STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601476	A. BUILDING: _____ B. WING _____	R-C 11/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARM POND GROUP HOME	4933 FARM POND LANE CHARLOTTE, NC 28212

(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 11-13-23. The complaint was substantiated (Intake # NC00206841). 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 3 and currently has a census of 3. The survey sample consisted of audits of 2 current clients.	V 000		
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 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,	V 291		

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V 291	Continued From page 1	V 291		

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 ensure service coordination was maintained with other professionals and the guardian responsible for treatment affecting 1 of 2 audited clients (#1). The findings are:

Review on 10-17-23 and 10-18-23 of client #1's record revealed:
-Date of admission: 3-1-21.
-Diagnoses: Arteriovenous Malformation of Cerebral Vessels, Epilepsy, unspecified, Conduct Disorder, unspecified, Post-Traumatic Stress Disorder, unspecified, Mild Intellectual Disabilities, Intermittent Explosive Disorder, Cerebral Infraction Specific, Disruptive Mood Dysregulation Disorder, Unspecific Psychosis not due to a substance or known physiological condition, Sleep Apnea, other Schizoaffective Disorder.
-Physician's order dated 7-3-2023 for:
-aripiprazole 10 mg (milligram) (antipsychotic).
-baclofen 10 mg (muscle relaxant).
-benztropine 1 mg (anti tremor).
-docusate sodium 100 mg (stool softner).
-gabapentin 600 mg (anticonvulsant).
-haloperidol 20 mg (antipsychotic).
-Hydrochlorot 25 mg (hypertension).
-hydroxyzine 50 mg (anxiety).
-lacosamide 100 mg (anticonvulsant).
-pantoprazole 20 mg (proton pump inhibitor).

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-peg 3350 powder 17 grams (constipation).
-pravastatin 40 mg (statin).
-Tab-A-Vit (supplement).
-Tegretol 200 mg (anticonvulsant).
-Trazodone 100 mg (sedative).
-Vitamin E 180mg/400IU (International Unit) (supplement).
-fluticasone 50 mcg (micrograms) (sinusitis).
-ketoconazole cream 2% (anti-fungal).

-"E-Rx" (Electronic prescription) pharmacy information noting "Allergy/Adverse Event Information" documenting client #1's allergy and severity to the following medications:
-Drug: risperidone.-
-"Severity": severe.
-After Visit Summary for local emergency room visit on 8-19-23, "reason for visit: Medication Evaluation. Diagnosis: Accidental overdose."

Review on 10-17-23 and 10-18-23 of client #2's record revealed:
-Date of admission: 3-1-21.
-Diagnoses: Severe Intellectual Disability, Schizoaffective Disorder Bipolar type.

Review on 10-17-23 of client #2s August 2023 MAR revealed:
-doxepin HCL 100 mg: One by mouth every night at bedtime.
-olanzapine 20 mg: one by mouth every night.
-lamotrigine 25 mg: one by mouth twice daily.
-metoprolol 50 mg: one by mouth twice daily.
-risperidone 3 mg: one by mouth three times daily.

Review of the facility records on 10-18-23 revealed:
-A facility incident report dated 8-19-23 documenting the following: "On Saturday @ (at)

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V 291	Continued From page 3 7:50pm I (staff #1)was administering meds (medications) in the middle of preparing meds another individual (client #2) was having a behavior I provided [client #1] with his control med got distracted redirecting the other individual [Client #2] thought his meds were popped and took the meds that was in the cup on the freezer when the staff turned around realized he took the wrong meds that belonged to other individual immediately called [residential team lead] didn't receive and answer then called [supervisor] on the way to the hospital." -Documentated on the back of the form under "Additional Research and/or Follow up by QP (Qualified Professional). QP was made aware on Monday morning. QP talked to staff member [staff #1] and educated her on protocol with notifying other team members. Nurse + QP." Interview on 10-23-23 with staff #1 revealed: -Worked at the facility for 5 to 6 years as a direct support professional. - She administered the medications on 8-19-23. -"I had popped (removed from package) [client #2's] meds (medications) first. I called [client #2] to come to the kitchen to take his meds. When he came to the kitchen he went into a behavior (cursing, yelling and banging on the table) because he had messed (urinated and defecated) on himself. I redirected him and told him to go upstairs and get in the shower. He went upstairs and I pushed his meds to the side and started popping [client #1's] meds. I called [client #1] to come and get his meds but [client #2] was still having his behavior, he was cussing and beating on the walls and I got distracted trying to redirect him. So I went up stairs to try to get him in the shower and calm him down. When I came back [client #1] had taken [client #2's] meds." -"I immediately called the [Residential Team Lead	V 291		

