STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-878	A. BUILDING: _____ B. WING _____	R-C 11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE HOME #5	201 RAND MILL ROAD GARNER, NC 27529

(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 and follow up survey was completed on 11/23/21. The complaint was unsubstantiated (Intake # NC00183188). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. The survey sample consisted of audits of 3 current clients.	V 000		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure fire and disaster drills were held quarterly and repeated on each shift. The findings are: Review on 11/9/21 of the facility records revealed:	V 114		

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V 114	Continued From page 1 - No fire drills completed - No disaster drills completed Interview on 11/9/21 Client #5 stated: - There had not been any fire drills since he was admitted September 2021. Interview on 11/9/21 Staff #1 stated: - Hadn't done any fire drills since he started working in the facility October 2021 Interview on 11/18/21 the Qualified Professional (QP) stated: - No fire or disaster drills had been done - Thought there was at least 1 completed but she couldn't find it - "We will just have to take the loss for this one because I can't find any." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114		
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.	V 118		

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V 118	Continued From page 2 (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 observation, record review and interview the facility failed to assure 1 of 1 audited staff (#1) demonstrated competency to administer medications as well as assure the medication administered was recorded immediately after administration affecting 1 of 3 audited clients (#5). The findings are: Review on 11/9/21 & 11/12/21 of Client #5's record revealed: - Admitted 9/30/21 - Diagnoses: Bipolar 2 disorder and Substance Abuse disorder - November 2021 MAR included: -Wellbutrin XL 150 milligram (mg) - take 1 tablet (tab) in the morning (antidepressant) -Latuda 80 mg - take 1 tab in the	V 118		

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V 118	Continued From page 3	V 118		

evening (antipsychotic)
-Quetiapine ER 50mg - take 2 tabs in the evening (antipsychotic)

Review on 11/12/21 of Staff #1's personnel record revealed:
- Hired: 7/27/21
- Training in Introduction to Medication Administration completed 7/18/21 and Medication Management 10/29/21

A.Failure to administer medications correctly leaving them unattended:

Observation on 11/9/21 between 10:00am - 12:05pm revealed 2 clients (#5, #6) at home with no staff supervision. Staff arrived at the facility at 11:10am with 4 clients (#1, #2, #3, #4). Inside the facility were 6 pill containers on the kitchen table labeled with each client's name. One container with client #5's name on it had medication inside.

Interview on 11/9/21 Client #5 reported:
- Staff#1 gave him his medications.
- Staff put the medications in "our" cups and put them on the table.
- He called them all in the kitchen to take them.
- "We just get our cups with our name on it."

Interview on 11/18/21 Client #2 reported:
- If he was asleep, staff #1 would put his medication container on his nightstand and then staff would leave out of the room.
- Staff put their medications on the kitchen table and they would all come to get them.
- He knew which cup was his because his name was on it.

Interview on 11/9/21 & 11/18/21 Staff #1 reported:
- He pulled everyone's medications and put

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them in a container.
- He called the clients to come take them.
- The clients would get their medications out of their containers with their names on it.
- Had medication training and they told him that when he brought the medications out, to call the clients and give it to them one by one.
- Client #5 had started taking his morning pill at night about 2 days ago, 11/7 & 11/8/21 and that's why the pill was still in the container on the table because "he will take it tonight."

Interview on 11/9/21 the Qualified Professional (QP) reported:
- Medication should not have been given together.
- It should have been done individually and given to the clients one at a time.
- No medication should have been left out on the table for the clients to "just come get it".
- Staff had been trained and knew this already
- Will speak with staff #1 again and have him retrained.

B. MAR not signed after administration

Observation on 11/9/21 at 12:05pm revealed 1 round white pill in a container on the kitchen table with client #5's name on it.

Review on 11/9/21 at 11:50am of Client #5's November 2021 MAR included:
- Wellbutrin XL 150 mg - take 1 tab in the morning (antidepressant)
- 11/7, 11/8 and 11/9/21 8am Wellbutrin was signed off as administered by staff #1

Interview on 11/9/21 Client #5 reported:
- He did not want to take his Wellbutrin in the morning because he needed to take all his

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medications at night because taking it in the morning "would keep me up later and I sleep better during the day than I do at night and I need to stay up later at night."
- Had been taking his Wellbutrin at night for the past 2 nights, 11/7 & 11/8/21.

Interview on 11/9/21 Staff #1 reported:
- Client #5 was refusing his morning medication and said that he would take it at night with his other medications.
- The pill was still in the container because client #5 refused it this morning.
- He signed off on the MAR because he still took the pill just not in the morning.
- Client #5 started taking the Wellbutrin at night about 2 days ago, 11/7 & 11/8/21.

Interview on 11/9/21 the QP reported:
- Would call client #5's doctor in the morning, 11/10/21, about the Wellbutrin time change
- Staff should not have been signing off on the MAR if the medication was not given at that time.
- She didn't understand why staff #1 did that.

Review on 11/23/21 the facility's Plan of Protection dated 11/23/21 and submitted by the QP revealed:

-"What immediate action will the facility take to ensure the safety of the consumers in your care?

