STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL065-267	A. BUILDING: _____ B. WING _____	12/15/2021

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THE CHELSEA HOUSE	109 CHELSEA LANE WILMINGTON, NC 28409

(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 and complaint survey was completed on December 15, 2021. The complaint was unsubstantiated (intake #NC00182595.) Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C supervised Living for Adults with Developmental Disabilities. The survey sample consisted of audits of 3 current clients.	V 000		
V 105	27G .0201 (A) (1-7) 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: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's	V 105		

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V 105	Continued From page 1 needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2	V 105		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to follow the facility admission assessment policy. The findings are:

Reviews between 12/8/21 and 12/10/21 of client #2's record revealed:
-35 year old female admitted to the facility on 7/19/21.
-Diagnoses included schizoaffective disorder, bipolar type; unspecified gender dysphoria; intellectual developmental disabilities, mild; history of seizure disorder; urinary incontinence; gastroesophageal reflux disease; chronic constipation; dry skin.
-Admission assessment to a sister facility dated 11/21/19.
-Documentation in the Addendum section of the admission assessment dated 11/21/19 read, "Moved from [sister facility] to [facility] on 7/19/21."
-No admission assessment documented for the current facility admission on 7/19/21.

Reviews between 12/8/21 and 12/10/21 of client #1's record revealed:
-24 year old female admitted to the facility on 7/17/20.
-Diagnoses included schizophrenia; intellectual developmental disabilities, mild; and autism spectrum disorder.
-No admission assessment documented for the current facility admission on 7/17/20.

Reviews between 12/8/21 and 12/10/21 of client #3's record revealed:
-59 year old female admitted to the facility on

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V 105	Continued From page 3	V 105		

4/2/20.
-Diagnoses included intellectual developmental disabilities, moderate; major neurocognitive disorder due to traumatic brain injury; diabetes; epilepsy; and, Encephalitis.
-No admission assessment documented for the current facility admission on 4/2/20.

Review on 12/10/21 of the facility admission policy revealed:
-If a client transferred from another service, a pre-existing admission assessment may be used if the information contained was accurate and complete.
-If a pre-existing admission assessment was used, an addendum must be completed by the Qualified Professional (QP) which indicated the assessment was accurate and valid at the time of the subsequent assessment.

Interview on 12/10/21 the QP stated:
-She was a QP employed by the licensee and was helping "fill in" after the recent resignation of the facility QP.
-Client #1 had moved from a sister facility located in another town because of some behaviors and incompatible issues.
-Client #1 and her guardian both wanted the client to move.
-Client #2 had moved from a sister facility due to some mental health issues.
-Client #3 had moved from another group home that had closed.
-Other than the comment in client #2's addendum, she could not locate any other documentation of an admission assessment or updates to a prior admission assessments for the 3 clients.
-The admission assessment form had been updated in March 2020 and should help make

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V 105	Continued From page 4 sure admission assessments were updated when clients were transferred from other facilities.	V 105		
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. This Rule is not met as evidenced by:	V 112		

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V 112	Continued From page 5 Based on record review and interview, the facility failed to ensure goals/strategies were developed in partnership with the client or legally responsible person to meet client needs affecting 1 of 3 clients (client #3) audited. The findings are: Reviews between 12/8/21 and 12/10/21 of client #3's record revealed: -59 year old female admitted to the facility on 4/2/20. -Diagnoses included intellectual developmental disabilities, moderate; major neurocognitive disorder due to traumatic brain injury; diabetes; and epilepsy. -Treatment plan, "What others need to know to best support me" documented a 40% hearing loss and the need for hearing aids ... she had limited dexterity and was not able to push an emergency button; she could complete most tasks but required reminders and prompting; some tasks required physical prompting. -Risk support/needs assessment for plan years 2019-2020 and 2020-2021 documented client #3 did not hear well ..."my speech and hearing loss are barriers when communicating." -She had moved "from home to home" over the past year and her hearing aids had been misplaced. -Treatment plans for the past 2 years had documented a need to replace client #3's hearing aids. -Goals included client #3 would make efforts to interact with peers and community members appropriately with no more than 1 and 2 verbal prompts, respectively. -Invoice dated 6/4/21 for hearing aids, $2950 for each ear; a total cost was $5200. -No goals or strategies to increase client #3's compliance with wearing her hearing aids. -No goals or strategies for the care, cleaning, or	V 112		

