STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL096-277	A. BUILDING: _____ B. WING _____	R 02/09/2023

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RENU LIFE EXTENDED INC	201 WINDSOR CREEK PARKWAY GOLDSBORO, NC 27530

(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 February 9, 2023. The complaint was substantiated (intake #NC00194594). 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 24 and currently has a census of 21. The survey sample consisted of audits of 3 current clients.	V 000		
V 105	27G .0201 (A) (1-7) Governing Body Policies 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (1) delegation of management authority for the operation of the facility and services; (2) criteria for admission; (3) criteria for discharge; (4) admission assessments, including: (A) who will perform the assessment; and (B) time frames for completing assessment. (5) client record management, including: (A) persons authorized to document; (B) transporting records; (C) safeguard of records against loss, tampering, defacement or use by unauthorized persons; (D) assurance of record accessibility to authorized users at all times; and (E) assurance of confidentiality of records. (6) screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility	V 105		

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V 105	Continued From page 1 can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations; (7) quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges: (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice. For this purpose, "applicable standards of practice" means a level of competence established with reference to the prevailing and accepted methods, and the degree of knowledge, skill and care exercised by other practitioners in the field;	V 105		

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V 105	Continued From page 2	V 105		

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews the facility failed to implement a written policy for adoption of standards of practice related to medication cart security. The findings are:

Review on 2/09/23 of the facility's "Medication Storage" policy last revised 4/24/02 revealed:
- "Policy: It is the policy of ReNu Life to maintain a secured area to store all medications for the residents of the facility."
- "Procedure: Medication will be stored in a locked, clean, well-lit area between 59 and 86 degrees Fahrenheit."

During interview on 2/09/23 staff #1 stated:
- She left the medication cart unlocked with the drawer open.
- She "forgot to push the button" to lock the medication cart when she walked away from it; she could not recall where she went or what she was doing.

During interview on 2/09/23 staff #2 stated:
- Medication Aides were trained to push the medication cart from room to room when administering medications and to make sure all drawers were closed and the cart securely locked if it was necessary to leave it unattended.

During interviews on 2/08/23 and 2/09/23 the Resident Care Coordinator stated:
- It was not acceptable practice to leave the medication cart unlocked and open when not in

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V 105	Continued From page 3 use. - She would emphasize to the Medication Aides the importance of ensuring the medication cart is securely locked when not in use. During interview on 2/09/23 the Program Director stated: - The facility had a policy regarding secure storage of medications. - On 2/08/23 she entered a memorandum into the facility's electronic record system reminding staff of the importance of securing the medication cart when it was not in use.	V 105		
V 120	27G .0209 (E) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments.	V 120		

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V 120	Continued From page 4 This Rule is not met as evidenced by: Based on observations, record review and interviews the facility failed ensure medications were securely locked. The findings are: Observation on 2/08/23 at 10:20 am revealed an unattended, unlocked medication cart with the third drawer open; the open drawer contained medications for 12 clients. The medications included clozapine (anti-psychotic), propranolol (anxiety and migraine headaches), risperdal (anti-psychotic), trazodone (insomnia), baclofen (muscle spasticity), fluphenazine (anti-psychotic), gabapentin (seizures and neuropathy), Viibryd (major depressive disorder), and olanzapine (antipsychotic). No staff were in the immediate vicinity of the medication cart; an unidentified client was observed within 12 feet of the unattended, unlocked, and open medication cart. The Resident Care Coordinator was observed to call the first name of staff #1 and staff #1 was observed to approach the medication cart from a closed room. Observation on 2/09/23 at 1:18 pm revealed the medication cart also contained the following: - Top drawer: glucometer supplies and insulin pens for two clients. - Second drawer: bubble cards of medications that were delivered within the week, topical treatments, and over the counter medications. - Third drawer: "smart packs" (plastic packaging with medications contained in small pockets for each administration time), medication bubble cards, and liquid medications for 12 clients. - Fourth drawer: "smart packs" for 5 clients, prescription shampoos, and house stock	V 120		

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V 120	Continued From page 5	V 120		

medications such as over the counter antacid tablets.
- Smaller drawers on the left side of the medication cart included:
- Top drawer: scissors, ink pens, tape, and other miscellaneous items used by staff.
- Second drawer had a separate lock and contained control drugs in bubble cards and a bottle of liquid modafinil (treats narcolepsy).
- Third drawer contained medications obtained through the Veteran's Administration for one client.
- Fourth drawer contained medications obtained through the Veteran's Administration for two clients.

During interview on 2/09/23 staff #1 stated:
- As a Medication Aide she was responsible for administering medications and administered medications on 2/08/23.
- She left the medication cart unlocked with the drawer open.
- She "forgot to push the button" to lock the medication cart when she walked away from it; she could not recall where she went or what she was doing.
- Medication Aides were "not supposed to leave the cart" unsecured.
- She may have left the medication cart unlocked and unattended "a time or two" in the past.

During interview on 2/09/23 staff #2 stated:
- She was a Medication Aide and was responsible for administering medications and providing client care.
- Medication Aides were trained to push the medication cart from room to room when administering medications and to make sure all drawers were closed and the cart securely locked if it was necessary to leave it unattended.

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V 120	Continued From page 6 During interviews on 2/08/23 and 2/09/23 the Resident Care Coordinator stated: - The medication cart was unattended and unlocked with an open drawer on 2/08/23 at 10:20 am. - "I tried" to close the open medication cart drawer before the surveyor observed it to be open. - The open drawer contained medications for 12 clients. - The drawers that contained controlled medications, such as Ambien (insomnia), lorazepam (agitation), and alprazolam (anxiety) had a separate lock. - The main drawers could be unlocked, but the controlled medication drawers had to be unlocked separately. - She did not know why the medication cart was left unattended and unlocked with an open drawer. - She would emphasize to the Medication Aides the importance of ensuring the medication cart is securely locked when not in use. During interview on 2/09/23 the Program Director stated: - Staff should never leave the medication cart unattended when it was in use. - The facility had a policy regarding secure storage of medications. - On 2/08/23 she entered a memorandum into the facility's electronic record system to remind staff of the importance of securing the medication cart when it was not in use. Review on 2/09/23 of the Plan of Protection dated 2/09/23 written by the Program Director revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care?	V 120		

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V 120	Continued From page 7 A memo was sent out immediately explaining the importance of keeping the cart locked @ (at) all times and the consequences of the cart being left unlocked. A training will be done by Feb. (February) 28th for all staff regarding medication admin (administration) & (and) regulations. The supervisor of the cart will check the cart daily to ensure it is locked & closed." - "Describe your plans to make sure the above happens. Director of Programs will meet with the cart supervisor weekly to ensure the cart is being monitored as it should. Each weekly meeting will be documented." The facility served adult clients diagnosed with traumatic brain injury but who had other diagnoses including dementia and history of substance abuse. The medication cart was observed to be unattended and unlocked with an open drawer that contained various anti-psychotics and anti-depressants as well as numerous medications for physical medical needs; a client was observed within 12 feet of the open medication cart. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $3000.00 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 compliance beyond the 23rd day.	V 120		