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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
	MH1892-759	A. BUILDING: _____ B. WING _____	R-C 08/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESTINY FAMILY CARE HOME	3509 ALLENDALE DRIVE RALEIGH, NC 27604

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 8/8/22. The complaints were substantiated (intake #NC00191402 and #NC00191597). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and currently has a census of 4. The survey sample consisted of audits of 3 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	Training occurred on Saturday, August 6, 2022. The training was conducted by Nuevo Health Pharmacy's RN. The training focused on following physician's orders, documentation on the medication administration record. This included: reviewing orders provided by a prescriber prior to administering any new medication or prior to the start of each shift for new hires or relief staff. Training was also provided on how to document missed or late meds, following the legend provided at the top of the MAR, documenting in the appropriate time slots, indicating when meds were not given as ordered by the prescriber, protocols to follow when meds are not given as prescribed, including notifying the prescriber or pharmacist. Alll medication orders are to be documented on the MARS including PRNs, blood pressure readings, other approved orders, meds or procedures, blood sugar readings, etc..	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Elaine Rota — RP — 9/15/22

STATE FORM — MKN — UBKT11 — If continuation sheet 1 of 12

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V 118	Continued From page 1 (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) and failed to assure the MAR was current for 3 of 3 audited clients (#1, #2 & #4). The findings are: Review on 8/3/22 of client #1's record revealed: - Admitted: 6/23/18 - Diagnoses: Schizoaffective disorder, Asthma, Diabetes Mellitus, History of Cerebrovascular Accident, Hypertension and Gastroesophageal Reflux Disease (GERD) - Physician's order dated 5/2/22 for Finger Stick Blood Sugar Check three times daily - Physician's order dated 8/12/21 for the following medications administered at 8 AM: -Toujeo Solostar 200 unit inject 46 units (diabetes) -Fluticasone prop 50 mcg (micrograms) instill 1-2 sprays in each nostril (allergies) -Proair HFA (hydrofluoroalkane) 90 mcg inhale 2 puffs as needed every 4-5 hours (asthma) -Carvedilol 25 mg (milligrams) 1 bid (twice a day)(hypertension) -Esomeprazole mag (magnesium) dr	V 118	appropriate follow up after administering a PRN and ensuring that all days have entries to reflect the status of the administration of each medication, procedure, etc.. on the MARs. All MARs must contain documentation on days meds are given or missed. Reasons for that particular documentation must be completed in the appropriate place on the back of the MAR.	

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V 118	Continued From page 2 (delayed release) 20 mg 1 bid (GERD) -Meloxicam 7.5 mg 1 daily with breakfast as needed for knee pain (arthritis) -Amlodipine Besylate 5 mg 1 daily (hypertension) -Cetirizine hcl (hydrochloric acid) 10 mg (allergies) -Physician order dated 2/16/22 for the following medications administered at 8 AM: -Stiolto Respimat inhaler apply two puffs by mouth every day (asthma) -Albuterol Sulfate Inhalation solution 0.083% 2.5mg/3 ml (millimeters) inhale contents of one vial via nebulizer 4 times daily as needed for wheezing or shortness of breath -Physician order dated 2/18/22 for the following medication administered at 8 AM: -Glycopyrolate 1 mg 1 tid (three times a day) (8 AM, 2PM, 8 PM) (stomach ulcer) -Physician order dated 5/21/21 for the following medication administered at 8 AM: -QC (Quality Choice) Aspirin EC (enteric coated) 81 mg 1 daily (heart health) -Physician order dated 7/19/22 for the following medication administered at 8 AM: -Nicotine 14 mg/24 hour patch apply 1 patch topically daily (smoking cessation) -Physician order dated 6/21/22 for the following medication administered at 8 AM: -Trulicity 3mg/0.5 ml (milliliter) pen inject 0.5 ml once a week for four weeks (diabetes) -Physician order dated 8/9/21 for the following medication administered at 8 AM: -Triamcinolone 0.1% cream apply to breast bid (eczema) -Physician order dated 2/18/22 for the following medication administered at 2 PM: -Glycopyrolate 1 mg Review on 8/3/22 of client #2's record revealed:	V 118	The RN provided the training and has agreed to return to the group home to perform unannounced reviews of MARS, orders and medications periodically over the next quarter. Additionally the administrator will check MARs monthly to ensure all documentation is present and follow protocols when it's not present, which might include additional training or disciplinary action.	

