Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	MHL020-083		R-C **06/20/2023**

NAME OF PROVIDER OR SUPPLIER

THE OVERLOOK

STREET ADDRESS, CITY, STATE, ZIP CODE

205 HAMPTON CHURCH ROAD
MURPHY, NC 28906

(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 6/20/23. The complaint (#NC 203276) was substantiated. 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 6 and currently has a census of 6. The survey sample consisted of audits of 2 current clients.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills.	V 110		

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

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V 110	Continued From page 1 (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional. This Rule is not met as evidenced by: Based on record reviews and interviews, 1 of 1 paraprofessional staff (Staff #1) failed to demonstrate knowledge, skills and abilities required by the population served. The findings are: Review on 6/13/23 of facility incident reports from 5/11/23-6/13/23 revealed: -On 6/5/23, "[Client #1] was outside smoking a cigarette when he fell off the step to the flower bed. [Client #1] hit his head against the house. Staff could not get him up. He was talking out of his head. Staff called 911." -Staff completing the incident report form was Staff #1. Record review on 6/15/23 of hospital records for Client #1 revealed: -Admission 6/5/23; discharge 6/8/23. -"Chief complaint: fell backwards and hit his head at a group home. History of Present Illness: 56-year-old male with traumatic brain injury presents from group home after he fell hitting his head. Denies loss of conscious, palpitations, chest pain, dizziness, motor weakness, urinary or fecal incontinence, tongue biting, fever, chills, neck pain or stiffness. The patient is multiple psychotropic medications.	V 110		

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V 110	Continued From page 2 In the ED (emergency department), labs are notable for sodium 124, white blood cell count of 13.5, negative head CT (computerized tomography) scan and cervical spine films which revealed apical alveolar infiltrates." -"Discharge Diagnoses: Multifocal pneumonia; Acute Respiratory Failure with Hypoxemia; Hyponatremia; Closed Head Trauma." Record review on 6/16/23 for Staff #1 revealed: -Hired on 6/13/16 as a paraprofessional. -Was currently working as Operations Support Specialist although worked on most Sundays overnight as direct care staff at the facility. -Worked on 6/5/16 when Client #1 fell, contacted EMS (emergency medical services) and completed incident report. Interview on 6/16/23 with Staff #1 revealed: -Was outside with Client #1 on 6/5/23 when he fell. "I was giving meds (medications) so he had to wait to smoke. It was about 7:30am. I tried to get him to sit down but he just kept walking around and just walked right into the flower bed. He fell into the house and bumped his head; not hard but just laid there until EMS came." He slid himself over onto the sidewalk in front of the glass doors and would sat up then laid down then sit up again. -Client #1 told her he didn't feel good. -Other clients were eating breakfast but only Client #1's roommate came to see if he was ok. -"I did not laugh at [Client #1] falling. I waited with him until EMS got there." Interview on 6/13/23 with Client #1 revealed: -Did not remember falling or hitting his head on 6/5/23. -Did not remember who was at the facility when he fell.	V 110		

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V 110	Continued From page 3 Interview on 6/16/23 with Staff #2 revealed: -Came into work Monday morning (6/5/23) to find Client #1 laying on the concrete in front of the facility with Staff #1 standing beside him. "He was unresponsive then came to all of a sudden. [Staff #1] said 'I know it's not funny but it is funny'. I was concerned about getting something under his head. [Staff #1] said she had called the ambulance." -Observed Staff #1 laughing. -"I had told her (Staff #1) the day before he (Client #1) had been sleeping a lot which was not his normal routine." -"I always go outside with him (Client #1) cause he wobbles around." Interview on 6/15/232 with an informant who wished to remain anonymous revealed: -"Saw [Client #1] sitting on the ground after he had fallen while [Staff #1] stood there laughing."	V 110		
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	V 118		

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V 118	Continued From page 4 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. 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 failed to keep the MARs current for 2 of 2 clients (Clients #1, #2). The findings are: Record review on 6/13/23 for Client #1 revealed: -Date of Admission: 9/7/22 -Diagnoses: Anxiety Disorder, Major Depressive Disorder, Schizophrenia, history of Traumatic Brain Injury. -Review of physician's orders dated 5/4/23 revealed: -Hydroxyzine 25mg (milligram) (anxiety) - 3 times daily. -Buspirone 30mg (anxiety)- twice daily. Review on 6/14/23 of Client #1's MARs from	V 118		

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V 118	Continued From page 5 5/11/23-6/14/23 revealed: -Hydroxyzine was not initialed as administered on 5/27/23, 5/29/23-5/31/23 am doses, 5/27/23, 5/29/23-5/31/23 noon doses and 5/27/23, 5/29/23 pm doses. -Buspirone was not initialed as administered on 5/27/23, 5/29/23-5/31/23 am doses and 5/27/23-5/30/23 pm doses. Record review on 6/13/23 for Client #2 revealed: -Date of Admission: 4/18/23. -Diagnoses: Bipolar, Depressive Disorder, Severe IDD (Intellectual Developmental Disability). -Review of physician's orders dated 4/15/23 revealed: -Loratadine 10mg (allergies) once daily. Review on 6/14/23 of MARs from 5/11/23-6/14/23 for Client #2 revealed: -Loratadine was not initialed as administered on 5/31/23. Interview on 6/15/22 with the Director of IDD Services revealed: -Facility staff did not notify anyone that Client #1 was out of 2 medications until 6/1/23. -The house manager, who was responsible for reordering medications, left in May and had not been replaced yet. -Staff could have let anyone in the office know about the need for refills. -Was unsure why Client #2's Loratadine was overlooked but felt it had been administered correctly. This deficiency constitutes a recite deficiency and must be corrected within 30 days.	V 118		