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	MHL068-099	A. BUILDING: _____ B. WING _____	R-C 09/15/2022

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V 000	INITIAL COMMENTS A complaint and follow-up survey was completed on September 15, 2022. The complaints (intake #NC00192066 and #NC00192110) were substantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600C Supervised Living for Adults with Developmental Disabilities The facility is licensed for 6 and currently has a census of 4. The survey sample consisted of audits of 3 current clients.	V 000	RECEIVED OCT 2 0 2022 DHSR-MH Licensure Sect	
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	V 112	27G .0205 When a resident is non-compliant with the use of recommended safety equipment, the facility will address this by implementing strategies such as incentive plans, and will consult with other disciplines as needed for suppport. The success of the implemented strategies will be documented by support professionals and will be reviewed at least weekly by a QP.	9/11/2022

[redacted] RESENTATIVE'S SIGNATURE | TITLE: Director of Supported/Independent Living Services | (X6) DATE: 10/5/2022

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V 112	Continued From page 1 obtained. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to develop and implement strategies to address non-compliance of the use of safety equipment affecting one of three audited client (#1). The findings are: Review on 8/30/22 and 9/1/22 of Client #1's record revealed: -Admission date of 9/28/18. -35-years old. -Diagnoses of Moderate Intellectual Disability, Lennox-Gastaut Syndrome, Seizure Disorder and Idiopathic Urticaria. -Call Button implemented on 8/24/16. -Gait Belt implemented on 7/24/19. -Seizure Hat implemented on 1/12/22. -Started offering the use of a wheelchair on 3/25/22. -Vagus Nerve Stimulation (VNS) Magnet provided by Neurologist - was used for any fall or assumption the fall was a drop seizure. -Last visit with Neurologist on 7/20/22. -Quarterly Physical Therapist Appointment on 9/1/22. -Alarm on bed and wheelchair implemented on 9/1/22 per request of physical therapist. -Date of Discharge Letter was 8/1/22 for a planned dicharge on 9/30/22.	V 112		

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V 112	Continued From page 2 Review on 9/1/22 of Client #1's Individual Support Plan (ISP) dated 10/1/21 revealed: "-[Client #1] is diagnosed with a seizure disorder. Specifically, Lennox-Gastaut Syndrome. This is a seizure form of epilepsy that usually beings in early childhood. It is characterized by frequent seizures of multiple types, mental impairment, and a slow spike-and-wave pattern seen on an electroencephalogram (EEG) Atonic drop seizure intensity has increased over the last year causing more significant injuries with more sudden drops. -[Client #1] has shown to have different seizures and the most dangerous one for [Client #1] is the Atonic Seizure ('drop attacks' or 'drop seizures') which can be difficult to witness or identify as a seizure. Staff always need to be aware of this and monitor [Client #1]. When an atonic seizure happens, staff need to ensure [Client #1's] safety to prevent injuries and falls. -When [Client #1] has an atonic seizure, staff need to be aware that part or all of [Client #1's] body may become limp. [Client #1's] eyelids may droop, [Client #1's] head my nod or drop forward, and [Client #1] may drop things. If [Client #1] is standing, [Client #1] will often fall to the ground. These seizures typically last less than 15 seconds. Monitor [Client #1] for any injuries [Client #1] may have gotten from the fall. -[Client #1] has also experienced complex partial seizures which can have multiple possible symptoms. However, these symptoms may occur during one seizure and not another. Complete partial seizures normally last a few minutes ... -[Client #1] has a call button in [Client #1's] bedroom and [Client #1's] bathroom and wears a call button around her neck at home. The call button is used for [Client #1] to communicate with support staff to let them know [Client #1] is having	V 112		

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a seizure or that [Client #1] want to move about the home so staff can be within arm's reach of [Client #1]."
-The ISP did not have goals and strategies to address Client #1's non-compliance with use of safety equipment.