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V 118	Continued From page 3 - Admitted: 11/10/17 - Diagnoses: Schizophrenia, Diabetes, Anemia, Asthma, and Obesity -Physician order dated 9/1/21 for Finger Stick Blood Sugar Check once daily -Physician order dated 7/22/22 for the following medication administered at 8 AM: -Ferrous Sulfate 325 mg 1 at breakfast (anemia) -Escitalopram 20 mg 1 daily (anxiety) -B-12 1,000 Mcg 2 daily (supplement) -Glimepiride 2 mg 1 daily with breakfast (diabetes) -Atorvastatin 20 mg 1 daily (cholesterol) -Metformin Hcl 500 mg 2 bid (diabetes) -Benztropine MES (mesylate) 0.5 mg 1 bid (anti-tremor) -Omeprazole Dr 20 mg 1 bid (GERD) -Hydroxyzine HCL 25 mg 1 q am and 1 at bedtime as needed (anxiety) -Ventolin Hfa 90 mcg inhaler inhale two puffs every 4 as needed for wheezing (asthma) -Physician order dated 7/6/22 for the following medication administered at 8 AM: -Clotrimazole 1% topical cream apply bid (antifungal) Review on 8/3/22 of client #4's record revealed: - Admitted: 2/15/15 - Diagnoses: Schizophrenia, Hyperlipidemia and GERD -Physician order dated 8/20/21 for the following medication administered at 8 AM: -Docusate Sodium 100 mg 1 bid (stool softener) -Low Ogestrel 0.3 mg 1 daily (birth control) -Vyvanse 50 mg 1 every morning (attention deficit-hyperactivity disorder) -Levetiracetam 250 mg 1/2 tablet in the	V 118		

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V 118	Continued From page 4	V 118		

morning (seizures)
-Invega Er (extended release) 9 mg 1 in the morning (antipsychotic)
-Propranolol 20 mg 1 bid (hypertension)
-Benztropine Mes 0.5 1 bid as needed
-Omeprazole Dr 20 mg 1 daily before each meal as needed
-Physician order dated 2/23/21 for the following medication administered at 8 AM:
-Topiramate 100 mg 1 bid (seizures)
-Physician order dated 1/23/22 for the following medication administered at 8 AM and 2PM:

record it
- didn't check it at noon (on 7/24/22) because FS#3 wasn't there
- didn't know why FS#3 didn't check her noon sugars from 7/17/22-7/23/22

Interview on 8/3/22 the Qualified Professional (QP) reported:
- FS#3 had been trained in diabetes management and medication administration prior to hire and was aware that client #1's blood sugars were to be checked three times a day

Interview on 8/2/22 the Licensee reported:

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V 118	Continued From page 5 - unaware that FS#3 was not checking client #1's blood sugars from 7/17/22-7/23/22, as she received diabetes management training prior to hire B. Review on 8/3/22 of client #2's July 2022 MAR revealed: - the following were not initialed as having been administered for the 8 AM dose on 7/24/22: -Ferrous Sulfate 325 mg -Escitalopram 20 mg -B-12 1,000 Mcg -Glimepiride 2 mg -Atorvastatin 20 mg Review on 8/3/22 of the facility's Investigative Report (not dated) revealed: "...[client #2] information was most consistent in that she did go to church on that day and that she attempted to alert the staff that she was leaving for church. She indicated that she thought that she heard the staff person earlier that morning, but was unable to get her attention after knocking on the staff room door. She consistently stated that the staff did not come to the door to administer her medications..." [redacted] that she left at approximately 8:30 AM. She stated that she texted the administrator at the time and told her that she had to leave due to a family emergency. She indicates that her son had involved in an incident involving a gun and that she could only think about her son being injured and acted prematurely when she left the facility. She does admit that she doesn't remember whether she administered meds (medications) and accepts responsibility for that..." "...Outcome: The staff person clearly exercised	V 118		

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V 118	Continued From page 6 poor judgement by leaving the facility before ensuring that relief would be coming. She was a new hire (7/18/22). Although the QP (Qualified Professional) met with her to review treatment goals and supervision needs she did not process that she could not leave the clients unsupervised. This incident wasn't discovered until approximately 6:00 pm on Sunday July 25th when the person returning [client #1] to the facility realized that staff was not available at the facility to receive [client #1]. The police were called and remained with the clients until the administrator arrived at approximately 6:00 after receiving several calls about the the status of staff not being available at the home. The administrator provided coverage to the home on that evening and remained there until another staff person could relieve her the next day..." Interview on 8/2/22 client #2 reported: - FS#3 was at the facility on the morning of 7/24/22 until she left at 9:30 AM for church - FS#3 administered morning medications to her prior to her departure for church - got back from church at 4 PM and the Licensee was at the home when she arrived - recanted her statement and said she remembered FS#3 leaving before church and not administering her medications but did not remember what day that happened Interview on 8/2/22 client #4 reported: - was in her bed in her room in the basement the day FS#3 left them alone in the facility - didn't know what time the staff left - did not remember the last time she saw the staff, it was some time the night of 7/23/22 - didn't get her Sunday (7/24/22) morning medications because staff wasn't at the facility	V 118		

