STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-579	A. BUILDING: _____ B. WING _____	R 05/02/2022

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THE EMMANUEL HOME III	5212 SWEETBRIAR DRIVE RALEIGH, NC 27609

(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 5/2/22. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.	{V 000}		
{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}		

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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 goals and strategies to address the needs for 2 of 3 audited clients (#2, #4). The findings are: I. Review on 4/21/22 of client #2's record revealed: - Admitted: 4/10/20 - Diagnoses: Traumatic Brain Injury, Epilepsy, Type 2 Diabetes, Vitamin D deficiency, History of Prostate Cancer, Hyperlipidemia, and Liver Neoplasm with Metastasis - Physician's order dated 6/11/21 revealed Finger Stick Blood Sugar Check before meals and at bedtime. - Treatment plan dated 6/1/21 listed no goals or strategies related to diabetes and his refusal to do blood sugar checks. Interview on 5/2/22 the Licensee/Registered Nurse (RN) stated: - Client #2 would curse people out and would refuse to have his blood sugar read. - She was meeting with staff on Wednesday, 5/4/22, in reference to client #2 to discuss management of his diabetes. Interview on 4/28/22 the Qualified Professional (QP) stated: - Management of client #2's diabetes was not in his treatment plan but they have been trying to get the paperwork from his primary doctor to add	{V 112}		

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{V 112}	Continued From page 2 it. - The Chief Operating Officer (COO) is "handling that" and she was just following the COO's lead so she was not sure where the COO was in the process. Interview on 5/2/22 the COO stated: - There were a lot of issues with client #2's case. - They were in the process of trying to update client #2's treatment plan but the Managed Care Organization (MCO) was not helping. - They had "no say" over client #2's treatment plan. - The numerous change in MCO workers had been the issue with getting the treatment plan updated. - "The MCO does their own thing and we have no say" II. Review on 4/21/22 of client #4's record revealed: - Admitted: 2/1/13 - Diagnoses: Autism Spectrum, Moderate Intellectual Developmental Disability, Fetishism (foot) , Seizure Disorder, Dermatitis, PICA and Depressive Disorder with mixed Bipolar Disorder - Treatment plan dated 12/1/21 listed no goals or strategies related to PICA. Interview on 4/28/22 the QP stated: - They just had a meeting because client #4 was not "actually" diagnosed with PICA but he "does eat raw meat and eat out of the trash can." - They had 2 meetings on 4/18/22 & 3/30/22 in reference to client #4's treatment plan. - They were going to update the behavior in the plan and continue to monitor the behavior. - She just signed off on the updated plan	{V 112}		

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{V 112}	Continued From page 3 4/27/22 and they were in the process of completing it. Interview on 5/2/22 the COO stated: - Client #4 was diagnosed with PICA. - They had been trying to request records for client #4. - The group home was able to put it in the short-range goals. - Client #4's plan was recently changed to reflect the PICA and will go into effect May 1, 2022. Interview on 5/2/22 the Licensee/RN stated: - She did not oversee the treatment plans but she would if she had to. - When the COO left, she would get someone in to fill the position. - "God will provide and find a way."	{V 112}		
{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	{V 118}		

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{V 118}	Continued From page 4 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 interview the facility failed to administer medications as prescribed for 1 of 3 audited clients (#2). Additionally, the facility failed to assure the MAR was current for 1 of 3 audited clients (#6). The findings are: A. Review on 4/21/22 of client #2's record revealed: - Admitted: 4/10/20 - Diagnoses: Epilepsy, Type 2 Diabetes, Hypertension, Liver Neoplasm with Metastasis, Traumatic Brain Injury (TBI), History of (H/O) Prostate Cancer and Hyperlipidemia - Physician's order dated 6/11/21 revealed Finger Stick Blood Sugar Check before meals and at bedtime. - Physician's order dated 11/26/21 of Humalog sliding scale: 70 - 150 = 0 units	{V 118}		

