (Hormone replacement)
-Quetiapine 300 mg at bedtime. (Schizoaffective Disorder; bipolar type)
-Quetiapine 50 mg every morning.
-Nicotine Patch every 24 hours. (Nicotine withdrawal)
-Order dated 5/28/21 for Prazosin 1 mg at bedtime for "flashbacks."
-Order dated 5/28/21 and 6/11/21 for Depakote

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{V 118}	Continued From page 4 500 mg, 2 tablets (=1,000 mg) at bedtime. -Order dated 6/2/21 for Fluticasone 50 mcg nasal spay, 2 sprays in each nostril daily. (Congestion) -Order dated 6/10/21 for Hydroxyzine 50 mg twice daily, every morning and at bedtime for anxiety/agitation. Review on 9/7/21 of FC #3's MARs 4/1/21 - 6/14/21 revealed: -The following medications were documented as not administered because the client was out of the medication: -4/4/21: Atorvastatin 20 mg at bedtime. -4/15/21: Benztropine 1 mg, 8 pm dose. -4/15/21 and 4/16/21: Depakote 500 mg 8 am doses. -4/15/21: Hydroxyzine 100 mg, 8 pm dose. -4/15/21, 4/16/21: Levothyroxine 25 mcg, 8am dose. -4/15/21, 4/16/21: Quetiapine 50 mg, 8 am doses. -4/22/21, 4/23/21: Nicotine Patch, 8 am -5/28/21: Depakote 500 mg, 8 pm dose. -5/28/21 - 5/31/21: Prazosin 1 mg, 8 pm doses (4 consecutive days). -6/4/21: Fluticasone 50 mcg nasal spray, 8 am dose. -6/13/21, 6/14/21, 6/16/21: Hydroxyzine 50 mg, 8 am doses. -6/10/21, 6/13/21, 6/14/21: Hydroxyzine 50 mg, 8 pm doses. Interview on 9/7/21 the Medical Coordinator stated: -MARs were printed and used as a paper back up MAR when the computer system was down at the time a medication was given. -Client #2's MARs with hand written initials were most likely done when the computer system was down.	{V 118}		

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{V 118}	Continued From page 5 -If a medication was both electronically and manually documented, it would be because the staff initialed the MAR when the medication was given, then made a late entry in the computer system once the system was back on line. All electronic entries were time stamped, so if there was a question she could always look it up in the computer system to determine by whom and when the entry was made. -There had been some problems with getting refills and it seemed to coincide with an ownership change of the pharmacy. -A process had been put in place for the Group Home Leaders to review medications on hand every 7 days and reorder those needed to prevent not having medications on hand. 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}		