Review on 9/1/22 of Client #1's Incident Reports from February 2022 through August 2022 revealed:
-2/9/22 - "[Client #1] had a fall at 5:28 p.m., while standing in the dining room as [Client #1] was about to sit down for dinner. [Client #1] fell back and bounced off her bottom and hit the back of [Client #1's] head on the way down. [Client #1] did not lose consciousness at any time throughout the event. [Former Staff #3] (FS) was closest to [Client #1] and went to [Client #1's] side to offer assistance. [Client #1] was able to get up off the floor within 5 minutes of the event and of [FS#3] swiping [Client #1's] magnet over [Client #1's] chest. [Client #1] was offered an icepack to use on the back of [Client #1's] head which [Client #1] refused. [Client #1] was in good spirits for the rest of the night and sat in the living space with the other residents ..."
Plan of Future Corrective Actions: none indicated.
-3/16/22 - "[Client #1] got on the treadmill around 6:30 p.m. without notifying staff. While on the treadmill one of [Client #1's] housemates turned the treadmill speed all the way up resulting in [Client #1] falling. Both [Former Staff #2] and [FS #3] came running when they heard [Client #1] yelling and the treadmill making noise. [FS#3] immediately unplugged the treadmill to stop it. When [Client #1] fell she [Client #1] hit her chin which resulted in [Client #1] chin being swollen and also having a bruise. [Client #1] did refuse an icepack but did take Tylenol.
Plan of Future Corrective Actions: [Client #1] will

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V 112	Continued From page 4 notify staff before getting on the treadmill." -3/24/22 - "[Client #1] was at the joy prom and had a drop fall seizure and hit her head really hard. [FS#2] contacted 911 and another staff member contacted the [On-call Supervisor] (OCS) and the [OCS] contacted the [Director of Supported-Independent Living Services/Qualified Professional] (D/QP) and [Client #1's] mom. [Client #1's] mom refused to have [Client #1] treated and transported. [Client #1] had a lump the size of an apple on the back of [Client #1's] head and [Client #1's] who body was shaking. Plan of Future Correction Actions: Staff will continue to prompt [Client #1] to wear [Client #1's] seizure hat, use a wheelchair, wear [Client #1's] gait belt and have someone walk side by side with [Client #1]." -5/6/22 - "[Supervisor] received a call from [Human Resource Director] (HRD) who is helping at Hamilton at that time that [Client #1] had a fall seizure in the dining room. [HRD] informed [Supervisor] that [Client #1] has [Client #1's] safety hat and her gait belt on. No injuries and [HRD] used [Client #1's] (VNS) on [Client #1]. [HRD] informed [Supervisor] that [Client #1] also had a seizure with [Client #1's] mom in the car after [Client #1's] doctor's appointment before coming back to the group home. Plan of Future Correction Actions: Staff will continue to try to be with [Client #1] in close proximity." -5/11/22 - "[Client #1] had a drop fall seizure. [FS #2] used the VNS magnet. [Client #1] sat on the ground for about ten minutes until [Client #1] was ready to get up and then staff assisted [Client#1] with getting up ... Plan of Future Corrective Actions: Staff will continue to try and remain in close proximity with [Client #1] and continue to monitor [Client #1]." 5/12/22 - "[Client #1] had a drop seizure in the	V 112		

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V 112	Continued From page 5 kitchen at 3:54 pm this afternoon. [Client #1] remained conscious directly after the event. [Staff #4] was standing next to [Client #1] when the event occurred and observed [Client #1's] fall face forward towards the hallway in the kitchen. [Client #1] was wake and alert, however remained on the floor in the same position for 25 minutes. [Staff #4] sat next to [Client #1] on the kitchen floor and called the [OCS] to inform [OCS] of the situation. [Staff #4] assisted [Client #1] into a sitting position 25 minutes after the fall and noticed [Client #1] had a large bump on [Client #1's] forehead. [Client #1] was wearing [Client #1's] seizure hat and had a bump directly behind the rim of the hat on her forehead. There was a cut on [Client #1's] forehead that had bled during the initial fall. [Staff #4] sent the [OCS] pictures of the injury at which point it was determined appropriate call to 911. 911 arrived, assessed [Client #1] and took [Client#1] via ambulance to the [Hospital]. Followed up Comments: [D/QP] have reviewed this approved report. [Client #1] had two lacerations on [Client #1's] forehead. [Client #1] was transported to the [Hospital] by emergency medical services and [FS#2] accompanied [Client#1]. At the ED (Emergency Department), ED looked at [Client #1's] injuries and applied 3 stitches to the laceration on [Client #1's] right brown bone and the ED applied glue to another smaller laceration nearby. ED also did a heat Computer Tomography (CT) scan and saw no abnormalities. [Client #1's] stitches will need to be removed in a week which can be done at an [Hospital] Urgent Care office by [Nurse Practitioner] (NP). The sutures were removed on 5/19/22 at [Hospital] Urgent Care. There was redness still around the wounds so the [NP] recommended [Client #1] use mupirocin on the wounds three times a day for 7 days. The	V 112		

