Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-214	A. BUILDING: ______ B. WING ______	R 05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHTON W LILLY HOME	**566 WILKES ROAD FAYETTEVILLE, NC 28306**

(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 on May 26, 2022. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600E Supervised Living for Adults with Substance Abuse Dependency. This facility is licensed for 14 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills.	V 110		

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V 110	Continued From page 1 (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record reviews and interviews the governing body failed to develop and implement policies and procedures for individualized supervision plans of paraprofessionals by a Qualified or Associate Professional (QP or AP) affecting three of three audited paraprofessional staff (#1, #2 and #5). The findings are: Review on 05/24/22 of the facility's plan of correction for the survey dated 02/23/22 and signed by the Executive Director on 03/18/22 revealed: - "...QP supervise all paraprofessional staff." - "Will get QP supervision plan together for staff." Review on 05/26/22 of the QP's job description revealed: - QP was responsible for supervision of all paraprofessional staff. Review on 05/24/22 of staff #1's personnel record revealed: - Hire date of 04/05/13. Review on 05/24/22 of staff #2's personnel records revealed: - Hire date of 11/14/19.	V 110		

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V 110	Continued From page 2 Review on 05/25/22 of staff #5's personnel records revealed: - Re-Hire date of 01/11/22. Review on 05/25/22 of personnel records for the paraprofessional staff listed above revealed no documentation of an individualized supervision plan by a QP or AP. Interview on 05/24/22 the QP stated: - She had served as the QP for approximately 1 year. - She did not provide supervision for the paraprofessional staff. Interview on 05/25/22 and 05/26/22 the Executive Director stated: - The QP was supposed to supervise the paraprofessional staff. - A supervision plan had been created but had not been implemented. - She understood an AP or QP was required to supervise the paraprofessional staff at the facility. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 110		
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.	V 118		

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V 118	Continued From page 3 (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 reviews, observations, and interviews the facility failed to administer medication as ordered and failed to keep MARs current for 1 of 3 audited clients (#3). The findings are: Review on 05/24/22 of client #3's record revealed: -59 year old male. -Admission date of 02/21/22. -Diagnoses of Stimulant Use Disorder-Alcohol (Severe).	V 118		

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V 118	Continued From page 4	V 118		

Review on 05/24/22 of client #3's Physician's orders revealed:
04/29/22
-Escitalopram 20mg (milligrams) (Anxiety and Depression) Take 1 by mouth once daily for mood.
04/08/22
-Olanzapine 20mg (psychotic disorder) Take 1 by mouth at bedtime.
-Gabapentin 300mg (Nerve pain/Seizures) Take 1 by mouth 3 times daily. Take 1 300mg in morning and afternoon at night take 2 tablets (600mg).

Review on 05/24/22 of client #3's May 2022 MAR revealed:
-The MAR had a key where an "X" on the MAR meant PRN (as needed) refused or not needed.
-Escitalopram 20 mg had an "X" from 05/18/22-05/23/22.
-Olanzapine 20 mg had an "X" from 05/20/22-05/23/22.
-Gabapentin 300 mg had an "X" from 05/09/22-05/14/22, 05/16/22-05/20/22, 05/23/22.
-The medications listed above were not PRN medications.

Observation on 05/24/22 at approximately 2:30pm of client #3's medications revealed:
-A Ziploc bag with client #3's pharmacy filled medication.
-The Ziploc bag did not contain Olanzapine 20mg or Gabapentin 300mg.

During interview on 05/25/22 client #3 revealed:
-He had resided at the facility for 93 days.
-He was a veteran and received his medications through the Veterans Administration (VA).
-He did not have a primary doctor and was not able to get a visit with the primary doctor at the

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V 118		V 118		

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VA until November 4, 2022.
-He had to go to an urgent care to get refills on his medication and spend hours to see anyone to be able to get his medication.
-He ran out of refills on his Gabapentin and Olanzapine medication.
-Going to the urgent care was "a pain" because he had to sit and wait over half of the day.
-He was able to make contact with a nurse at the VA that had helped him get his medication refilled until he was able to see a doctor.

During interview on 05/26/22 staff #1 stated:
-He worked at the facility for approximately 10 years.
-The facility was made up of VA clients.
-The medications were difficult to get refilled from the VA at times.
-Staff reminded clients to contact their Primary Care Provider when the medication supply was low.

During interview on 05/26/22 staff #2 revealed:
-He worked 2nd shift at the facility.
-He administered medications on his shift.
-Medication not being available for clients happened often.
-He would remind the clients when the medication was getting low to make an appointment with the doctor or get the medication refilled.
-Sometimes the clients would not get the medication refilled.

During interview on 05/24/22 and 05/26/22 the Executive Director revealed:
-Client #3 ran out of medications.
-She did not know why the staff were putting a "X" on the MAR.
-Client #3 was a VA client and it was very hard to get the medications.

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V 118	Continued From page 6 -The House Manager had told client #3 he needed to get prescriptions for refills and to get the medication refilled. Review on 05/26/22 of the Plan of Protection dated 05/26/22 and completed by the Executive Director revealed: "-What immediate action will the facility take to ensure the safety of the consumers in your care? -The VA has a new nurse [name] that will be assisting and oversee that our veterans have their medication in a timely manner. -Describe your plans to make sure the above happens. -When client has 10 days left of meds client will notify [VA Nurse] to help get their meds so they will not run out." Client #3 was a 59 year old male with a diagnosis of Stimulant Use Disorder-Alcohol (Severe). In the month of May 2022 client #3 missed approximately 7 days of his Escitalopram 20mg, 5 days of his Olanzapine 20mg and 13 days of his Gabapentin 300mg. The facility requires each client residing at the facility to schedule and coordinate their doctors appointments and make sure they continue to receive their own medication without running out of their prescribed medications. The facility failed to ensure client #3 did not run out of his medication and received them daily as prescribed by the physician. This deficiency constitutes an Imposed Type B rule violation which is detrimental to the heath, safety and welfare of the clients. An administrative penalty of $200.00 per day is imposed for failure to correct within 45 days.	V 118		
V 736	27G .0303(c) Facility and Grounds Maintenance	V 736		

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V 736	Continued From page 7 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observation on 05/26/22 at approximately 10:15am of the facility revealed: -The common sitting area had paint missing to expose drywall approximately 12 inches long and 6 inches wide. -The chair cushion seat exposed the pillow padded stuffing. -The loveseat in the common sitting area had leather ripped around the edge of the loveseat. -The common sitting area had a crack on the ceiling the length of the wall. -Bedroom #1-walls were dirty and discolored and a small hole over the area of the bed. -Bedroom #2: walls smudged/discolored; broken window blind and the walls were dirty and discolored. -Bedroom #3-the blind was broken on one of the windows and the walls were dirty and discolored. -Bedroom #4: damaged walls where items were hung on the walls and the walls were dirty and discolored. -Bedroom #6: the walls were dirty and discolored. Interview on 05/26/22 staff from sister facility	V 736		

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V 736	Continued From page 8 revealed the blinds had been replaced since the last survey and the men kept breaking them. The entire inside of the facility needed to be painted and updated. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		