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{V 118}	Continued From page 5 151-200 = 2 extra units 201-250 = take 4 extra units 251-300 = take 6 extra units 301-350 = take 8 units Greater than 350 take 10 extra units Review on 4/21/22 of client #2's March 2022 Glucometer readings, Vital Signs Measurement Form (VSMF) and MAR revealed the following discrepancies: -15th -Glucometer reading - 8:29pm = 222 -MAR - initialed as having checked BSL (blood sugar level) 4 times without any actual results recorded -MAR - initialed for 8:30am that insulin was given however no unit amount documented -VSMF - BSL readings: 8am = 119 and 11:30am = 129 -VSMF - no units of insulin documented -16th -Glucometer reading - 1:23pm = 276 and 12:05pm = 169 -MAR - initialed as having checked BSL 2 times without any actual results recorded -MAR - initialed for 8:30am that insulin was given however no unit amount documented -VSMF - BSL reading: 8am = 119 -VSMF - BSL reading: 11:30am = 169 with 2 units of insulin documented -17th - 22nd Client #2 in hospital per VSMF and MAR -22nd -Glucometer readings - 4:58pm = 421, 5:31pm = 216 and 8:16pm = 340 -MAR - a number "2" documented indicating "patient off-site"	{V 118}		

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{V 118}	Continued From page 6 -VSMF - documented "client in hospital" -23rd -Glucometer readings - 9:11pm = 132, 8:03pm = 95 and 4:43pm = 252 -MAR - initialed as having checked BSL 4 times without any actual results recorded -MAR - initialed for 8:30am that insulin was given with no unit amount documented -MAR - initialed that insulin was given with no time or unit amount documented -VSMF - BSL readings: 8am = 119 and 7:56pm = 95 -VSMF - BSL reading: 4:36pm = 252 with 6 units of insulin documented -24th -Glucometer readings - 8:09pm = 234, 5:09pm = 299 and 7:37am = 111 -MAR - initialed as having checked BSL 4 times without any actual results recorded -MAR - initialed for 8:30am that insulin was given with no unit amount documented -VSMF - BSL reading: 8am = 111 -VSMF - BSL reading: 5pm = 299 with 6 units of insulin documented -VSMF - BSL reading: 8pm = 229 with 4 units of insulin documented -29th -Glucometer readings - 7:29pm = 232 and 4:31pm = 149 -MAR - initialed as having checked BSL 4 times without any actual results recorded -MAR - initialed for 8:30am that insulin was given with no unit amount documented -VSMF - BSL readings: 8am = 129 and 5:15pm = 140 -VSMF - BSL reading: 8:30pm = 239 with 4 units of insulin documented	{V 118}		

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{V 118}	Continued From page 7 -30th -Glucometer readings - 7:22pm = 140 and 4:43pm = 164 -MAR - initialed as having checked BSL 4 times without any actual results recorded -MAR - initialed for 8:30am that insulin was given with no unit amount documented -MAR - initialed 2 additional times that insulin was given without a time and unit amount documented -VSMF - BSL readings: 8am = 130 and 7:20pm = 140 -VSMF - BSL reading: 4:45pm = 164 with 2 units of insulin documented -31st -Glucometer reading - 4:31pm = 158 -MAR - initialed as having checked BSL 2 times and a number "1" documented twice indicating client refused -MAR - initialed for 8:30am that insulin was given without a time and unit amount documented -VSMF - BSL readings: 8am = 121 and 11:30am = 134 -VSMF - BSL reading: 4:45pm = 158 with 2 units of insulin documented -VSMF - Nothing documenting client refusal to have BSL taken Review on 4/21/22 of client #2's April 2022 Glucometer readings, Vital Signs Measurement Form (VSMF) and MAR revealed the following discrepancies: -1st -Glucometer readings - 7:52pm = 210 and 5:28pm = 174 -MAR - initialed as having checked BSL 3 times without any actual results recorded -MAR - initialed for 5:00pm that insulin was	{V 118}		