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V 112	Continued From page 6 wounds were resolved after mupirocin treatment." -7/24/22 - "When staff turned around [Client #1] was laying on her back with her head on the porch rail. [Supervisor] inform [Staff #5] who was here from [sister facility] to give a resident a PRN (as needed) and the other staff that [Client #1] had fallen. [Supervisor] felt the back of [Client #1's] head. [Client #1] had a large knot on the back of [Client #1's] head. [Supervisor] asked [Client #1] if [Client #1] was able to get up without assistance. [Client #1] shook her head, indicating [Client #1] could not. [Supervisor] asked [Client #1] if [Client #1] was in pain. [Client #1] replied, "yes." [Supervisor] asked staff to call 911. [Supervisor] was informed that we [Supervisor] and [Staff #5] cannot call 911, but that [Supervisor] and [Staff #5] had to call the [OCS] who then had to obtain permission from [Client #1's] mother before [Supervisor] and [Staff #5] could call 911. The [OCS] was called who talked with [Client #1] for about 20 minutes. [Supervisor] sat with [Client #1]. [Supervisor] tried to apply an ice pack on the back of [Client #1's] head, but [Client #1] refused ... The [OCS] came and assessed [Client #1's] injury. [OCS] then communicated to [Supervisor] that [OCS] had spoken with [Client #1's] mother about what [OCS] observed. [Client #1's] mother said she did not want [Client #1] to go to urgent care or for [OCS] and [Supervisor] to call 911, but instead, [Client #1's] mother wanted ice to be applied to [Client #1's] head. [Supervisor] continued to monitor [Client #1] until the end of [Supervisor's] shift. Plan of Future Corrective Actions: Staff will ensure that [Client #1] is using all [Client #1's] safety equipment to prevent [Client #1] from getting hurt." -8/22/22 - "[Client #1] was in the living room when [Client #1] tripped and fell. [Client #1] did not hit	V 112		

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anything and [Supervisor] assisted [Client #1] to get up. [Supervisor] assessed [Client #1] for any pain. [Client #1] was receptive and conscious during the time. [Supervisor] offered [Client #1] the wheelchair and reminded [Client #1] that it will be safer for [Client #1] if [Client #1] stays in the wheelchair.
Plan of Future Corrective Actions: Staff will continue to monitor [Client #1] and encourage [Client #1] to sit in the wheelchair."
-8/30/22 - [Staff #4] was in the medication room preparing [Client #1's] medication as [Staff #4] had just left [Client #1's] room after informing [Client #1] it was [Client #1's] medication time. [Staff #4] heard a loud thump in the vicinity of the kitchen and went out to investigate. At 7:12 p.m. [Staff #4] found [Client #1] laying flat on [Client #1's] back on the floor in front of the pantry door. Initially [Staff #4] thought [Client #1] had a seizure however now believes [Client #1] slipped on the floor in [Client #1's] socks. [Client #1] did not lose consciousness and stayed alert during the 4 minutes on the floor. [Staff #4] wiped [Client #1's] magnet over [Client #1's] heart without the usual refusal from [Client #1]. [Staff #4] asked [Client #1] to let her know when [Client #1] was ready to get up so [Staff #4] could assist and administer medication. [Client #1] stated [Client #1] was ready and allowed [Staff #4] to help [Client #1] up. [Staff #4] had a hard time getting [Client #1] off of the floor as [Client #1] was in socks and could not get a grip on the floor to stand up. [Staff #4] and [Client #1] even joked that [Client #1] was ice skating on the kitchen floor. [Staff #4] informed [Supervisor] and then administered [Client #1's] medication. [Client #1] remained in a positive mood with no signs of distress or discomfort.
Correction Actions Taken: [Client #1] was assessed for injury. No visible injury was noted. When asked if [Client #1] had pain, [Client #1]

