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PRINTED: 03/08/2023
FORM APPROVED

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
	MHL030-034	A. BUILDING: ______ B. WING ______	03/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLING MANOR,INC-SANFORD HOUSE	**785 SANFORD AVENUE MOCKSVILLE, NC 27028**

(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 complaint survey was completed on 3/6/23. One complaint was substantiated (intake #NC00197021) and two complaints were unsubstantiated (intakes #NC00197596 and #NC00198113). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. 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 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;	V 118	DHSR - Mental Health APR 10 2023 Lic. & Cert. Section	

Division of Health Service Regulation

LABORATORY DI RE | TITLE | (X6) DATE

BA, OP Executive Director 4/4/23

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V 118	Continued From page 1 (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. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure medications were administered on the written order of a physician and that the MAR for each client was kept current affecting 2 of 3 audited current clients (#2 and #3.) The findings are: Finding #1: Review on 3/6/23 of client #2's record revealed: -Admission date of 2/25/81; -Diagnoses included Mild Intellectual Developmental Disability, Impulse Control Disorder, Obesity, Chronic Obstructive Pulmonary Disease, Hypertension and Hyperglycemia. Interview on 3/6/23 with client #2 revealed he was administered client #1's medications (date unknown) in error once. Review on 3/6/23 of a level I incident report completed by the House Manager (HM) dated 1/11/23 at 9:39am revealed: -Incident: 1/11/23 at 7:30am;	V 118	Finding #1: The wrong medications were administered to the wrong individual (Client #2) on 1/11/23. The error was immediately recognized and the doctor's office and pharmacy was contacted and instructions received to hold medications. The primary support was notified, and the individual was monitored closely throughout the day. He did appear sleeping but there was no lasting harm or other negative effects. Identified Problem: Residents go in and out of the staff/office room where medication is administered. Action steps to prevent reoccurrence: 1. The residents are required to sit outside of the room and wait until called into the room for the administration of medication. Only one person is allowed in the administration room at a time. 2. Immediately after this error occurred, management reached out to the pharmacy provider to inquire about other products that may assist in reducing risk for error. After reviewing several vendors, a decision was made to transition to Quick Mar electronic MARS. The	3/1/2023

color codes, pictures and alerts assist in reducing risk of errors. We also obtained a scanner to scan each medication card. This also assist in reducing risk.

Monitoring: The House Manager checks in meds and compares to orders with follow up behind all medical visits to ensure copies of orders obtained and followed.
The QP monitors the MARs to ensure completeness and accuracy and compares to orders. (Katrina Taylor, Manager and DeeAnna Kerns, QP)

A monitoring tracking sheet was instituted on 4/1/23. The manager with monitor a minimum of 1 time per week and the QP will monitor monthly. (Katrina Taylor, Manager and DeeAnna Kerns, QP).

Medication errors will continue to be examined by the Human Rights Committee at least quarterly. Stacey Williams, QP, QM will oversee as well as Julie Wood, ED.

Responsible: House Manager,
Qualified Profes
Quality Manage
Executive Director:

V 118 Continued From page 2 — V 118

-"Describe what happened before the event. I had put [client #1's] medication in a cup because he had come into the med (medication) room, but he left. I set it aside to wait for him to come back into the room. I thought he came back into the room so I handed him the cup to take his medications. As soon as the meds (medications) were taken I realized that it was [client #2] and not [client #1] that had taken the medication;"
-Client #2's medical provider was contacted at 7:45am;
-Medications administered in error: Atorvastatin 20 mg (milligrams), Famotidine 20 mg, Sertraline 25 mg, Benztropine .5 mg, Divalproex extended release 500 mg, Propranolol 40 mg, Risperidone 2 mg;
-"Summary: Wrong medications were given. Normal medications not given by order of the doctor's office."

Interview on 3/6/23 with the HM revealed:
-"I hadn't been there (employed at the facility) very long...I didn't realize it but they (clients) tend to come in and out of the staff room (medication room)...They all tend to come and go back and forth...I called somebody (client #1) and said I have your medicine. I thought it was him (client #1) and I handed him (client #2) the medicine;"
-Immediately attempted to notify the Executive Director (ED) and the Qualified Professional (QP) via telephone but was unable to reach them;
-Contacted client #2's medical provider and was advised to not administer anything else to client #2 the remainder of the day;
-Client #2 didn't attend the day program so she was able to monitor him;
-Other than being sleepy, there were no adverse effects.