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{V 118}	Continued From page 8	{V 118}		

given without a unit amount documented
-MAR - initialed on a separate line for 5:00pm that insulin was given without a unit amount documented
-VSMF - BSL reading: 8am = 129
-VSMF - BSL readings: 4:30pm = 174 with 2 units of insulin documented and 7:51pm = 210 with 4 units of insulin documented

-2nd
-Glucometer readings - 5:46pm = 73, 12:27pm = 224 and 8:13am = 122
-MAR - initialed as having checked BSL 3 times without any actual results recorded
-MAR - initialed for 7:00am and 12:00pm that insulin was given at each time without a unit amount documented
-VSMF - BSL reading: 8am = 122

-4th
-Glucometer readings - 6:57pm = 164 and 4:22pm = 147
-MAR - initialed as having checked BSL 4 times without any actual results recorded
-MAR - initialed for 12:00 pm, 5:00pm and 8:00pm that insulin was given at each time without a unit amount documented
-VSMF - no data documented for this date

-5th
-Glucometer reading - 7:04pm = 152
-MAR - initialed as having checked BSL 4 times without any actual results recorded
-MAR - no initials documented
-VSMF - BSL reading: 8pm = 152 with 2 units of insulin documented
-6th
-Glucometer readings - 7:58pm = 268 and 5:01pm = 138
-MAR - initialed as having checked BSL 4

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{V 118}	Continued From page 9	{V 118}		

times without any actual results recorded
-MAR - initialed for 12:00pm and 5:00pm that insulin was given at each time without a unit amount documented
-VSMF - no data documented for this date

-7th
-Glucometer reading - 4:20pm = 191
-MAR - initialed as having checked BSL 3 times without any actual results documented
-MAR - no initials documented as insulin being given
-VSMF - BSL reading: 4:40pm = 191 with 2 units of insulin documented
-VSMF - 7:40pm "client refused when returning from outing" documented

-10th
-Glucometer readings - 6:13pm = 145, 1:41pm = 154 and 7:44am = 138
-MAR - initialed as having checked BSL 4 times without any actual results documented
-MAR - initialed for 7:00am, 12:00pm, 5:00pm and 8:00pm as insulin being given without a unit amount documented
-VSMF - BSL readings: 7:41am = 138 and 6:09pm = 134
-VSMF - BSL reading: 1:44pm = 157 with 2 units of insulin documented

-11th
-Glucometer reading - 8:27pm = 180 and 4:26pm = 184
-MAR - initialed as having checked BSL 4 times without any actual results documented
-MAR - initialed for 5:00pm and 8:00pm as insulin being given without a unit amount documented
-VSMF - BSL readings: 8:00am = 129 and 11:30am = 134

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{V 118}	Continued From page 10 -VSMF- BSL readings: 4:30pm = 184 with 2 units of insulin documented and 8pm = 180 with 2 units of insulin documented -12th -Glucometer reading - 8:39pm = 217 and 5:13pm = 137 -MAR - initialed as having checked BSL 3 times without any actual results documented -MAR - no initials documented that insulin was given -VSMF - BSL readings: 8am = 127, 11:30am = 139 and 4:45pm = 137 units -13th -Glucometer reading - 7:42pm = 253 and 5:51pm = 142 -MAR - initialed as having checked BSL 4 times without any actual results documented -MAR - initialed for 8:00pm as insulin being given without a unit amount documented -VSMF - BSL readings: 8am = 139, 11:30am = 141 and 5pm = 142 -VSMF - BSL reading: 8pm = 253 with 6 units of insulin documented -14th -Glucometer reading - 7:09pm = 299 and 5:08pm = 175 -MAR - initialed as having checked BSL 4 times without any actual results documented -MAR - initialed for 8:00pm as insulin being given without a unit amount documented -VSMF - BSL readings: 8am = 127 and 11:30am = 139 -VSMF - BSL readings: 5:00pm = 175 with 2 units of insulin documented and 7:30pm = 299 with 6 units of insulin documented -15th	{V 118}		

