STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL096-115	A. BUILDING: ______ B. WING ______	R **06/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTRY PINES #2	**2600 NORTH BESTON ROAD LA GRANGE, NC 28551**

(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 June 2, 2022. The complaint was substantiated (Intake #NC00187767). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 5 and currently has a census of 5. The survey sample consisted of audits of 2 current clients.	V 000		
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	V 118		

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(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 reviews, observation and interviews, the facility failed to administer medications on the written order of a physician affecting one of two clients (#5), failed to keep the MARs current affecting two of two clients (#2 and #5) and 1 of 3 staff failed to to demonstrate competency in medication administration (Staff #1). The findings are:

Finding #1
A.
Review on 05/17/22 of client #5's record review revealed:
-35 year old male.
-Admission date of 03/01/10.
-Diagnoses of Mild Mental Retardation, Asperger's Syndrome, Impulse Control Disorder and Acne.

Review on 05/17/22 of client #5's Physician's orders revealed:
01/25/22
-"D/C (Discontinue) Ativan 1mg(milligrams) (treat anxiety disorders)."
04/19/22
-Geodon 60mg (treat Schizophrenia) Take 1

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capsule by mouth every morning.
-Depakote DR 250mg (treat Bipolar Disorder) Take 1 capsule by mouth three times a day.
-Geodon 40mg (antipsychotic) Take 1 capsule by mouth every evening at 8pm.
-In bold capitalized letters "NO ATIVAN."

Review on 05/17/22 of client #5's January-April 2022 MARs revealed:
-January 2022 MAR had Lorazepam (Ativan) 1mg PRN (as needed) and no initials the medication had been administered.
-February 2022 MAR had Lorazepam 1mg PRN and no initials the medication had been administered.
-March 2022 MAR had Lorazepam 1mg and D/C written on the MAR.
-April 2022 MAR had Lorazepam 1mg and D/C written on the MAR.

Review on 05/17/22 of the May 2022 MAR revealed no initials for the morning medications on 05/17/22 for the following medications:
-Geodon 60mg
-Depakote DR 250mg

Observation and review on 05/18/22 at approximately 10:15am in the live-in staffs bedroom to the left of the entrance door was a two drawer cabinet. In the top of the two drawer cabinet had a Ziploc bag with "Lorazepam (Ativan) 2mg" hand written on the bag and approximately 16 white pills with EP/906 on each pill. Review on 05/18/22 of www.drugs.com website the pills matched the identity of Lorazepam 2mg.

During interview on 05/16/22 client #5's former case manager revealed:
-She was retired but still continued to be very

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active in client #5's life because he was like family.
-In March client #5 was in a behavior and his one-on-one worker called her to get assistance with client #5 to help calm him down.
-She volunteered to ride back with the one-on-one worker to the facility so the one-on-one worker would not be in the car with client #5 by herself.
-When they got to the facility with client #5 staff #1 immediately went to her bedroom and she got a pill and gave it to client #5.
-Staff #1 was complaining that the dosage was not strong enough and he needed 2mg and not 1mg.
-She knew then staff #1 was giving him the Ativan and she knew that medication had been discontinued and staff #1 was still giving him the Ativan.
-The incident really upset her and the one-on-one worker.
-The staff that worked at the facility did not like to deal with client #5 because of his behaviors and "they drug him up and the drugs make him act worse."
-Client #5 came to her one day and told her something was not right with his medications.
-Client #5 knows exactly how many pills he is supposed to take and what color they are.
-Client #5 told her he had flushed the medicine he was not supposed to take down the toilet.
-She told him not to do that anymore and to bring her the pill.
-Client #5 brought her a pill and she looked the pill up and it was the Ativan.
-Staff #1 told her she was not giving him the Ativan.
-She reported the incident and staff #1 had not been giving him the Ativan and he is a totally different person and "sweet" now.

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During interview on 05/17/22 client #5's one-on-one worker revealed:
-She had worked with client #5 approximately 2 years.
-In March she witnessed staff #1 give client #5 an Ativan that had been discontinued by the doctor.
-The Ativan had been discontinued in January 2022.
-In March client #5 was having a bad day and his former case manager rode with her to the facility to take client #5 back to the facility.
-Client #5 did not like loud noises, people laughing and strangers.
-Staff #1 went to her bedroom and got the Ativan from a cabinet in her bedroom.
-Staff #1 stated client #5 needed 2mg because the 1mg was not enough.
-The cabinet was at the entrance of her bedroom door when you entered her bedroom.
-Staff #1 did not keep the medication in the medication cart.
-The Ativan did not help him, it would make him act worse.
-Staff #1 did not want to deal with client #5 due to his behaviors and would give him the Ativan.
-When she took client #5 back to the doctor in April she asked the doctor to put Ativan discontinued again on the paperwork so staff #1 would stop giving him the Ativan.

During interview client #5 revealed:
-Staff #1 use to give him a white pill.
-He would flush the pill down the toilet.
-He flushed his melatonin down the toilet because the medication made him sleepy and made his eyes hurt.
-Client #5 was able to identify his current medications and the color of his current medications.

