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	MHL096-270	A. BUILDING: _____ B. WING _____	10/27/2021

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GRACE	1290 MARK EDWARDS ROAD GOLDSBORO, NC 27534

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on October 27, 2021. The complaint was substantiated (intake #NC00181662). 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	DHSR - Mental Health NOV 5 2021 Lic. & Cert. Section	11/15/21
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	V112 In order to ensure that this deficiency is brought back into compliance, the identified member's treatment plan will be updated to include a short range goal that addresses the member's newly identified behavior. This will highlight the behavior for staff members, as well as create a better metric by which to track the individual's med refusals. In order to prevent this deficiency in the future, a "Behavioral Tracking Log" will be created and implemented. This log will track both medication and behavioral incident reports. Upon noticing a pattern of behavior, the Service Coordiantor/QP will update the individuals Short Range Goals, obtain LRP signature, and implement the plan update with	

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V 112	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview the facility failed to develop and implement strategies based on assessment for 1 of 3 audited clients (#2). The findings are: Review on 10/19/21 of client #2's record revealed: - 30 year old admitted 9/01/17. - Diagnoses included Schizoaffective Disorder, depressive type and Intellectual/Developmental Disability, mild. - "Individual Support Plan Short Range Goals" implemented 9/01/21 did not include any goals or strategies to address medication refusals. Reviews on 10/19/21 and 10/26/21 of level I incident reports completed August 2021 - October 2021 for client #2 revealed client #2 spit out his morning medications shortly after administration 9/07/21, 9/22/21, 9/28/21, and 9/30/21. During interview on 10/26/21 client #2 stated he took his medications every day with staff assistance and he never spit them out. During interview on 10/26/21 the Director of Operations confirmed client #2's Individual Support Plan Short Range Goals did not include goals or strategies to address medication refusals. He agreed medication refusals should be addressed in the treatment/habilitation plan.	V 112	Grace home staff members. The behavioral tracking log will be updated constantly (as new incident reports come in), and the log will be analyzed at least monthly by the Service Coordinator/QP of the Grace Home.	

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V 118	Continued From page 2	V 118		
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. This Rule is not met as evidenced by:	V 118	V118 Ambleside, Inc. will continue to work diligently to ensure that members are receiving their meds as prescribed by their PCP or other medical provider. Ambleside's Medical Coordinator will monitor the E-MAR system on a daily basis to ensure that all meds are passed. Furthermore, the Medical Coordinator will conduct Bi-weekly med cart audits at the home to ensure that all prescribed medication is present in the home. If any deficiencies are present, the Medical Coordinator will perform continuing education with the staff member identified as deficient as evidenced through a coaching/counseling form (or disciplinary notice. The Medical Coordinator will monitor this system daily, and perform the actions identified above as necessary.	11/15/21

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V 118	Continued From page 3 Based on record reviews, observations and interviews the facility failed (1) to administer medications as ordered by the physician for 3 of 3 audited clients (#1, #2 and #3), and (2) to ensure 1 of 3 audited staff (staff #1) was trained to administer medications. The findings are: Finding 1: Review on 10/19/21 of client #1's record revealed: - 21 year old admitted 4/01/19. - Diagnoses included Autism Spectrum Disorder, severe Intellectual/Developmental Disability, Attention Deficit Hyperactivity Disorder, and Generalized Anxiety Disorder. - Physician's orders signed 4/01/21 for Flonase (treats allergies) 50 micrograms (mcg) 2 sprays to each nostril daily, gabapentin (anti-convulsant and nerve pain medication) 100 milligrams (mg) 1 capsule three times daily, and clonidine (anti-hypertensive and sedative) 0.1 mg 2 tablets twice daily. Review on 10/19/21 of client #1's MARs for August - October 2021 revealed: - No staff initials for administration of gabapentin 10/07/21 2:00 pm, Flonase 10/16/21, or clonidine 10/17/21 8:00 pm; with no documented explanations of the omissions. - Clonidine 8/23/21 8:00 am "med (medication) not available;" 8/23/21 8:00 pm "medicine did not arrive;" and 8/24/21 8:00 am "med not available." Client #1 was not interviewed due to his limited communication skills and agitated behaviors at the time of the survey. Review on 10/19/21 of client #2's record revealed: - 30 year old admitted 9/01/17.	V 118		