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V 118	Continued From page 7 Interview on 8/2/22 the Qualified Professional (QP) reported: - FS#3 left the facility on the morning of 7/24/22 and may have left between 8 AM and 8:30AM - FS#3 texted the Licensee at 8:30 AM and said she had an emergency, but she didn't say she was leaving the facility - FS#3 did not text or call the QP about the situation - client #2 told her that she knocked on the staff bedroom door and no one answered - client #2 told the QP she had not had her medications that morning prior to leaving for church - medications are administered by 8 AM - clients #1 and #4 were poor historians and have said they did not get their medications and then recanted and said they did receive their medications - believed none of the clients were administered 8 AM medications Interview on 8/2/22 the Licensee reported: - FS#3 did not follow protocol by only texting the Licensee and did not tell her in the message that she was leaving the facility - FS#3 left that morning between 8 AM and 8:30 AM. - aware of the incident around 3:30 PM when the police called her - administered the 2 PM medications after 4 PM when she arrived at the facility - according to client #1, they got their meds that morning before the staff left, but she was not sure that was correct. II. Examples of the MAR not kept current A. Review on 8/3/22 client #1's July 2022 MAR	V 118		

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V 118	Continued From page 8 revealed the following medications initialed for the 8 AM dose on 7/24/22 by the Licensee: -Glycopyrrolate 1 mg -Carvedilol 25 mg -no documentation on MAR to indicate medications had been given at any different time other than the scheduled 8 AM time listed B. Review on 8/3/22 client #2's July 2022 MAR revealed the following medications initialed for the 8 AM dose on 7/24/22 by the Licensee: -Metformin HCL 500 mg -Hydroxyzine HCL 25 mg -no documentation on MAR to indicate medications had been given at any different time other than the scheduled 8 AM time listed C. Review on 8/3/22 of client #4's July 2022 MAR revealed the following medication initialed by the Licensee on 7/24/22: -Levetiracetam 250 mg for the 8 AM dose -Topiramate 100 mg for the 8 AM dose -Carbamateprine 100 mg for the 2 PM dose - no documentation on MAR to indicate medications had been given at any different time other than the scheduled 8 AM and 2 PM times listed Interview on 8/3/22 the QP reported: - the Licensee contacted the pharmacy on 7/25/22 to report the missed medication dosages Interview on 8/4/22 the Pharmacist reported: - Licensee called the pharmacy on 7/25/22 and spoke to the pharmacist about the clients' missed medications on 7/24/22. - The pharmacy is closed on Sundays and was closed on 7/24/22 when the incident occurred. Interview on 8/2/22 the Licensee reported:	V 118		

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V 118	Continued From page 9 - arrived at the facility after 4 PM on 7/24/22 - administered 2 PM medications to client #1 and #4 after she arrived at the facility, sometime after 4 PM. - was not at the facility the morning of the incident, 7/24/22 and did not administer morning medications to clients - client #2 didn't return to the home until after 4 PM - she did not note any time changes in medication administration on the back of any of the MAR's - FS#3 was terminated on 7/24/22 Review on 8/8/22 of the Plan of Protection completed by the QP dated 8/8/22 revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care? The facility arranged training, which occurred on Saturday, August 6, 2022. The training was conducted by [pharmacy]'s RN (registered nurse). The training focused on documentation on the medication administration record. This included: how to document missed or late meds (medications), following the legend provided at the top of the MAR, documenting in the appropriate time slots, indicating when meds were not given as ordered by the prescriber, protocols to follow when meds are not given as prescribed, all medication orders are to be documented on the MARS (including PRN's, (as needed) blood pressure readings (or approved document), blood sugar readings (or approved document), etc.. appropriate follow up after administering a PRN and ensuring that all spaces on the MARs contain documentation on dates meds are given or missed. - Describe your plans to make sure the above happens. The RN provided the training and has agreed to	V 118		

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V 118	Continued From page 10 return to the group home unannounced to do a review of MARS, orders and medications by the end of this month. Additionally the administrator will check MARs monthly to ensure all documentation is present and follow protocols when it's not present, which might include additional training or disciplinary action. The QP has developed a shift exchange checklist which requires a review of all MARs prior to the exchange or the shift. This will be reviewed within 72 hours of a shift exchange." Clients whose diagnoses included Schizophrenia, Schizoaffective Disorder, Diabetes, Anemia, Asthma, GERD, and Obesity resided at the facility. The staff left the clients alone in the facility on the morning of 7/24/22 from 8:30 AM until after 4 PM. Some clients' medications were initialed as having been administered prior to staff leaving while others were not, however none of the clients were awake prior to staff leaving. The Licensee initialed as having administered some of the 8 AM and 2 PM medications to the clients sometime after 4 PM on 7/24/22 without documenting the late administration time on the MAR. Clients were inconsistent on whether the morning medications were administered, however, client #2's July 2022 MAR revealed no initials for some of her morning medications that day which included her Glimepiride for her diabetes. It is unclear if the clients received those medications and if so, who administered them. Client #1 had a physician order for blood sugar checks three times per day. Between 7/17/22-7/24/22 client #1's blood sugar was not checked 11 times. This deficiency 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		

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