STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL054-178	A. BUILDING: _____ B. WING _____	R 08/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSEX	2505 HOGES ROAD KINSTON, NC 28504

(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 August 23, 2022. The complaint was substantiated (intake #NC00191674). Deficiencies were 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 4 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.	V 000		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the	V 117		

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V 117	Continued From page 1 pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that medications for administration were labeled as required for 1 of 3 audited clients (client #1). The findings are: Review on 8/23/22 of client #1's record revealed: - 60 year old male admitted 2/04/19. - Diagnoses included Intellectual/Developmental Disability, moderate; Traumatic Brain Injury; Schizoaffective Disorder, bi-polar type; and Seizure Disorder. - Physician's order signed 7/25/22 for Spiriva (chronic obstructive pulmonary disease) 2.5 micrograms (mcg) 2 puffs twice daily. Observation on 8/23/22 at approximately 10:35 am of client #1's medications on hand revealed: - Spiriva inhaler, expiration date March 2025 with small white label with client #1's name printed. - No pharmacy label with the prescriber's name, pharmacy dispense date, directions for administration, or pharmacy information. During interview on 8/23/22 the Director of Operations stated he did not know why there was no pharmacy label for client #1's Spiriva. He thought facility staff may have disposed of the box with the pharmacy label. He understood the requirement to maintain the pharmacy label for	V 117		

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V 117	Continued From page 2 client medications and would make sure facility staff were re-trained regarding medication requirements.	V 117		
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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V 118	Continued From page 3 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to administer medications as ordered by a physician affecting 3 of 3 current clients (clients #1, #2, and #3). The findings are: Review on 8/23/22 of client #1's record revealed: - 60 year old male admitted 2/04/19. - Diagnoses included Intellectual/Developmental Disability, moderate; Traumatic Brain Injury; Schizoaffective Disorder, bi-polar type; and Seizure Disorder. - Physician's orders signed 8/03/22 for olanzapine (anti-psychotic) 10 milligrams (mg) 1 tablet at bedtime. Review on 8/23/22 of client #1's MARs for June - August 2022 revealed: - Transcription for olanzapine 10 mg 1 tablet at bedtime. - Circled staff initials on 8/16/22 and 8/17/22 indicated the medication was not administered. - "Exceptions . . . " included "Med (medication) not available . . . medication is not in stock and should be delivered tomorrow . . . medication still hasnt been received in after being reported to pharmacy. . . " During interview on 8/23/22 client #1 stated staff gave him his medications five times a day; he had never missed any medications because "I can't live without them." One medication he took was for seizure disorder. Review on 8/23/22 of client #2's record revealed: - 42 year old male admitted 7/10/17.	V 118		

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V 118	Continued From page 4 - Diagnoses included Intellectual/Developmental Disability, moderate; Schizophrenia; Diabetes, Hypertension, Hyperlipidemia, Hypothyroidism, and Anemia. - Physician's orders signed 6/16/22 and 7/14/22 for aripiprazole (anti-psychotic) 30 mg 1 tablet at bedtime, trazodone (antidepressant) 100 mg 1 tablet at bedtime, and hydroxyzine (antihistamine) 50 mg 1 tablet three times daily, and signed 5/19/22 and 7/14/22 for Certavite (multi-vitamin) 1 tablet daily.. Review on 8/23/22 of client #2's MARs for June - August 2022 revealed: - Transcriptions for aripiprazole 30 mg 1 tablet at bedtime; hydroxyzine 50 mg 1 tablet three times daily, 8:00 am, 2:00 pm, and 8:00 pm; and Certavite 1 tablet daily. - Circled staff initials indicated the medications were not administered as follows: - August 2022: aripiprazole 8/15/22 ". . . Exceptions . . . med not available . . . ;" hydroxyzine 8/15/22 2:00 pm and 8:00 pm and 8/16/22 8:00 am ". . . Exceptions . . . med not available . . . " - July 2022: Certavite 7/11/22 ". . . Exceptions . . . med not available . . . " - June 2022: aripiprazole 6/16/22 8:00 pm " . . . Exceptions . . . withheld per DR/RN (Doctor/Registered Nurse) Orders . . . Pass Notes . . . Medication changes made by [the Psychiatrist] not approved . . . ;" hydroxyzine 6/16/22 8:00 pm; 6/17/22 8:00 am; 6/18/22 2:00 pm and 8:00 pm; 6/19/22 8:00 am and 2:00 pm; 6/20/22 8:00 am and 2:00 pm " . . . Exceptions . . . med not available . . . ;" trazodone 6/16/22 8:00 pm " . . . Exceptions . . . Withheld per DR/RN orders . . . Pass Notes . . . Medication changes made by [the Psychiatrist] not approved . . . " - Staff initials hydroxyzine was administered at	V 118		