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V 112	Continued From page 6 storage to maintain and prevent the loss of hearing aids in the future. Unable to interview client #3 on 12/8/21 due to communication deficits. Interview on 12/10/21 client #3's Guardian stated: -Client #3 had lost her hearing aids and they were replaced about 4 months ago. -Client #3 "does not wear them (hearing aids) enough." -Client #3 had a difficult time putting the hearing aids in her ears because they were very tiny and had to "fit down" into her ears. -The Guardian had asked one of the facility staff about client #3 not wearing her hearing aids, and the response was, "it's up to her." -The Guardian did not know the staff's name. -The guardian had bought the client a "cheap pair" of hearing aids in the past and when she wore them during a session with her therapists, it made a "big difference in her responses." -She thought the reason client #3 was not wearing the hearing aids was because of the special cleaning requirements. Interviews on 12/8/21 and 12/10/21 Staff #1 stated: -She worked at the facility in the mornings from 7 am - 9 am and then would work 1:1 with client #3 at the Day Program. -Client #3 had hearing aids in the home but did not like to wear them. Interview on 12/10/21 the Group Home Manager stated she had found client #3's hearing aids in her room in a container that was used in the cleaning procedure.	V 112		

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V 114	Continued From page 7	V 114		
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 interview and record review, the facility failed to hold fire and disaster drills at least quarterly repeated for each shift. The findings are: Interview on 12/9/21 the Group Home manager stated there were 3 shifts as follows: -1st shift: 7 am - 3 pm -2nd shift: 3 pm - 11 pm -3rd shift: 11 pm - 7 am Review on 12/10/21 of fire and disaster drills documented between 10/1/20 and 12/9/21 revealed: -No fire drill documented for the 3rd shift during the Quarter, 1/1/21-3/31/21. -No disaster drills documented for any shift during the Quarter, 1/1/21-3/31/21.	V 114		

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V 114	Continued From page 8 Interview on 12/10/21 the Director stated she would work with the new manager to make sure staff understood and completed the requirements for fire and disaster drills.	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. (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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This Rule is not met as evidenced by:
Based on interview, observation, and record review, the facility failed to ensure medications were administered and recorded as ordered affecting 2 of 3 clients audited (clients #2 and #3); and, and blood sugars monitored as ordered affecting 1 of 1 client with orders to monitor their blood sugars (client #3). The findings are:

Finding #1:
Reviews between 12/8/21 and 12/15/21 of client #3's record revealed:
-59 year old female admitted to the facility on 4/2/20.
-Diagnoses included intellectual developmental disabilities, moderate; major neurocognitive disorder due to traumatic brain injury; type 2 diabetes; and epilepsy.
-Order dated 7/22/21 for Atorvastatin 20 mg (milligrams) at bedtime. (lowers cholesterol)
-Order dated 7/22/21 for Risperidone 3 mg ½ tab 4 times daily. (mental/mood disorders)
-Order dated 1/6/20 and 11/30/21 for Mapap 325 mg every 4 hours as needed. (pain, fever)
-Order dated 11/22/21 Clonazepam 1 mg 3 times daily as needed. (seizure control)
-Medications ordered to treat client #3's type 2 diabetes were as follows:
-7/21/21 and 11/22/21: Januvia 100 mg daily.
-7/23/21: Trulicity 3 mg/0.5 mg ML (milliliter) Pen, inject once a week.
-10/12/21: Trulicity 4.5 mg/0.5 mg ML Pen inject once a week.
-Order dated 4/26/21 "monitor pt (patient) for