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V 291	Continued From page 4 (RTL)], she didn't answer. On the way to the emergency room I called [supervisor] and let her know what was going on. I guess she got a hold of [RTL] because by the time we got to the hospital she was calling and I told her what was going on. She came to the hospital and stayed with [client #1]." -Did not call or notify client #1's guardian. "That's not my job to notify the guardians. That's the RTL's job." -Not sure who notified the guardian or when the guardian was notified. Interview on 10-20-23 with client #1's legal guardian revealed: -"I got a text Monday morning (8-21-23) from [RTL], she was thanking me for that past weekend. I think that first text came about 7:42 that morning. Then a few minutes later she sent another text saying she forgot to tell me that [client #1] had taken the wrong medications and had to be sent to the hospital. I sent a message back to her asking who took him, what happened, and did they contact the nurse (provider nurse). She never responded back. I contacted [Local Managed Care Entity] care coordinator and asked her if she knew anything about it and she said no so she contacted [office administrator]. [Office administrator] did not know anything about it so she said she would check into it." -Took client #1 to a therapy appointment that afternoon. "When I spoke to the therapist he said [client #1] told him he had taken someone else's meds.' -The therapist looked in the system and could see the notes from the hospital. -"He (therapist) said [client #1] was treated for an accidental overdose and that he had taken risperidone. He said 'Oh that's not good.' That was when I found out what he (client #1) had	V 291		

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V 291	Continued From page 5 taken. He's very allergic to risperidone." Interview on 10-24-23 with the former Residential Team Lead (RTL) revealed: -"[Client #1] was taken to the emergency room that night (8-19-23 for ingesting client #2's medications). I went up (to the hospital) and sat with him. He was monitored and discharged a few hours later." -Did not notify the guardian until the following day. Believes she sent guardian a text around 7 to 7:30am on Sunday 8-20-23. -"I didn't call her (the guardian) that night due to the time, it was late and she is older, I know older people usually go to bed early, I thought she might be sleep. I called her the next morning and told her what happened." -She thought she saved the text on an old phone. "When I get off work I will charge that phone and send you the text I sent her (guardian) that morning." No information was received from the former (RTL) by the survey exit. Interview on 11-13-23 with former Qualified Professional (QP) Supervisor revealed: -"I don't really remember the incident in detail. I remember hearing something about a medication error. I really can't remember what happened." Interview on 10-17-23 with the QP revealed: -She was notified of medication error on Monday 8-21-23. -Not sure why she was not notified on 8-19-23 -"I should have been notified the night it happened." -"I reached out to [guardian] on 8-21-23 to apologize to her about what had happened (client #1 taking client #2's medication).....She already	V 291		

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V 291	Continued From page 6 knew about the incident when I talked to her. She was okay, she thanked me for calling her and we talked about communication. She has not been happy with the communication at the group home for sometime....I want to say I spoke to her around 11am." -Believes the guardian was notified on 8-19-23. -"[Guardian] was notified on Saturday the 19th by the [RTL]." Interview on 11-9-23 with the Human Resources/Training Coordinator revealed: -It is the QP's responsibility to notify the legal guardians when an incident occurs. -"We don't have a written policy stating when guardians are to be called, but best practice is that guardians are contacted immediately after a incident happens."	V 291		