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V 112	Continued From page 8 stated no. [Client #1] did not report pain when staff pressed on the areas of her body that had made contact with the floor. [Supervisor] was contacted and notified [Client #1's] legal guardian. [Client #1's] legal guardian asked that [Client #1] be seen at the emergency room. 911 was called and [EMS] assessed [Client #1] then transported [Client #1] to the [Hospital]. The doctor reviewed history, the event, listened to [Client #1's] heart and lungs, checked her muscles, range of motion and extremities. [Client #1] had no concerns. The triage team had also ordered x-rays which were completed. The x-rays were negative for injury. Plan of Future Corrective Actions: Staff will continue to encourage [Client #1] to wear shoes around the house as well as her seizure helmet, and gait belt. Staff will also continue to encourage [Client #1] to stay seated and use her wheelchair when moving around the home." Attempted interviews on the morning of 8/30/22 and 9/1/22 with Client #1. Client #1 was sitting in her wheelchair with her safety equipment on. Client #1 did not want to talk to surveyor. Interview on 8/31/22 with Client #1's Guardian revealed: -She was client #1's mother and guardian. -Client #1 functioned like a 4-year-old. -During falls she learned client #1 either did not wear her seizure hat, gait belt or was in a wheelchair. -"It's not all refusal; these are professionals that should help with that and felt they did not bother." -Client #1 had a physical therapist on staff. -Physical therapist issued a safety policy. -He offered to trained staff on safety with the increase seizures. -It was to teach staff to walk with client #1 with the	V 112		

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gait belt.
-She felt client #1 did not refuse to wear safety equipment.
-She asked staff to call her if client #1 refused to wear her safety equipment.
-Client #1 told her she wore her safety equipment and sat in the wheelchair.
-During prom client #1 had a fall and was not wearing her safety equipment.
-She emailed the Supervisor before the prom asking to bring a wheelchair.
-The wheelchair was not brought to the prom until speaking with the Executive Director.
-She felt having the wheelchair would have prevented falls.
-Admitted that she refused EMS transport because she wanted client #1 to stay at the prom.
-Client #1 "has a right to have fun."
-Confirmed staff contacted her anytime client #1 fell and had injuries.
-She determined whether or not client #1 should go to the hospital for injuries due to a fall.
-Client #1 needed guidance.
-The facility did not offer any other options.
-She was willing to move client #1.
-She reported the Executive Director asked her "why don't they take (client #1) out."
-She tried to resolve issues with the facility.
-There was no other place to put client #1.
-Client #1 needed 24-hour care.
-The facility was unable to care for client #1.
-Local Management Entity/Managed Care Organization (LME/MCO) offered the facility an enhanced rate for one-on-one services and the facility rejected it.
-This occurred around April 2022.
-LME/MCO did not address issue any further.
-During meeting on 7/25/22 it was agreed client #1 needed level IV support.
-She received a 60 days discharge letter from the

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V 112	Continued From page 10 Director via email on 8/1/22. -She currently had a few options for placements. Interview on 8/30/22 with Staff #4 revealed: -She worked Tuesday, Thursday and Friday. 7-10 a.m.; 3-8 p.m. and as needed. -Client #1 often refused to sit in the wheelchair and put on her seizure hat. -Client #1 would wear her gait belt. -Client #1 liked to walk. -It was difficult to keep client #1 in the wheelchair. -Client #1 used the wheelchair due to drop seizures. -A few times while she worked client #1 had a seizure. -Client #1's mother wanted her to be in the wheelchair to prevent falls. -Client #1 had to use wheelchair or ask staff to walk with her. -Client #1 had to wear gait belt and seizure hat all day until bedtime. -Client #1 did not have a walker. -There were no triggers or clues to when the seizures occurred. -Client #1 did not use the call button for its purpose. -Client #1 would walk around without first asking for staff support. -Client #1 was getting better at wearing her gait belt. Interview on 8/30/22 with Staff #5 revealed: -She worked 3rd shift with some flexibility in the morning. -Worked Monday night to Thursday night. -Client #1 could walk but needed assistance to prevent falls. -Seizures were happening more often. -Client #1 had to wear a gait belt and seizure hat. -Client #1 should wear the gait belt and hat every	V 112		