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V 118	Continued From page 10 hyper/hypoglycemia and call provider if any changes occur." -Order dated 7/1/21: use test strips to check glucose twice daily. -Prior to 12/15/21 there was no documentation the physician had been contacted for blood sugar (BS) parameters to identify when staff were to notify the doctor or take any action in response to hyper/hypoglycemia. -Order dated 12/15/21 to call to the provider for BS results less than 60 or greater than 450 and to give orange juice for results less than 60. Review on 12/14/21 and 12/15/21 of client #3's BS results from 9/1/21 - 12/15/21 revealed: -9/29/21 at 7:30 am BS result = 454. The physician was not notified. -10/7/21 at 7:50 am BS result = 495. The physician was not notified. -September 2021 - 10 BS results were not documented: -No morning BS result: 9/24/21. -No evening BS results: (9 days): 9/3/21, 9/11/21, 9/15/21, 9/17/21, 9/20/21, 9/22/21, 9/23/21, 9/24/21, 9/25/21. -October 2021 - 18 BS results not documented: -No morning BS results: (15 days): 10/11/21, 10/12/21, 10/13/21, 10/14/21, 10/16/21, 10/17/21, 10/19/21, 10/21/21, 10/22/21, 10/25/21, 10/26/21, 10/27/21, 10/28/21, 10/30/21, 10/31/21. -No evening BS results: (3 days): 10/1/21, 10/9/21, 10/20/21. -November 2021 - 7 BS results not documented: -No morning BS results: (4 days): 11/3/21, 11/5/21, 11/18/21, 11/26/21. -No evening BS results: (3 days): 11/20/21, 11/26/21, and 11/29/21. Review on 12/8/21 and 12/9/21 of client #3's MARs from 9/1/21 - 12/8/21 revealed:	V 118		

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V 118	Continued From page 11 -Atorvastatin 20 mg, scheduled to be administered at 8 pm, had not been documented on 10/24/21. -Risperidone 3 mg ½ tab scheduled 4 pm dose had not been documented on 9/22/21. -MAR transcribed Mapap 325mg order to read, administer 2 tablets every 4 hours as needed. Mapap 325mg, 2 tablets, was documented as given 10/28/21 at 11:41am, 12/1/21 at 6:51pm, and 12/2/21 at 6:52pm. -MAR transcribed Clonazepam 1 mg to be administered 3 times daily and had been documented three times daily at 8am, 2pm, and 8 pm from 11/22/21-12/8/21. Observations on 10/8/21 between 3:30 pm and 4:30 pm of client #3's medications on hand revealed: -Label for Mapap 325 mg read to give 1 tablet as needed every 4-6 hrs; dispense date was 1/6/20. -Label for Clonazepam 1 mg read to give 3 times daily as needed; dispense date was 11/23/21. Unable to interview client #3 due to communication deficits. Finding #2: Reviews between 12/8/21 and 12/10/21 of client #2's record revealed: -35 year old female admitted to the facility on 7/19/21. -Diagnoses included schizoaffective disorder, bipolar type; unspecified gender dysphoria; intellectual developmental disabilities, mild, history of seizure disorder; urinary incontinence; gastroesophageal reflux disease; chronic constipation; dry skin. -Orders dated 8/9/21 included the following: -Clindamycin PH (phosphate) 1% Solution twice daily. (acne)	V 118		

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V 118	Continued From page 12 -Depakote Delayed Release (DR) 500 mg twice daily. (seizure control) -Clozapine ODT (orally disintegrating tablet) 100 mg ½ tab every morning. (mental/mood disorders) -Flonase Nasal Spray 50 mcg (micrograms) daily. (nasal symptoms, i.e. runny nose) -Lamotrigine 100 mg twice daily (mood swings) -Prozac 20 mg QD (depression) -Vitamin B Complex - Folic Acid 1 daily (supplement) -Zinc Oxide ointment twice daily to pelvic area and thighs (minor skin irritations) Review on 12/8/21 and 12/9/21 of client #2's MARs from 9/1/21 - 12/8/21 revealed: -The 8 am scheduled doses for the following medications had not been documented on 10/29/21: -Clindamycin PH 1% Solution -Depakote DR 500 mg -Clozapine ODT 100 mg ½ tab -Flonase Nasal Spray 50 mcg -Lamotrigine 100 mg -Prozac 20 mg -Vitamin B Complex - Folic Acid 1 daily -Zinc Oxide ointment Interview on 12/8/21 client #2 stated he received his medications daily from staff. Interviews on 12/9/21 and 12/15/21 the Group Home Manager stated: -There were no guidelines or orders for staff to determine when to take action or call the doctor for client #3's blood sugar results. -The blanks on the MARs for client #2 and #3 had no reasons documented for leaving the MAR blanks.	V 118		

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V 118	Continued From page 13 -She believed the blanks were most likely documentation errors. -Client #3 had an appointment with her primary care provider (PCP) on 12/15/21. -She would discuss with the PCP the need for parameters to report or take action on BS results for client #3. 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		