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V 118	Continued From page 4 - Diagnoses included Schizoaffective Disorder, depressive type and Intellectual/Developmental Disability, mild. - Physician's orders signed 6/17/21 and 10/11/21 for aripiprazole (anti-psychotic) 10 mg 1 tablet every morning; signed 4/06/21 for benztropine (anti-tremor and treats side effects of other medications) 1 mg 1 tablet three times daily, citalopram (can treat depression) 20 mg 1 tablet in the morning, haloperidol (anti-psychotic) 10 mg 1 tablet three times daily, omeprazole (can treat gastroesophageal reflux disease) 40 mg 1 capsule daily, trazodone (anti-depressant and sedative) 50 mg 1 tablet daily at 6:00 pm; and signed 9/21/21 for over the counter Vitamin E 400 - 800 units (dietary supplement) 1 capsule daily. Review on 10/19/21 of client #2's MARs for August - October 2021 revealed: - No staff initials for administration of aripiprazole 10/17/21; benztropine 10/07/21 2:00 pm, 10/16/21 8:00 pm, and 10/17/21 8:00 am and 8:00 pm; citalopram 10/17/21; haloperidol 10/07/21 2:00 pm, 10/16/21 8:00 pm, and 10/17/21 8:00 am and 2:00 pm; omeprazole 10/16/21 and 10/17/21; and trazodone 10/06/21 and 10/16/21; with no documented explanations for the omissions. - "Pass Notes" included ". . .6-Sep(September) 2021 2:00 pm Benztropine 1 mg tablet . . . Staff missed medication pass . . . 6-Sep-2021 2:00 pm Haloperidol 10 mg tablet . . . Staff missed medication pass . . . " - No transcriptions for Vitamin E 400 - 800 units 1 capsule daily. Observation on 10/19/21 at 10:45 am of client #2's medications on hand revealed no Vitamin E 400-800 units available.	V 118		

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V 118	Continued From page 5 During interview on 10/26/21 client #2 stated he took his medications every day with staff assistance. Review on 10/19/21 of client #3's record revealed: - 26 year old admitted 8/26/19. - Diagnoses included mild Intellectual/Developmental Disability, Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder, and Bi-Polar Disorder. - Physician's orders signed 6/08/21 for phenazopyridine (relieve symptoms of urinary tract infections) 10 mg 1 tablet three times daily as needed for 15 days, anti-dandruff shampoo "use when showering" signed 4/28/21, and fluconazole (anti-fungal) 150 mg "take 1 tablet now" signed 8/13/21. Review on 10/19/21 and 10/26/21 of client #3's MARs for August 2021 revealed: - Transcription for "fluconazole 150 mg tab Take 1 tablet by mouth now . . . PRN (as needed)" with "DC'd" (discontinued) printed beside the transcription; no staff initials for administration and no documented explanation for the omission. Review on 10/26/21 of client #3's "Admin (Administration) History . . . Anti-Dandruff 1% Shampoo" for August - October 2021 revealed: - 9/19/21 8:00 pm "Staff unable to locate medication," 9/12/21 8:00 pm "Medication not delivered to the home," 9/11/21 8:00 pm "Medication not delivered to the home." Observation on 10/19/21 at 10:30 am of client #3's medications on hand revealed: - Bubble card with pharmacy label for phenazopyridine 10 mg 1 tablet three times daily as needed, dispensed 6/08/21; contained pills.	V 118		

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V 118	Continued From page 6 - Bubble card with pharmacy label for fluconazole 150 mg "Take 1 tablet by mouth now," dispensed 8/13/21; the bubble card contained 1 pill. During interview on 10/19/21 client #3 stated he took his medications daily. Finding 2 Review on 10/26/21 of staff #1 record revealed: - Hire date 9/23/21, title Paraprofessional. - Training in "Medication Documentation/Administration" by the Medical Coordinator completed 9/24/21. During interview on 10/19/21 staff #1 stated: - She had been trained in Medication Administration by the Medical Coordinator. - She had administered medications since her hire date. During interview on 10/26/21 the Medical Coordinator stated: - She was responsible for monitoring MARs; she checked MARs daily. - She was responsible for requesting medication refills from the pharmacy. - The Group Home Leads were responsible for communicating when medications needed to be refilled. - The Group Home Leads were supposed to notify her at least 7 days in advance of running out of a medication. - The pharmacy has undergone a management change and has not been getting "batches" or refills sent out in a timely manner; some medications had been delivered to the wrong facility. - She and the Director of Operations met with the pharmacy 3 times to resolve the issues; they explained to the pharmacy the delays in	V 118		

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V 118	Continued From page 7 medication deliveries could "cause problems with the State.". - Issues with medications and the MARs were exacerbated by staffing issues at the facility; a new Group Home Lead was assigned to the facility and it was hoped that the issues would resolve quickly. - She confirmed the blanks on the MARs and confirmed that the medications may not have been administered as ordered. - If a medication was not available, staff was not able to administer the medication as ordered. - Client #2's over the counter Vitamin E was not added to the MAR. - Client #2 went on home visits and his family failed to administer his medications. - If there were pills left in client #3's phenazopyridine bubble card, staff did not finish the course of he medication; if the single dose of fluconazole was left in the bubble card, it was not administered as ordered. - She was not a Nurse. - She taught documentation of medication administration, not medication administration training. - Staff #1 was not trained to administer medications by a registered nurse or pharmacist. - Staff #1 should have completed medication administration training before documentation training. - Staff #1 administered medications "multiple times" at the facility but did not currently administer medications. - Staff #1 would not administer medications until she completed medication administration training with a Registered Nurse. - She was not sure how the training mix up occurred. - She knew the clients not getting their medications as prescribed, the blanks on the	V 118		