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V 112	Continued From page 11 day. -Client #1 did not like to be in the wheelchair. -Client #1 did not use the call button when she wanted to move around. -Client #1 would refuse to wear her seizure hat and sit in the wheelchair. Interview on 9/1/22 with the Group Home Supervisor revealed: -She worked all shifts and provided supervision. -Staff received training with physical therapist on 4/8/22 and 6/24/22. -Training was to help staff provide support for client #1. -Client #1's appointment was on 9/1/22 with physical therapist due to the last 2 falls possibly unrelated to seizures. -Client #1 often refused to wear and use her safety equipment. -Staff encouraged client #1 to use the safety equipment all the time. -Client #1 did not like the wheelchair. -The day of the prom client #1 did not want to wear her safety equipment with her prom dress. -She never received an email from client #1's guardian before the prom outing requesting to bring a wheelchair. -Client #1 did not start using the wheelchair everyday until after the prom incident. -Client #1 was to wear and use her safety equipment from morning until bedtime. -Client #1 was not wearing all of her safety equipment during any of the iincidents. Interview on 8/30/22, 9/1/22 and 9/6/22 with the Director of Supported-Independent Living Services revealed: -There were two staff on shift. -One third shift overnight was a sleep staff. -Client #1 had to use safety equipment from the	V 112		

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V 112	Continued From page 12	V 112		

morning until bedtime.
-Safety equipment was implemented during different stages of treatment.
-Client #1 did not use the call button to request for help to move around.
-Client #1 used the call button for unrelated purposes.
-Client #1 would often refuse to wear her seizure hat and did not like the wheelchair.
-Client #1 would wear her gait belt.
-Incident on the treadmill client #1 did not use the call button to request for staff's help.
-Client #1 was not supposed to use the treadmill without staff supervision.
-The day of the prom client #1 refused to wear her safety equipment with her prom dress.
-Staff had to continuously encourage client #1 to use her safety equipment.
-During some incidents client #1 was not in a wheelchair or had on her safety equipment.
-The call button sound was a chime which would alert staff that client #1 needed support.
-Client #1 met with her physical therapist on 9/1/22 for falls that occurred in August 2022.
-New intervention added on 9/1/22 for an alarm after appointment with the physical therapist.
-The physical therapist recommended an alarm to be placed on client's bed and on her wheelchair.
-The purpose of the alarm was to alert staff when client #1 stood up from her bed and wheelchair.
-All staff that worked with client #1 were trained to work in the group home.
-Client #1's mother did not communicate with the facility as much.
-Client #1's mother managed grievances with other agencies rather than the facility.
-Early in the year in April 2022, they discussed changes in client #1's environment with care coordinator.
-They provided support to find client #1 an

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V 112	Continued From page 13 environment with more medical support and smaller setting. -Client #1's mother was open to what they would locate. -They were unable to identify a location to move client #1. -Client #1's mother was not opened to discussion regarding other options. -Providing support to client #1 was difficult and complex. -Client #1 refused to eat, take medication and refused to wear safety equipment. -Staff would follow client #1 around the house with the wheelchair because she refused to use it. -It was times client #1 had the seizure hat on but would push it back from her forehead which caused injuries if she fell. -Client #1 was offered her seizure hat every day. -Around the house client #1 wanted to take off the hat and did not want to put it on. -Client #1 would wear her seizure hat when she left the house. -The issue was discussed with client #1's mother. -Client #1's mother told the facility they needed to make her wear it. -"Staff had to give client #1 the space she was asking for." -Client #1 had a history of being aggressive. -They would offer client #1 to put on the seizure hat but she often refused. -Client #1 immediately removed the gait belt when she returned home from program. -She provided client #1's mother a 60 days discharge notice August 1, 2022 due to the inability to keep her safe. -RSI was no longer able to keep client #1 safe. -RSI did not provide 1:1 services. -Client #1's last day at the group home would be September 30, 2022.	V 112		