Interview on 3/6/23 with the QP revealed:

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V 118	Continued From page 3 -Aware that the HM had administered client #1's morning medications to client #2 on 1/11/23; -The HM notified the ED and her immediately of the error; -Client #2's medical provider was contacted by the HM immediately (1/11/23) and was advised to hold all of client #2's medications for the remainder of the day; -Client #2 was monitored by her and the HM the entire day (1/11/23); -"He (client #2) was groggy but there were no other adverse effects;" -The HM completed a level I incident report; -As a plan of correction, clients were asked to wait outside the medication room and not enter until they were requested by staff. Interview on 3/1/23 with the ED revealed: -Aware that the HM had administered client #1's morning medications to client #2 on 1/11/23; -Level I incident report was completed; -"There was no harm done." Finding #2: Review on 3/6/23 of client #3's record revealed: -Admission date of 6/22/22; -Diagnoses included Cerebral Palsy and Severe Intellectual Developmental Disability; -Order dated 10/19/22 for Creon (used to aide with digestion) delayed release (DR), 3,000 units, 1 capsule by mouth (po) three times daily (TID). Review on 3/6/23 of client #3's MAR for the month of March 2023 revealed Creon DR 3,000 units, 1 capsule po daily. Interview on 3/6/23 with a representative from client #3's physician's office revealed: -Original order dated 10/19/22 for Creon DR	V 118	Finding #2: The QP, Sherry Oglesby (former QP-still with agency) recalled that the order had been changed, during a zoom call, to Creon DR being administered 1 time. During the on-site survey, the office could only see the order for twice daily. The QP was able to go the physician's office, meet with the nurse, who found notes from the zoom visit indicating that 1 Creon was to be administered per day regularly but that it could be given up to four times a day if needed. The physician, did not however, update the orders. On 3/9/23 a order was given for 1 time per day regularly scheduled administration. It was not felt that the prn was necessary at this time due to improvements in elimination of dietary triggers. Action, anytime there is a change in instructions, the staff at the physician office will ask for the order to be sent to the pharmacy. Our procedure is that the pharmacy, then sends the group home a copy by fax. Staff are to make sure to leave all physician appointments with orders and instructions in writing at that time. With the new Quick Mar system, orders are updated by the pharmacy. The group home manager with QP oversight, will ensure timely updates and changes in orders to the MAR.	4/1/23

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V 118	Continued From page 4 3,000 units, 1 capsule po TID; -Updated order dated 2/7/23 for Creon DR 3,000 units, 1 capsule twice daily. Interview on 3/6/23 with the ED revealed: -Aware that client #3 was administered Creon daily; -Contacted client #3's pharmacy and unable to provide an updated order for Creon, 1 capsule daily; -Contacted the QP and she was sure that the order for client #3's Creon had been changed to once daily; -The HM was responsible for verifying MAR's were correct.	V 118	Monitoring: The House Manager checks in meds and compares to orders with follow up behind all medical visits to ensure copies of orders obtained and followed. The QP monitors the MARs to ensure completeness and accuracy and compares to orders. (Katrina Taylor, Manager and DeeAnna Kerns, QP) A monitoring tracking sheet was instituted on 4/1/23. The manager with monitor a minimum of 1 time per week and the QP will monitor monthly. (Katrina Taylor, Manager and DeeAnna Kerns, QP). Medication errors will continue to be examined by the Human Rights Committee at least quarterly. Stacey Williams, QP, QM will oversee as well as Julie Wood, ED. Responsible: House Manager Qualified Profe Quality Manag Executive Dire	
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a	V 291		

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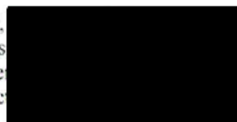
V 291	Continued From page 5 conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain coordination of services with the legal guardian for 1 of 3 audited current clients (#1). The findings are: Review on 3/6/23 of client #1's record revealed: -Admission date of 12/1/11; -Diagnoses included Mild Intellectual Developmental Disability, Mood Disorder and a history of drug and alcohol abuse; -Legal guardian was appointed 1/12/11; -Psychological Evaluation completed 5/6/15 included a full-scale intelligence quotient of 57; -No documentation of approved unsupervised time. Interview on 3/6/23 with client #1's legal guardian revealed: -The Qualified Professional (QP) informed her on 1/23/23 that client #1 was allowed to attend church with his father and friend on 1/22/23 without her approval. -The Executive Director informed her on 1/27/23 that in response to client #1's behaviors the past week that it was not in his best interest to attend church with his father and friend at that time and she agreed;	V 291	Instructions and changes to instructions must be communicated effectively. Loops of communication must be closed and must make it to all parties in an effective and efficient manner. Critical safeguards and instructions will be given in writing (which may include text, without identifiable information, depending on time sensitivity) and require acknowledgment of understanding. This communication shall correct and prevent a reoccurrence of such incidence. Monitoring: During our quality management monitoring, any incidents resulting from lack of communication will be assessed and corrective action implemented in a timely	3/15/2023

manner.
Responsible: House Manager,
Qualified Profes
Quality Manage
Executive Direc