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During interview on 05/17/22 and 05/18/22 staff #1 revealed:
-She administered medications every day at the facility.
-The Ativan for client #5 was discontinued approximately 4 months ago.
-Client #5 gets a white pill in the evening that looks like Ativan but it was Melatonin.
-Client would take all of his medications except the Melatonin and he would flush it down the toilet.
-She did not know if he was still flushing the Melatonin down the toilet.
-Client #5 did not like her to watch him take his medications.
-She was informed by a Social Worker with the Department of Social Services (DSS) that they had received a complaint about client #5's medications.
-The white pill that a staff member saw her give client #5 was the Melatonin.
-The medication in the cabinet in her room was client #5's old Ativan and had been in the cabinet in her room for over a year.
-She was not using the Ativan in the cabinet in her bedroom and giving it to client #5.
-She did not know what the staff saw but she would not give any medications that was not authorized by the doctor to give.

During interview on 05/17/22 and 05/18/22 the Assistant Director revealed:
-The Administrative Assistant spoke with staff #1 and reviewed the MARs and did not find anything being wrong.
-She was not aware staff #1 was giving a medication that had been discontinued.
-She did not know staff #1 had any medication in her bedroom.

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During interview on 05/18/22 the Qualified Professional/Director revealed:
-He was not aware that staff #1 was giving client #5 a medication that had been discontinued.
-He did not know staff #1 had Ativan in her bedroom.

B.
Review on 05/17/22 of staff #1's record revealed:
-Hire date of 07/19/06.
-Paraprofessional/Live-in staff.

During interview client #5 revealed:
-Staff #1 use to give him a white pill.
-He would flush the pill down the toilet.
-He flushed his melatonin down the toilet because the medication made him sleepy and made his eyes hurt.
-Client #5 was able to identify his current medications and the color of his current medications.

During interview on 05/17/22 and 05/18/22 staff #1 revealed:
-She administered medications every day at the facility.
-The Ativan for client #5 was discontinued approximately 4 months ago.
-Client #5 gets a white pill in the evening that looks like Ativan but it was Melatonin.
-Client would take all of his medications except the Melatonin and he would flush it down the toilet.
-She did not know if he was still flushing the Melatonin down the toilet.
-Client #5 did not like her to watch him take his medications.
-She can not remember if she told anyone in the administration office client #5 was flushing his

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medications down the toilet.

During interview on 05/18/22 the Assistant Director revealed:
-She did not know client #5 had flushed any of his medications down the toilet.
-Staff #1 had not informed her client #5 was flushing his medication down the toilet.

During interview on 05/18/22 the Qualified Professional/Director revealed:
-He was not aware client #5 had flushed any medications down a toilet.
-Staff #1 had not informed him client #5 was flushing his medication down the toilet.

Finding #2
Review on 05/17/22 of client #2's record revealed:
-26 year old male.
-Admission date of 06/19/17.
-Diagnoses of Autistic Disorder, Intermittent Explosive Disorder, Hypertension, Poor Impulse Control, Mild Mental Retardation and Obesity.

Review on 05/17/22 of client #2's Physician's orders revealed:
04/21/22
-Fenofibrate 145mg (treat high cholesterol) Take 1 tablet by mouth every day.
-Miralax 3350 (Constipation) Take by mouth every morning.
03/29/22
-Magnesium Oxide 400mg (treat indigestion) Take 1 tablet by mouth every day.
03/10/22
-Benztropine 2mg (treat symptoms of Parkinson's disease) Take 1 tablet by mouth twice daily.
-Risperidone 2mg (antipsychotic) Take 1 tablet by mouth twice a daily.

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07/22/21
-Haloperidol 5mg (antipsychotic) Take 1 tablet by mouth twice daily.
-Divalproex DR (treat Bipolar disorder) 500mg Take 1 tablet by mouth three times daily.
10/21/22
-Propranolol 10mg (treat high blood pressure) Take 1 tablet by mouth three times daily.
-Buspirone 10mg (treat anxiety) Take 2 tablets by mouth three times a day.

Review on 05/17/22 of the May 2022 MAR revealed no initials for the morning medications on 05/17/22 for the following medications:
-Fenofibrate 145mg
-Magnesium Oxide 400mg
-Benztropine 2mg
-Risperidone 2mg
-Haloperidol 5mg
-Divalproex DR 500mg
-Propranolol 10mg
-Buspirone 10mg

Review on 05/18/22 of the Plan of Protection dated 05/18/22 and completed by the Assistant Director revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care?
1. Weekly med (medication administration) review.
2. Document any findings.
3. Weekly S.O.P (Standard Operating Procedures) for med administration.
    A. Right dosage at correct time.
4. Staff will be provided retraining on med administration.
-Describe your plans to make sure the above happens.
Develop a review sheet with administrative staff

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signature post weekly review.
Each month med reviews conducted with staff and documented.
All meds will be remained locked in med cart at all times and that d/c (discontinued) meds will be disposed of properly."

Clients #2 and #5 had diagnoses that consisted of Autistic Disorder, Asperger Syndrome, Impulse Control and Mild Mental Retardation. Client #2 and client #5's MARs were not initialed immediately after medications were administered for the morning medications in the month of May 2022. Staff #1 was a live-in staff and had a Ziploc bag in her bedroom in a two drawer cabinet that was labeled with Lorazepam (Ativan) 2mg. The former case manager and one-on-one staff witnessed staff #1 administer the Lorazepam 2mg to client #5 on one occasion in March 2022 because client #5 was having behaviors. Client #5's Lorazepam had been discontinued by the doctor in January 2022. Client #5's one-on-one worker indicated the Lorazepam did not help client #5 and made his behaviors worse. Client #5 was also prescribed Melatonin 3mg and was flushing the Melatonin down the toilet and staff #1 was aware and did not alert administrative staff of client #5's behaviors. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $2000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.