STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411161	A. BUILDING: _____ B. WING _____	R-C 03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHANGING LIVES GROUP HOME IV, LLC	1404 CUSHING STREET GREENSBORO, NC 27405

(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 March 21, 2023. The complaint was unsubstantiated (intake # NC00199283). 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 2. The survey sample consisted of audits of 2 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		

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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 reviews, interviews and observations, the facility failed to ensure medications were administered on the written order of a physician affecting 1 of 2 clients (client #2). The findings are: Review on 3/21/23 of client #2's record revealed: -Date of Admission: 12/1/20 -Diagnoses: Disruptive Mood Dysregulation Disorder; Attention Deficit/Hyperactivity Disorder, combined type; Pervasive Developmental Disorder; Impulse Control and Conduct Disorder; Mild Intellectual Disability; Obesity. -Physician order dated 1/24/23 for Linzess 290 microgram, take one capsule by mouth once daily for irritable bowel. Observation on 3/9/22 at 1:10 pm of client #2's medications on hand revealed: -Linzess 290 mcg was not available for administration; -All morning medications were package together in bubble packs; -Linzess was not identified on the package as a medication in the bubble packs; -No separate package or bottle found of Linzess.	V 118		

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V 118	Continued From page 2 Review on 3/9/22 of client #2's MAR for the month of March 2023 revealed: -Linzess was documented as being administered daily 3/1/23 through 3/9/23. Interview on 3/9/23 with client #2 revealed: -Staff administered his medicine daily. Interview on 3/9/23 with staff #2 revealed: -Was unaware Linzess was not available for administration; -"I usually check the individual medications once received but on Monday (3/6/23), I was ready to leave; -I did not check the new order of medications that were received from the pharmacy." Interview on 3/13/23 with the Qualified Professional revealed: -Was unaware of client #2 not having his Linzess medication; -"I last reviewed medication in January to my knowledge. I don't have my calendar with me; -I review meds (medications) but not that often. I try to review quarterly and the pharmacy also completes medication reviews onsite at the facility."	V 118		
V 132	G.S. 131E-256(G) HCPR-Notification, Allegations, & Protection G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (g) Health care facilities shall ensure that the Department is notified of all allegations against health care personnel, including injuries of unknown source, which appear to be related to any act listed in subdivision (a)(1) of this section.	V 132		

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V 132	Continued From page 3 (which includes: a. Neglect or abuse of a resident in a healthcare facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided. c. Misappropriation of the property of a healthcare facility. d. Diversion of drugs belonging to a health care facility or to a patient or client. e. Fraud against a health care facility or against a patient or client for whom the employee is providing services). Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department. This Rule is not met as evidenced by:	V 132		

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V 132	Continued From page 4 Based on record reviews and interviews, the facility failed to ensure the Health Care Personnel Registry (HCPR) was notified of all allegations against facility staff and also failed to ensure the results of the investigations were reported to HCPR within five working days of the initial report affecting 1 of 2 staff (staff #1). The findings are: Record review on 3/13/23 of the facility's internal investigation dated 3/6/23 revealed: -The allegation made by client #1 that staff #1 hit him in the eye was not reported to HCPR. Interview on 3/8/23 with client #1 revealed: -Did not get hit anywhere else and staff #1 did not choke him; -"I did bang my head against the concrete outside but I don't know why I did that;" -Client #1 could not provide details about what happened prior to staff #1 hitting him; -He jumped out of his window to get away from him (staff #1); -Staff #1 had never hit him before this incident. Interview on 3/15/23 with staff #1 revealed: -"Never hit or choked [client #1]; -I really don't know what happened. The kids (clients) were at the table eating and [client #1] got up from the table; " -"[Client #2] came to me and said 'I think you need to talk to [client #1] as he got up from the table and he seemed angry;'" -Client #1, told him (staff #1) that client #2 tried to touch him but did not explain where he attempted to touch him; -He asked for client #2's and client #1's tablets because they are supposed to turn their tablets in by a certain time; -Client #1 hit the wall, flipped his bed over, threw two shoes at him, and said he was going to kill	V 132		

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V 132	Continued From page 5 client #2; -"[Client #1] said f**k it, I'm out of here, lifted the blind, the window, and went out the window;" -Client #1 walked up to the facility's car and started hitting the car; -Client #1 said that he was not getting into the car with client #2; -[Client #1] tried to kick me, I got his hands behind his back to restrain him. -"[Client #1] tried to bite my ankle. I walked away to get my phone to call the police; -[Client #1] looked at me and started beating his head against the concrete curve; -I put [client #1's] hands behind him; -I bent [client #1's] knee to sit him down on the ground; -[Client #1] was still fighting and I released him." Interview on 3/21/23 with the Qualified Professional revealed: -"To my knowledge HCPR was not notified but if they were, the [co-owner] or the [owner] would have taken care of it; -They (owner or co-owner) never told me that they notified HCPR based on the findings of the internal investigation; -I was never told that I needed to make the report to HCPR and I would need additional training." Interview on 11/21/23 with the Co-owner revealed: -"I don't think anyone notified HCPR, and I did not know I needed to do that; -No state personnel has ever notified us that we needed to do that."	V 132		