STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-616	A. BUILDING: _____ B. WING _____	C 12/10/2021

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V 000	INITIAL COMMENTS A complaint survey was completed on 12/10/21. The complaint was unsubstantiated (intake #NC00183322). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. The survey sample consisted of audits of 1 current client.	V 000		
V 106	27G .0201 (A) (8-18) (B) GOVERNING BODY POLICIES 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (8) use of medications by clients in accordance with the rules in this Section; (9) reporting of any incident, unusual occurrence or medication error; (10) voluntary non-compensated work performed by a client; (11) client fee assessment and collection practices; (12) medical preparedness plan to be utilized in a medical emergency; (13) authorization for and follow up of lab tests; (14) transportation, including the accessibility of emergency information for a client; (15) services of volunteers, including supervision and requirements for maintaining client confidentiality; (16) areas in which staff, including nonprofessional staff, receive training and continuing education; (17) safety precautions and requirements for	V 106		

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V 106	Continued From page 1	V 106		

facility areas including special client activity areas; and
(18) client grievance policy, including procedures for review and disposition of client grievances.
(b) Minutes of the governing body shall be permanently maintained.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to implement their written policy regarding incident reporting of any incident or unusual occurrence. The findings are:

Review on 12/2/21 of client #1's record revealed:
-An admission date of 12/2/20;
-Diagnoses included moderate Intellectual Developmental Disability with Down Syndrome, Alzheimer Disease with Behavioral Disturbance and a history of Epilepsy;
-She was declared incompetent and a legal guardian appointed on 3/17/83.

Interview on 12/2/21 with client #1's legal guardian revealed:
-It was discovered by staff #1 on 11/8/21 that the client had fallen sometime during the previous night;
-She was not informed of client #1's fall until she called the facility on the evening of 11/9/21 and was then informed by staff #1;
-She was informed of incidents in the past by the Qualified Professional (QP) or the Registered Nurse (RN) employed by the facility.

Review on 12/8/21 of the facility's policies 102.04

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V 106	Continued From page 2 Informing Legal Representatives of Unusual Occurrences and 102.041 Notification of case responsible person revealed: -"This policy is developed to provide information to legal representatives as soon as possible, regarding significant events that occur concerning an individual, or any experience at the residence and/or any RHA service site that is out of the normal daily routine of the person's program or daily life; -Legal representatives will be promptly informed of unusual occurrences that are unanticipated and have a direct significant effect on a person receiving services or, if anticipated, represent a significant, sudden change in the person's normal status; -When something unusual and significant happens to an individual, the appropriate staff (e.g. nurse, doctor, Direct Support Associate) will immediately contact the case responsible person, or the Administrator/Director if the case responsible person cannot be reached; -The case responsible person, with that staff, will determine the method and strategy for legal representative notification." Interview on 12/6/21 with staff #1 revealed: -She had been working the night of 11/7/21 and the morning of 11/8/21; -On the morning of 11/8/21, she observed client #1 sitting on her bed; -"Her (client #1) knee was red...it look like a scratch or something on her ankle and her forehead had a scratch;" -"The QP was out so I couldn't speak with her;" -She was not sure if it was the responsibility of the QP or the RN to inform legal guardians of incidents; -She had informed client #1's legal guardian of the fall when she called the facility on the evening	V 106		

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V 106	Continued From page 3 of 11/9/21. Interview on 12/2/21 with the QP revealed: -As the QP, she was the case responsible person that was referred to in the facility policies; -She had been out of work on 11/8/21 when client #1 fell; -"With me being out, another Q (QP) was filling in...he's brand new to the Q (QP position)...he may not been thinking to call (the legal guardian)...the ball did get dropped right there." Interview on 12/2/21 with the back up QP revealed he had not been notified that client #1 had fallen on 11/8/21. Interview on 12/2/21 with the RN employed by the facility revealed: -The legal guardian should have been notified of client #1's fall on 11/8/21; -"Yes, the QP should have done that...the QP has been out though." Interviews on 12/2/21 and 12/10/21 with the Regional Administrator revealed: -The legal guardian of client #1 should have been informed on 11/8/21 of her fall; -She was not aware that client #1's legal guardian had not been informed of the fall.	V 106		
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.	V 118		

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V 118	Continued From page 4 (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 review and interviews the facility failed to ensure medications were administered as ordered by a physician affecting 1 of 1 audited client (#1). The findings are: Review on 12/2/21 of client #1's record revealed: -An admission date of 12/2/20; -Diagnoses included moderate Intellectual Developmental Disability with Down Syndrome,	V 118		

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V 118	Continued From page 5 Alzheimer Disease with Behavioral Disturbance and a history of Epilepsy; -She was declared incompetent and a legal guardian appointed on 3/17/83; -An order dated 10/18/21 for Lamotrigine (used for seizures) 50 milligrams (mg) twice daily; -An order dated 11/23/21 for Lamotrigine 75 mg twice daily. Interview on 12/2/21 with client #1's legal guardian revealed: -She transported the client to doctor on 11/23/21; -The doctor wrote an order increasing Lamotrigine from 50mg twice daily to 75 mg twice daily; -She provided staff #2 the order on 11/23/21 when she transported the client back to the facility; -She had been informed yesterday (12/1/21) by staff #1 that the client had not yet been administered the increased dosage of Lamotrigine; -She didn't understand why it took 9 days for the client to be administered the correct amount of medication; -"This is serious to me...it's ridiculous." Interview on 12/2/21 with the Registered Nurse (RN) employed by the facility revealed: -An order was written on 11/23/21 to increase client #1's Lamotrigine from 50mg twice daily to 75mg twice daily; -The new dose of Lamotrigine had arrived yesterday (12/1/21) at the office; -She was going to update client #1's MAR today to reflect the new dosage of Lamotrigine and the client was going to be administered the increased dosage today. Interviews on 12/2/21 and 12/10/21 with the	V 118		

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V 118	Continued From page 6 Regional Administrator revealed: -She discussed with the RN on 12/2/21 why it took so long for the increased dosage of Lamotrigine to be administered; -She thought that the holiday was the primary cause for the delay; -She was informed by the RN that the order was provided to facility staff on 11/23/21; -"With the holiday, it didn't get to her (the RN) until Friday (11/26/21) morning...she (the RN) faxed it (the order) the same day...there's some issues with shipping so it didn't arrive until Tuesday (11/30/21) afternoon...I'm not sure why they (facility staff) didn't pick it up yesterday (12/1/21)."	V 118		