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V 118	Continued From page 5 2:00 pm and 8:00 pm 6/17/22; 8:00 am 6/18/22; and 8:00 pm 6/19/22. During interview on 8/23/22 client #2 stated staff gave him his medications daily. He refused to take "a big long pill once or twice" because he did not like to take it. Review on 8/23/22 of client #3's record revealed: - 61 year old male admitted 1/15/97. - Diagnoses included Intellectual/Developmental Disability, mild; Autism; Impulse Control Disorder; Depression; Hyperlipidemia; Senile Nuclear Sclerosis; and Hypocalcemia. - Physician's order signed 9/20/21 for pravastatin (high cholesterol) 20 mg 1 tablet at bedtime. Review on 8/23/22 of client #3's MARs for June - August 2022 revealed: - Transcription for pravastatin 20 mg 1 tablet at bedtime. - Circled staff initials on 7/08/22 and 7/9/22 indicated the medication was not administered. - ". . . Exceptions . . . med not available . . . " During interview on 8/23/22 client #3 stated he took his medications daily with staff assistance and had never missed or refused any doses. During interview on 8/23/22 the Director of Operations stated: - Staff had been re-trained regarding documentation of medication administration and medication policy and procedure relative to notifying the Medical Coordinator when medication supplies were low. - Medication refills should be requested from the pharmacy before the medications run out. - Facility staff should communicate low medication supplies to the Medical Coordinator	V 118		

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V 118	Continued From page 6 for needed refills. - The previous Medical Coordinator resigned 7/12/22; the current Medical Coordinator was hired 7/21/22 and was in training 7/21/22 - 8/01/22. - He understood the requirement for medications to be administered as ordered by the physician and would ensure staff were re-trained on medication policy and procedure. This deficiency has been cited 3 times since the original cite on 5/15/19 and must be corrected within 30 days.	V 118		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the physician or pharmacist immediately of medication errors affecting three of three clients (#1, #2, and #3). The findings are: Refer to V118 regarding medication	V 123		

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V 123	Continued From page 7 requirements. - Client #1 was not administered olanzapine on 8/16/22 as ordered. - Client #2 was not administered hydroxyzine at 2:00 pm or 8:00 pm on 8/15/22 or aripiprazole on 8/15/22 as ordered. - Client #2 was not administered Certavite on 7/11/22 as ordered. - Client #3 was not administered pravastatin on 7/08/22 or 7/09/22 as ordered. - No documentation of contact with the Physician or Pharmacist regarding the above listed medication errors. During interview on 8/23/22 the Director of Operations stated staff had been retrained regarding medication policies and procedures, including notifying the Pharmacist of medication errors. Pharmacist notification of medication errors should be documented on the level 1 incident reports. The Medical Coordinator monitored level 1 incident reports for completion including Pharmacist notification of medication errors; the Medical Coordinator provided coaching to staff as needed. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 123		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity.	V 291		

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V 291	Continued From page 8 (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain coordination between the facility operator and the professionals responsible for the client's treatment affecting 1 of 3 current clients (#1). The findings are: Review on 8/23/22 of client #1's record revealed: - 60 year old male admitted 2/04/19. - Diagnoses included Intellectual/Developmental Disability, moderate; Traumatic Brain Injury; Schizoaffective Disorder, bi-polar type; and Seizure Disorder. - Copy of "Hospitalist Progress Note" faxed to the Director of Operations 7/19/22 by a Case	V 291		

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V 291	Continued From page 9 Manager for a regional acute care hospital for "Continuity of Care/Treatment" with a hand written note to "Please call once reviewed." - Copy of "Discharge Summary," from the regional acute care hospital electronically signed by a Physician 7/25/22 faxed to the Director of Operations 7/26/22 by the Case Manager included ". . . Admit Date: 6/22/22 . . . The patient (client #1) is being discharged back to his group home . .. Pt (patient) has two appointments (at) [infusion center] scheduled for: tomorrow 7/26 . . . " - "Discharge Summary" included " . . . presented to the emergency department which he reported was secondary to right upper extremity pain and elbow pain. He says that the pain started approximately 2 months ago and became worse yesterday which is what prompted him to come to the emergency department. He is not the greatest historian, and I attempted to call the nurse facility without much avail. As result the history was obtained via the patient and also via chart review from the emergency department . . . " - Client #1 was admitted to the regional acute care hospital 6/22/22 for methicillin-susceptible Staphylococcus aureus right elbow septic arthritis and osteomyelitis of the distal humerus bone; he was discharged 7/25/22. During interview on 8/23/22 the hospital Case Manager stated: - She took over hospital case management responsibilities for client #1 on 7/11/22. - She contacted the Director of Operations on 7/13/22 to discuss discharge planning for client #1, to make sure he could return to the group home. - She faxed hospital documentation as requested to the Director of Operations on 7/13/22.	V 291		