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V 118	Continued From page 8 MARs, and staff #1 not being trained in medication administration were deficient practices. During interview on 10/26/21 the Director of Operations stated he was aware of issues with medication delivery and medication administration. The Medical Coordinator was working diligently to resolve the issues. He was not aware staff #1 did not have medication administration training.	V 118		
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 observation, record review, and interview the Licensee failed to maintain the facility in a safe, clean, orderly manner. The findings are: Observation on 10/19/21 between approximately 9:30 am and 10:00 am revealed: - Approximately 18 inch by 18 inch unpainted drywall repair to the kitchen wall by the table. - Heavy dust build up on the blades of the ceiling fan in the kitchen. - An approximate 3/4 inch gap between the ceiling and the trim ring around the ceiling fan	V 736	V736 Ambleside's Maintenance Supervisor will make all necessary repairs and equipment/furniture replacements. Grace's home staff will clean all identified areas indicated in this report The Service Coordiantor of the Grace home will follow-up to ensure appropriate completion of the maintenance/repair/cleaning activities. In order to prevent these deficiencies in the future, the SC/QP will conduct monthly home inspections, and follow-up with the appropriate staff to ensure that the repairs/cleaning corrective measures have been completed by the designated personnel. 12/25/21	

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V 736	Continued From page 9 motor in the kitchen. - Rusty spots inside the microwave. - Jugs of what appeared to be used cooking oil inside the lower cabinet to the left of the stove. - The kitchen floor was sticky. - Dark stains on the living room carpet. - 4 areas of unpainted repairs to the living room ceiling. - The gas fireplace fixtures had a heavy coating of dust. - An approximate 10 inch by 12 inch area of unfinished drywall repair beside the fireplace. - An unfinished drywall repair behind the sofa in the living room. - The middle seat of the living room sofa sagged. - A large cobweb in the corner of the living room near the front door. - Heavy dust build up on the living room ceiling fan. - The finish on the ceiling was peeling away in the corner by client #1's bed. - Client #1's box spring and mattress were on the floor; the box spring was encased in torn plastic. - Organic debris inside the window sill in client #1's bedroom. - Debris and particulate matter on client #2's bedroom floor. - The paint on client #2's bedroom door and walls was scuffed and scratched. - Brown stains to client #2's bedroom closet wall appeared consistent with water damage. - Client #2's bedside bureau had 2 drawer pulls loose and hanging from one screw. - Heavy dust build up on client #2's bedroom ceiling and the ceiling fan blades. - Black stains consistent with mold or mildew on the ceiling in the hall bathroom. - The rubber mat in the bathtub had black stains consistent with mold or mildew. - The paint was peeling around the hall bathroom	V 736		

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V 736	Continued From page 10 door frame. - The finish on the hall ceiling was peeling away near client #2's bedroom door. - The paint on the hall walls was scuffed. - An approximate 3 inch crack in the drywall at the light switch in the hall. - Large dark stains to the carpet in client #3's bedroom. - Red stains on the wall near the floor between the foot of client #3's bed and his sofa. - Several unfinished drywall repairs to client #3's bedroom walls, ranging in size from a nail head to approximately 18 inches by 22 inches. - The drawer front to the top drawer in client #3's chest of drawers was broken. - Nail holes and scuffed paint inside client #3's bedroom closet. - The finish to client #3's bathroom ceiling was peeling. - The floor covering was lifting up in front of client #3's shower. - Small brown stains to the wall beside client #3's toilet. - A large portion of the chain link fence surrounding the backyard was damaged, leaving support poles and fencing hanging. - An area of wood rot on the deck seating; nail heads were protruding up from the wood. Review on 10/29/21 of the "Shift Summary Report" dated 10/02/21 revealed: - ". . . 2nd Shift 7 pm - 7 am . . . I washed bathmat and both shower curtains in main bathroom. . . . please turn in a maintance form for mold that is on bathroom ceiling . . . " During interviews on 10/19/21 and 10/26/21 the Director of Operations stated: - He was unaware of the mildew/mold on the bathroom ceilings.	V 736		

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V 736	Continued From page 11 - He was unaware of the rot on the back deck and the damage to the fence but he would notify maintenance of the issues. - The bathroom ceiling was cleaned.	V 736		