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V 291	Continued From page 6 -Visited client #1 on 1/30/23 to explain why he was not allowed to attend church with his father and friend; -The QP had informed her today that client #1 was allowed to attend church with his father and friend yesterday; -Client #1 returned to the facility after church with cigarettes; -"I didn't find out until today they allowed him (client #1) to go again (church)." Review on 3/6/23 of an email from the QP to client #1's legal guardian dated 1/23/23 revealed: -"We had a new staff (staff #1) working his first shift this weekend. Many other house (facility) members (clients) were getting ready for church on Sunday (1/22/23), and [client #1] asked the new staff (#1) if he could go to church, as well. The staff (#1) text the HM (House Manager) and asked if he (client #1) could go, and the HM responded that he can't go to church alone. The staff (#1) then recommended that [client #1] call his dad to come and get him, as other parents were coming to pick up other members (clients) for church. [Client #1] did not disclose that he was not allowed to go to church without staff, and the HM did not specifically say that he had to go with staff, so [client #1] was able to get a ride to church with his dad and a deacon at the church." Interview on 3/6/23 with staff #1 revealed: -As a result of miscommunication between him and the HM, he allowed client #1 to attend church with his father and friend on 1/22/23; - A few days after 1/22/23, he was informed by the HM that client #1 was allowed to attend church in the future with his father and friend; -Allowed client #1 to attend church on 3/5/23 with his father and his friend; -Client #1's father informed him on 3/5/23 when	V 291		

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V 291	Continued From page 7 they returned from church that he needed to search the client and take his cigarettes from him; -Did not search client #1, "...I didn't feel like it was my right to do that;" -"A few minutes pass and I couldn't find [client #1] around the house (facility). When I went outside, he was around the side of the house smoking... He started putting them out when he saw me. I just went and took the cigarettes. [The HM], when she came in for her shift, I gave her the cigarettes." -According to client #1, his friend that he attended church with had given him the cigarettes; Interview on 3/6/23 with the QP revealed: -Staff #1 was working his first Sunday; -Client #1 asked staff #1 if he was allowed to attend church with his father; -Staff #1 contacted the HM and was informed that client #1 was not allowed to go anywhere without supervision; -Staff #1 was not aware that client #1 had a legal guardian that had to approve all outings without staff supervision; -Staff #1 thought it was appropriate for client #1 to attend church with his father and another church member. Interviews on 3/1/23 and 3/6/23 with the Executive Director revealed: -1/22/23 client #1 asked staff #1 if he was able to attend church with his father; -Staff #1 contacted the HM and was informed that client #1 was not able to attend church with his father without supervision; -Staff #1 allowed client #1 to attend church with his "...father and an assistant that was with the father;" -Client #1's legal guardian had not approved the outing;	V 291		

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V 291	Continued From page 8 -She and the QP had talked with the legal guardian (date unknown) and it was determined that it was not in client #1's best interest to attend church with his father and friend; -Staff #1 allowed client #1 to attend church with his father and friend without approval again on 3/5/23.	V 291		

MAR Weekly/Monthly Audit

Please initial and date when completed

Group Home Manager's Weekly Check

Resident	Orders Are Current	QuickMar Orders Match Doctor's Orders	Medication Quantity checked	Date Reorder was Submitted

Group Home Manager's Weekly Check

Resident	Orders Are Current	QuickMar Orders Match Doctor's Orders	Medication Quantity checked	Date Reorder was Submitted

Group Home Manager's Weekly Check

Resident	Orders Are Current	QuickMar Orders Match Doctor's Orders	Medication Quantity checked	Date Reorder was Submitted

Group Home Manager's Weekly Check

Resident	Orders Are Current	QuickMar Orders Match Doctor's Orders	Medication Quantity checked	Date Reorder was Submitted

QP's Monthly Check

Resident	Orders Are Current	QuickMar Orders Match Doctor's Orders	Medication Quantity checked	Date Reorder was Submitted