STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL048003	A. BUILDING: _____ B. WING _____	R 08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HYDE COUNTY GROUP HOME	9400 PINEY WOODS ROAD FAIRFIELD, NC 27826

(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 follow up survey was completed on August 4, 2022. 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 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 reviews and interviews the facility failed to develop and implement goals and strategies affecting one of three audited clients (#2). The findings are: Review on 08/02/22 of client #2's record revealed: - 74 year old male. - Admission date of 05/24/90. - Diagnoses of Severe Intellectual Developmental Disability, Type I Diabetes, Adjustment Disorder, Gout, Gastroesophageal Reflux Disorder, Psychosis, Hepatitis B Carrier and Speech Impairment. Review on 08/04/22 of a signed physician order for client #2 dated 04/30/20 revealed: - Check client #2's blood sugar values 3 times daily. Review on 08/02/22 of client #2's Medication Administration Records from May 2022 thru August 2022 revealed client #2's blood sugar values were checked 3 times daily. Review on 08/02/22 of client #2's Individual Support Plan (ISP) dated 11/01/21 revealed: - "What Others Need To Know To Best Support Me...I (client #2) have a glucometer for testing my blood sugar 4 times a day." - "Medical/Behavioral Medical...I use a glucometer because I have diabetes. I test my	V 112	The client #2 ISP is scheduled for revision to change glucometer testing from 4 times a day to 3 times a day during the annual plan. 9/16/22 During the annual ISP the QP shall verify with the care coordinator to ensure the glucometer testing and other pertinent information are correct. The supervisor shall review and monitor the ISP quarterly to verify the ISP is up to date.	

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V 112	Continued From page 2 blood sugar 4 times a day." - Goal #1: "I will remain in good health...I check my blood sugar 4 times daily. I need to learn to put the test strips in the meter correctly." Interview on 08/02/22 the Director stated: - He understood the ISP for client #2 had a goal for his blood sugar to be checked 4 times a day. - He understood client #2's blood sugar was checked 3 times a day and the ISP should reflect the current strategies.	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 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	V 118		

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V 118	Continued From page 3 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 and interviews the facility failed to ensure medications were administered as ordered by a physician for one of three audited clients (#2). The findings are: Review on 08/02/22 of client #2's record revealed: - 74 year old male. - Admission date of 05/24/90. - Diagnoses of Severe Intellectual Developmental Disability, Type I Diabetes, Adjustment Disorder, Gout, Gastroesophageal Reflux Disorder, Psychosis, Hepatitis B Carrier and Speech Impairment. Review on 08/02/22 of a signed FL-2 for client #2 revealed the following medication ordered: - Xanax (Alprazolam - treats anxiety) 0.25milligrams (mg) take one tablet twice daily. Review on 08/02/22 of client #2's August 2022 MAR revealed: - The Qualified Professional's (QP) initials with a line drawn thru them for 08/01/22 for the morning and evening dose and on 08/02/22 for the morning dose.	V 118	Client #2 received the Xanax prescription on 8/3/22 and was administered on 8/3/22. 8/3/22 The QP shall receive training on proper procedure for checking medicine coming from the pharmacy and the protocol when medicine is not received. 8/15/22 The supervisor shall monitor monthly check-ins until QP has demonstrated properly	

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V 118	Continued From page 4 Observation on 08/02/22 at approximately 10:00am of client #2's medications revealed no Xanax available for administration. Interview on 08/02/22 the QP stated: - Client #2's Xanax was not received from the pharmacy for August 2022. - The pharmacy indicated there were no refills for client #2's Xanax. - He had attempted to get client #2's Xanax refilled. - Client #2 had missed 3 doses of Xanax. Interview on 08/02/22 the Director understood client #2 was in need of prescription for his Xanax. [This deficiency constitutes a re-cited deficiency 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:	V 123		

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V 123	Continued From page 5 Based on record reviews and interviews, the facility failed to notify the physician or pharmacist immediately of medication errors affecting one of three clients (#2). The findings are: Refer to V118 regarding medication requirements. - Client #2 missed a total of 3 doses of Xanax. - No documentation of immediate notification of a physician or pharmacist of client #2's medication errors. - The Qualified Professional (QP) acknowledged he did not notify the physician or pharmacist of the medication errors. - The QP indicated he had contacted the pharmacy when client #2's Xanax was omitted from the August 2022 batch of medications sent to the facility. Interview on 08/02/22 the Director stated he understood a physician or pharmacist was required to be contacted for each medication error.	V 123		
V 366	27G .0603 Incident Response Requirments 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;	V 366		

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V 366	Continued From page 6 (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal	V 366		

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V 366	Continued From page 7 review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as	V 366		

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V 366	Continued From page 8 applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to document their response to level I incidents. The findings are: Refer to V118 regarding medication requirements. - Client #2 missed a total of 3 doses of Xanax in August 2022. - No incident reports were generated for the 3 missed doses of medication. - The Qualified Professional acknowledged he did not create an incident report for the 3 missed doses of medication for client #2. Interview on 08/02/22 the Director stated he understood an incident report was required to be generated when a medication dose was missed.	V 366	An incident report was done on indicating the missed doses. 8/16/22 The QP shall receive training on the protocol for missing medicine and documenting. The supervisor shall monitor quarterly.	

ROANOKE DEVELOPMENTAL CENTER, INC.
PO BOX 967 – 607 ADAMS STREET
PLYMOUTH, NORTH CAROLINA 27962
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August 16, 2022

Mr. Ketih Hughes
Facility Compliance Consultant 1
Mental Health Licensure & Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Annual Survey completed August 4, 2022
Hyde County Group Home
9400 Piney Woods Road
Fairfield, NC 27826
MHL #048-003

Dear Mr. Hughes

Enclosed you will find the plan of correction for the cited deficiencies during the Annual Survey of August 4, 2022.

Thank you for your input to enhance our quality of service. If you have any questions please contact me.

Sincerely,

Zebedee Taylor
Director