The administrator/RN (registered nurse) will complete a follow up training on medication administration. The staff was provided with training at the time this was observed by the surveyor. The areas that will be focused on will include: passing meds individually, ensuring that client is present prior to pouring of meds, etc.

-Describe your plans to make sure the above happens.

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V 118	Continued From page 6 The admin/RN will follow up and monitor med administration at least weekly to ensure all staff demonstrate compliance. Trainings will be documented." This deficiency constitutes a re-cited deficiency. Six clients admitted to the facility with dx of Schizoaffective disorder, Bipolar Mood disorder, Delusional Paranoid, Antisocial behavior, Personality disorder and Substance Abuse disorder. Clients were left unsupervised with medication left out on the table. Staff #1 who was hired on October 29, 2021 as a full-time live in staff left the pill in the container without supervision. Staff #1 routinely left the medications in containers sitting on the kitchen table with the clients' names on them for the clients to take when he called them to the kitchen. Clients knew which one was their medication to take based on their name being on the container. If client #2 was asleep, staff #1 would sometimes leave his medication container sitting on his nightstand unattended to take when he woke up. Staff #1 signed off on the MAR that client #5 was taking his Wellbutrin in the mornings, although client #5 was refusing to take it until the evening. Although staff #1 had medication administration training, he failed to administer medications individually to each client, left medication unsupervised when staff was not present at the facility and had not assured client #5's MAR was accurate. This deficiency constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 118		

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V 290	Continued From page 7	V 290		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on	V 290		

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V 290	Continued From page 8 duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on record review, interview and observation the facility failed to have the minimum of one staff present when any client is on the premise affecting 1 of 1 client (#5) not approved for unsupervised time. The findings are: Review on 11/12/21 of Client #5's record revealed: - Admitted 9/30/21 - Diagnoses: Bipolar 2 disorder and Substance Abuse - Treatment plan dated 10/23/21 did not have any unsupervised time for client listed Observation on 11/9/21 between 10:00am - 12:05pm revealed 2 clients (#5, #6) at home with no staff supervision. Staff arrived at the facility at 11:10am with 4 clients (#1, #2, #3, #4). Interview on 11/9/21 at 10:00am Client #5 stated: - Staff took a client on an appointment. - They left about 30 minutes ago (9:30am). - He had unsupervised time but didn't know how much time he had. Interview on 11/9/21 Staff #1 stated: - All the clients except one had unsupervised time.	V 290		

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V 290	Continued From page 9 - Client #5 had unsupervised time but he didn't know how much time he had. - He left to take a client to an appointment sometime before 10:00am. Interview on 11/18/21 with Qualified Professional (QP) stated: - Client #5 "had unsupervised time." - It was changed to 1 hour unsupervised time in the home on 11/1/21. - She did an assessment with him in order to have unsupervised time. - She thought she had a copy of the unsupervised time in his record but will put a copy in it. - She didn't realize staff had been gone from the facility for more than an hour. - Staff was not supposed to leave client #5 unsupervised for more than an hour. - She would speak with staff to make sure that he knew how much unsupervised time client #5 had. Review on 11/18/21 of Client #5's Level of Supervision dated 11/1/21 revealed: - "He will now be approved for up to 2 hours of unsupervised time in the community and 1 hour in the home."	V 290		
V 539	27F .0102 Client Rights - Living Environment 10A NCAC 27F .0102 LIVING ENVIRONMENT (a) Each client shall be provided: (1) an atmosphere conducive to uninterrupted sleep during scheduled sleeping hours, consistent with the types of services being provided and the type of clients being served; and (2) accessible areas for personal privacy,	V 539		

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V 539	Continued From page 10 for at least limited periods of time, unless determined inappropriate by the treatment or habilitation team. (b) Each client shall be free to suitably decorate his room, or his portion of a multi-resident room, with respect to choice, normalization principles, and with respect for the physical structure. Any restrictions on this freedom shall be carried out in accordance with governing body policy. This Rule is not met as evidenced by: Based on record review, interviews and observation, the facility failed to provide accessible areas for personal privacy affecting 2 of 6 clients (#5, #6). The findings are: Review on 11/12/21 of Client #5's record revealed: - Admitted 9/30/21 - Diagnoses: Bipolar 2 disorder and Substance Abuse Review on 11/12/21 of Client #6's record revealed: - Admitted 10/15/15 - Diagnosis: Schizoaffective disorder Observation and interview on 11/9/21 at 12:15pm revealed: - Staff #1 knocked on client #6's bedroom door - Staff #1 opened the door as he knocked - Client #5 stated "see, see what I mean" Interview on 11/9/21 Client #5 reported: - Staff didn't give them any privacy - He always knocked and just came into the room	V 539		

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V 539	Continued From page 11 - "He doesn't even wait until I say come in" Attempted interview on 11/9/21 with Client #6 but he refused. Interview on 11/9/21 Staff #1 reported: - He was getting client #6 to be interviewed - He did knock on client #6's door - He always knocked on clients' door Interview on 11/18/21 the Qualified Professional (QP) reported: - Staff was not supposed to just walk in a client's room - If a client did not answer staff after several knocks, then staff was to enter because something could be wrong - Giving a client privacy "that's like client rights 101" - She didn't know why staff would do that but she will have a talk with him	V 539		