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V 112	Continued From page 14 -The agency would hire a company to provide one-on-one 24 hours 7 days a week service until discharge. Review on 1/27/22 of the Plan of Protection written by the Director of Supported-Independent Living Services dated 9/6/22 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? Resident's LRP (Legally Responsible Person) and Alliance Health were notified on August 1, 2022 that she will be discharged from RSI-Hamilton on September 30, 2022. RSI shared on August 1, 2022 and has continued to share with Alliance Health that it is our strong recommendation to immediately find this individual a more appropriate placement that can guarantee her safety. On Thursday, September 1, a floor alarm was installed at resident's bed and a chair alarm was put in place for resident wheelchair and any other chair client uses. These alert support professionals when she gets up from bed or out of her chair so they can respond quickly to provide contact guarding assistance while she ambulates or until she is seated again. RSI is also working with Alliance to secure 1:1 24/7 support (and arms-length supervision) to maintain her safety until she moves out of the facility. Describe your plans to make sure the above happens. QP has provided training to support professionals on the floor alarm and chair alarm. QP will provide training to new employees as needed before resident moves out. RSI found and arranged for the additional 1:1 staffing support to	V 112		

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V 112	Continued From page 15 start as early as Sept 4, 2022, and RSI has agreed to cover the full costs of any additional 1:1 staffing support while knowing the costs will not be fully reimbursable." Client #1 is a 35-year-old woman diagnosed with Moderate Intellectual Disability, Lennox-Gastaut Syndrome Seizure Disorder and Idiopathic Urticaria. From 2/2022 to 8/2022 client #1 had 9 fall incidents with one resulting in stitches and others with knots, bumps and bruises on the head and face. Safety equipment including a seizure hat, gait belt, wheelchair and a call button in her bedroom, bathroom and around her neck was implemented to prevent falls and injuries. However, client #1 often refused to wear, use or would take off the safety equipment that resulted in injuries during falls. In addition, after client #1's appointment with her physical therapist on 9/1/22 an alarm was installed on her bed and wheelchair. The alarm would alert staff that client #1 stood up. During a meeting in April 2022 with client #1's care coordinator, the facility suggested a medical setting or smaller environment to best serve her increased medical needs. Since there were no potential placements the facility provided client #1 guardian a 60 days discharge noticed on August 1, 2022. Client #1's discharged date is September 30, 2022. The facility failed to develop strategies to address client #1's non-compliance in using safety equipment to keep her safe. 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	V 112		

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V 112	Continued From page 16 compliance beyond the 23rd day.	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 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	27G .0209 The facility will ensure that resident medications are administered as ordered by the physician. Medication orders will be received by the facility prior to administering a medication. Support professionals will administer medications as written on the MAR and as trained by the facility. The QP will monitor medication administration and documentation at least weekly.	9/23/2022

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V 118	Continued From page 17 This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure medications were administered as ordered by the physician for one of three audited clients (#1). The finding are: Review on 8/30/22-9/1/22 of Client #1's record revealed: -Admission date of 9/28/18. -Diagnoses of Moderate Intellectual Disability, Lennox-Gastaut Syndrome, Seizure Disorder and Idiopathic Urticaria. Review on 8/30/22-9/1/22 of Client #1's physicians orders revealed the following: -1/2822 - Epidiolex Sol 100mg/ML - take 5.75 ML (575) by mouth twice a day. -1/12/22 - Felbamate Tag 600mg - take one tablet by mouth twice a day. -1/21/22 - Senna Tab 8.6mg - take one tablet by mouth every day. -1/28/22- Melatonin 3mg Tab - take one tablet by mouth at bedtime. -1/28/22 - Citalopram 10mg Tab - take 3 tablets (30mg) by mouth every day. -1/28/22 - Levocarnitine 330mg Tab - Take one tablet by mouth twice a day. -1/28/22 - Docusate SOD Cap 100mg - take one capsule by mouth every day. -9/13/21 - Clobazam 10mg Tab - take one tablet by mouth twice a day. -1/28/22 - Divalproex 375mg - take two tablets in the a.m. and 3 tablets at night. -1/28/22 - Nortel Tab 1/35 - take one tablet by mouth once daily. -2/23/22 -Rogaine MENS AER 5% - Provide ½ capful topically once as directed.	V 118		