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{V 118}	Continued From page 11 -Glucometer reading - 8:04pm = 153, 5:17pm = 219 and 8:12am = 131 -MAR - initialed as having checked BSL 4 times without any actual results documented -MAR - initialed for 5:00pm as insulin being given without a unit amount documented -VSMF - BSL readings: 8am = 132, 11:30am = 129, and 8pm = 150 -VSMF - BSL reading: 5pm = 219 with 2 units of insulin documented -17th -Glucometer reading - 7:04pm = 147 -MAR - initialed as having checked BSL 1 time -MAR - initialed for 8:00pm that insulin was given without a unit amount documented -VSMF - BSL readings: 8:00am = client refused, 5:00pm = client refused and 7:00pm = 147 -18th -Glucometer reading - 8:07pm = 231 and 7:04pm = 170 -MAR - initialed as having checked BSL 4 times without any actual results documented -MAR - initialed for 5:00pm and 8:00pm that insulin was given without a unit amount documented -VSMF - BSL readings: 8am = 129 and 11:30am = 139 -VSMF - BSL readings: 7pm = 170 with 2 units of insulin documented and 8:40pm = 231 with 4 units of insulin documented -19th -Glucometer reading - 8:19pm = 158 and 5:02pm = 174 -MAR - initialed as having checked BSL 4 times without any actual results documented	{V 118}		

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{V 118}	Continued From page 12 -MAR - initialed for 5:00pm and 8:00pm insulin was given without a unit amount documented -VSMF - BSL readings: 8am = 141, 11:30am = 127 -VSMF - BSL readings: 5:00pm = 174 with 2 units of insulin documented and 8:00pm = 158 with 2 units of insulin documented -20th -Glucometer reading - 8:12pm = 188 and 5:03pm = 230 -MAR - initialed as having checked BSL 4 times without any actual results documented -MAR - initialed for 5:00pm and 8:00pm insulin was given without a unit amount documented -VSMF - BSL readings: 8am = 121, 11:30am = 139 -VSMF - BSL reading: 5pm = 230 with 2 units of insulin documented and 8pm = 188 with 2 units of insulin documented -21st -Glucometer reading - no readings -MAR - initialed as having checked BSL 1 time without any actual results documented -VSMF - BSL reading: 8am = 141 Interview and observation on 4/21/22 at 12:25pm staff #1 reported: - Client #2 is the only client with diabetes - Had to check client #2's BSL if he put it on the VSMF on 4/21/22. - Checked the glucometer and there was no reading. - "I don't know what happened then. I got the number from somewhere" as he shook his head from side to side.	{V 118}		

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{V 118}	Continued From page 13 Interview on 4/28/22 the Qualified Professional (QP) stated: - Only worked remotely. - Remembered having a discussion about retraining on diabetes and the glucometer but couldn't remember when. - Wasn't apart of the glucometer training. - She met with the staff weekly by zoom to go over medications, errors and anything they had a concern about in the facility. Interview on 5/2/22, the Chief Operational Officer (COO) stated: - "I fired myself and I'm only helping out right now." - Was responsible for medication reviews, electronic records and trainings. - The Licensee did the retraining on diabetes and the glucometer and the COO emailed it in. - She would look for the training documentation but that would take awhile to go through all her paperwork. - "This doesn't make any sense because the training was done and already sent in (to DHSR for the previous plan of correction)." Interview on 4/25/22 & 5/2/22, the Licensee/Registered Nurse (RN) stated: - She re-trained every staff on medication administration to include; insulin sliding scale, documentation, taking the BS and insulin administration and the documentation was already sent in (to DHSR for the previous plan of correction.) - "That's not like [staff #1] to write a BSL reading down that he didn't take." He had never done that before. - Diabetes training is done with the medication training but this most recent training included sliding scale and insulin administration.	{V 118}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-579	A. BUILDING: _____ B. WING _____	R 05/02/2022