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V 291	Continued From page 10 - She left a voice mail for the Director of Operations on 7/18/22. - On 7/19/22 she spoke with the Director of Operations and re-faxed the previously requested hospital documentation. - On 7/20/22 she attempted to contact the Director of Operations to ensure he received and reviewed the documentation and to discuss discharge planning; she left him a voice mail. - On 7/21/22 she made "multiple attempts" to contact someone from the group home to facilitate client #1's discharge. - On 7/22/22 client #1 was "medically cleared" for discharge from the hospital; she was unable to reach anyone from the group home so she contacted client #1's sister who contacted the Director of Operations. - On 7/25/22 she spoke with the Director of Operations who agreed to review the documentation provided and to "come look at him (client#1);" when speaking with the Director of Operations she "couldn't get a solid discharge plan." - On 7/25/22 facilty staff "randomly showed up" at the hospital with other clients to pick up client #1 for return to the facility. - Facility staff stated the other clients had medical appointments and they could not wait for client #1 to be ready for discharge so they left the hospital. - The hospital provided transportation for client #1 to return to the facility in a wheelchair van alone. - If the Director of Operations and facility staff had been more responsive to the hospital's attempts to discuss discharge planning, client #1 could have left the hospital three days sooner, would not have been subjected to two additional COVID tests at the hospital and would not have been sent home alone in a hospital wheelchair van. During interview on 8/23/22 the Director of	V 291		

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V 291	Continued From page 11 Operations stated: - He was out of the country when client #1 was admitted to the hospital. - The former Medical Coordinator would have been in contact with the hospital regarding client #1. - The former Medical Coordinator may not have documented her contacts with the hospital. - The former Medical Coordinator resigned 7/12/22. - After the former Medical Coordinator's resignation, he would have coordinated client #1's return to the facility. - He made and received numerous phone calls daily and did not keep "call logs." - He could not recall when his first contact with hospital staff took place. - He requested discharge information and an updated FL-2 from the hospital to "make sure he was ready to return" and to ensure the facility could provide the appropriate level of care. - It was "days if not a week" before he received the information he requested from the hospital. - He was "not 100% sure" about the dates of his contacts with the hospital. - Client #1's sister called him on 7/22/22 and informed him client #1 was ready to be discharged. - He contacted the hospital staff and requested the discharge be postponed until 7/25/22 at 10:00 am. - Hospital staff agreed for client #1 to be discharged 7/25/22 at 10:00 am and "said he'd be ready." - On 7/25/22 at 10;00 am facility staff went to pick up client #1 but he was not ready to leave the hospital; the facility staff's "main priority" was to ensure no one missed a medical appointment. - At approximately 1:00 pm on 7/25/22 hospital staff called the facility to arrange transportation	V 291		

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V 291	Continued From page 12 for client #1 to return to the facility; - He negotiated for the hospital to provide transportation for client #1 to the facility. - No one had expressed any concerns about not being able to reach him or other staff via telephone. - He could not say the hospital staff would have had his cell phone number.	V 291		
V 736	27G .0303(c) Facility and Grounds Maintenance 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 observations and interview the facility was not maintained in a safe, clean, attractive manner. The findings are: Observation on 8/23/22 at approximately 10:00 am revealed: - Dark stains on the carpets throughout the facility. - The ceiling exhaust fan in the hall bathroom was covered in gray dust. - A small hole approximately 1 inch long in the wall above the hall bathroom toilet. - A hole above the light switch in the hall bathroom. - The outlet near the bathroom mirror was loose and protruding from the wall.	V 736		

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ESSEX	2505 HOGES ROAD KINSTON, NC 28504

(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 736	Continued From page 13 - Client #1's room had an odor similar to urine. - An approximate 18 inch by 18 inch square repair to client #1's bedroom wall that was pushed into the wall. - Linens were piled between the head of client #1's bed and the wall; there was no pillow on client #1's bed. - A hole in the wall next to client #1's bed. - An approximately 8 inch by 8 inch square damaged wall repair behind client #1's bedroom door. - Dark, greasy appearing stain with scuffed paint at the head of client #2's bed. - 2 drawers in client #2's chest of drawers were off their tracks and appeared loose. - Client #3's bathroom had black matter on the floor behind and around the toilet. - Damage to the lower corner wall at the head of client #3's bathtub. - Organic matter inside the ceiling light fixture in client #3's bathroom. - An approximately 1 inch hole in the hallway wall beside the mirror. - Grass in the yard and around the backdoors of the facility was overgrown; a small pine tree was growing out of the chimney. During interview on 8/23/22 the Director of Operations stated the carpets were scheduled to be professionally cleaned within the week. He did not know how the holes in the facility walls occurred. He would ensure the items cited were corrected. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		