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V 118	Continued From page 18 Review on 8/30/22-9/1/22 of Client #1's Medication Administration Record for March 2022-July 2022 revealed blanks on the following dates: March 2022: -Epidiolex Sol 3/13/22, 3/14/22, 3/19/22-3/24/22 and 3/27/22 a.m. 3/6/22, 3/14/22, 3/18/22 and 3/19/22 p.m. -Felbamate 3/14/22, 3/19/22 - 3/23/22 a.m. 3/12/22, 3/18/22/, 3/19/22, 3/20/22 and 3/27/22 p.m. -Senna 3/7/22, 3/8/22 and 3/19/22 - 3/23/22 a.m. -Melatonin 3/5/22, 3/6/22, 3/12/22, 3/13/22, 3/14/22, 3/18/22 and 3/19/22 p.m. -Citalopram 3/14/22, 3/18/22, 3/19/22, 3/20/22 and 3/24/22 p.m. -Levocarnitine 3/9/22, 3/14/22, 3/15/22, 3/16/22, 3/19/22, 3/20/22, 3/21/22, 3/22/22 and 3/23/22 a.m. 3/18/22, 3/19/22 and 3/31/22 p.m. -Nortel 3/14/22, 3/19/22, 3/20/22, 3/21/22, 3/22/22, 3/23/22, 3/26/22 and 3/27/22 a.m. -Docusate 3/14/22. 3/19/22, 3/20/22, 3/21/22, 3/22/22, 3/23/22 and 3/27/22 a.m. -Clobazam 3/14/22. 3/19/22, 3/20/22, 3/21/22, 3/22/22, 3/23/22 and 3/27/22 a.m. 3/18/22, 3/19/22 and 3/20/22 and 3/31/22 p.m. -Divalproex 3/14/22. 3/19/22, 3/20/22, 3/21/22, 3/22/22, 3/23/22 and 3/27/22 a.m. 3/18/22, 3/19/22 and 3/20/22 and 3/31/22 p.m. -Rogaine 3/1/22 through 3/31/22. April 2022: -Nortel 4/1/22, 4/2/22, 4/3/22, 4/4/22, 4/5/22,	V 118		

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V 118	Continued From page 19 4/6/22, 4/7/22, 4/8/22, 4/9/22, 4/10/22, 4/11/22, 4/12/22 and 4/13/22 a.m. -Levocarnitine 4/1/22, 4/10/22 a.m. 4/12/22, 4/2/22, 4/30/22 a.m. -Rogaine 4/1/22 through 4/30/22. May 2022: -Rogaine 5/2/22-5/12/22, 5/14/22, 5/15/22, 5/16/22, 5/17/22, 5/18/22, 5/20/22, 5/21/22, 5/24/22, 5/25/22, 5/26/22, 5/27/22, 5/28/22, 5/30/22 and 5/31/22. July 2022: -Citalopram 7/29/22 p.m. -Melatonin 7/29/22 p.m. -Clobazam 7/29/22 p.m. -Divalproex 7/29/22 p.m. Review on 9/7/22 of www.wedmd.com revealed: -Epidiolex Sol - used to treat seizures. -Felbamate - used to treat seizures. -Senna - used to treat constipation. -Melatonin - used to for sleep. -Citalopram - used to treat depression. -Levocarnitine - used to prevent and treat a lack of carnitine. -Nortel - used for birth control. -Docusate SOD - used to treat constipation. -Clobazam - used to help control seizures. -Divalproex - used to treat seizures (epilepsy). -Rogaine MENS - used to help hair growth. Attempted interview the morning of 8/30/22 and 9/1/22 with Client #1. Client #1 was sitting in her wheelchair with her safety equipment on. Client #1 did not want to talk to surveyor. Interview on 8/30/22 with Staff #5 revealed: -She worked 3rd shift with some flexibility in the morning. -Worked Monday night to Thursday night.	V 118		

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V 118	Continued From page 20 -She went for retraining with medication administration on 6/18/22 -Admitted that she left blank spaces on the MAR. -Reported feeling overwhelmed because she just started school. -Client #1 either refused medication or she forgot to document after administering meds. Interview on 9/6/22 with the Director of Supported-Independent Living Services revealed: -Learn of medication errors from client #1's mother and staff. -Client #1's mother found errors with medication versus orders. -She conducted an internal investigation. -Confirmed medication was administered unless client#1 refused. -There were different staff that did not complete MAR's correctly. -MAR's that was left blank occurred under staff #5. -Staff #5 was suspended for 3 weeks until retrained. -Supervisor was responsible for ensuring the MAR's were completed correctly. -All Staff received training on medication procedures on 4/27/22 with a Registered Nurse. -Staff received PRN medication procedure training on 4/29/22 with the Director/QP. -Protocol would be to retrain staff for medication errors -Medication administration training was available monthly.	V 118		