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{V 118}	Continued From page 14 - She didn't have the documentation because it was already sent in (to DHSR for the previous plan of correction.) B. Review on 4/21/22 of client #6's record revealed: - Admitted: No date listed for current facility - Diagnoses: Intellectual Developmental Disparity Mild; Autism Spectrum Disorder; Schizoaffective Disorder; Depressive type; Unspecified Anxiety Disorder and Unspecified Depressive Disorder - Signed FL2 dated 4/4/22 listed: Clonazepam 1milligram (mg) tablet, take one tablet three times daily (panic disorder) Clozaril 100mg, take 3 tablets by mouth at bedtime (schizoaffective disorder) - There were no physician orders for Trazodone, Docusate Sodium or Stimulant Lax Plus Review on 4/21/22 of client #6's April 2022 MAR revealed the following medications were initialed as having been administered the 1st- 22nd: - Trazodone 100mg tablet, take 1 once daily Docusate Sodium 100mg Softgel , take 1 once daily Stimulant Lax Plus 50mg/8.6mg, take once daily Clonazepam 1mg tablet, take one tablet three times daily Observation on 4/21/22 at 11:30am of client #6's medications revealed two pill packets: Breakfast (8:00AM) - 1 tablet -Guanfacine 1mg - 2 tablets - Lithium Carbonate 300mg Bedtime (8:00PM) - 1 tablet -Guanfacine 1mg - 2 tablets -Lithium Carbonate 300mg	{V 118}		

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{V 118}	Continued From page 15 - The following medications were not at the group home and available for administration: Trazodone, Docusate Sodium, Stimulant Lax Plus or Clonazepam Interview on 4/21/22 of staff #1 revealed: - He did give medications to client #6 - Client #6's medications had changed a lot since he had been admitted - He didn't know why co-workers initialed that medications were given that were not present in the pill pack, probably because the person before them did cause "I initialed too" Interview on 4/25/22-5/2/22 the COO stated: - Client #6 was admitted March 28th 2022 - Client #6's medications have been an issue since he was admitted to the group home - Client #6 had 3 different FL2s from the local hospital discharges - Currently working with the local management entity psychologist to ensure the correct medications and care for client #6 - Staff had medication training March 2022 - She had not observed the staff initials on the April 2022 MAR 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. Review on 4/21/22 of the Plan of Protection (POP) dated 4/21/22 written by the Licensee/RN revealed: "What immediate action will the facility take to ensure the safety of the consumers in you care? Admin staff will monitor medication administration	{V 118}		

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{V 118}	Continued From page 16 at least of 2 days. We will meet with PCP (primary care provider), treatment team with in 5 days to discuss meds orders and correct all errors. [Licensee/RN], [QP] and [COO] will be responsible for this POP. Describe you plans to make sure the above happens. As above with consistent monitoring-will take to M.D. (medical doctor) to discuss any med (medication) changes to get the MAR's corrected and to come into compliance." Clients whose diagnoses included Traumatic Brain Injury, Diabetes, H/O Prostate Cancer, Liver Neoplasm with Metastasis, Epilepsy, Intellectual Developmental Disability, Autism Spectrum and Schizoaffective disorder resided at the facility. The staff were inconsistently documenting on 2 different forms along with inconsistency with results noted on the glucometer related to client #2's BS results and what if any insulin was administered. On 3/22/22, there were 3 readings in the glucometer that would have required insulin, however there was no documentation on the MAR or the VSMF related to the readings on the glucometer or of insulin being administered. The staff were inconsistently documenting the BS results and insulin administration on 2 different forms. These results were inconsistent with the glucometer readings. From 3/15/22 - 4/21/22, there were 114 opportunities to have client #2's BS checked, the glucometer reading indicated he should have had insulin 36 times and the VSMF documented 25 times insulin was given and the MAR had 40 times in which staff initialed that insulin was administered without any units documented. There were missing physician's orders for client #6 and staff were signing as having administered medications which were not at the group home and available for administration. This deficiency	{V 118}		

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{V 118}	Continued From page 17 constitutes a Failure to Correct the Type A1 rule violation originally cited for serious neglect. An administrative penalty of $500.00 per day is imposed for failure to correct within 23 days.	{V 118}		