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
	MHL034-382	A. BUILDING: ______ B. WING ______	11/07/2023

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HOME CARE SOLUTIONS AT FOLKSTONE RIDGE	1166 FOLKSTONE RIDGE LANE WINSTON SALEM, NC 27127

(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 11/7/23. The complaint was substantiated (intake #NC00207673). 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 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients. The Owner/Registered Nurse and the Owner #2 identified in the report are married and the Residential Group Home Manager identified is their daughter.	V 000		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by:	V 114		

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Based on record reviews and interviews, the facility failed to ensure disaster drills were held at least quarterly and repeated for each shift. The findings are:

Interview on 11/7/23 with the Residential Group Home Manager revealed:
-Staff shifts during the week were 3:00pm - 11:00pm (2nd) and 11:00pm - 8:00am (3rd);
-Staff shifts on Saturdays and Sundays were 8:00am - 8:00pm (1st) and 8:00pm - 8:00am (2nd);
-All staff worked shifts during the week and every other weekend;
-Responsible for ensuring drills were completed as required;
-"It doesn't specify (drills must be completed on each shift) on the paper (facility documentation of drills). That could be something we can change."

Reviews on 5/23/23 and 11/3/23 of the disaster drills for the months of April 2022 - March 2023 revealed:
-No documentation of a 1st shift drill completed during the months of April 2022 - June 2022;
-No documentation of 1st or 3rd shift drills completed during the months of July 2022 - September 2022;
-No documentation of 2nd or 3rd shift drills completed during the months of October 2022 - December 2022;
-No documentation of 2nd or 3rd shift drills completed during the months of January 2023 - March 2023.

Interviews on 5/22/23 with clients #1, #2 and #3 revealed:
-Previously participated in disaster drills at the facility;
-Unable to provide time frames for drills.

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V 114	Continued From page 2 Interview on 5/24/23 with staff #1 revealed: -Employed 11 years at the facility; -Facility staff held disaster drills monthly; -Not aware that disaster drills were required to be completed quarterly on each shift. Interview on 5/25/23 with staff #2 revealed: -Employed 7 months at the facility; -Had not participated in a disaster drill at the facility.	V 114		
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 (E) name or initials of person administering the	V 118		

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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 Owner/Registered Nurse (RN), the Qualified Professional (QP), the Associate Professional (AP) and the Residential Group Home Manager failed to demonstrate competency in medication requirements for 3 of 3 clients (#1, #2 and #3), failed to administer medications as ordered for 3 of 3 clients (#1, #2 and #3), failed to document MAR's immediately after medications were administered for 2 of 3 clients (#1 and #2), and failed to ensure medications administered had not expired affecting 1 of 3 clients (#2). The findings are:

Finding #1: The facility failed to administer medications as ordered to client #1.

Reviews on 5/23/23, 11/2/23 and 11/7/23 of client #1's record revealed:
-Admission date 9/6/19;
-Age 64;
-Declared incompetent and a guardian appointed 2/3/03;
-Diagnoses included Mild Intellectual Developmental Disability (IDD), Schizophrenia, Schizoaffective Disorder, Intermittent Explosive Disorder, Generalized Anxiety Disorder,

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V 118	Continued From page 4 Depression, Asthma, Diabetes Type 2, Hypertension, Nicotine Dependence and a History of Alcohol Abuse; -FL-2 dated 2/8/22 included check marks beside, "Verbally Abusive and Injurious to Self;" -Treatment Plan dated 12/29/22 included, "psychiatric symptoms are aggression, crying, yelling, screaming, using profanity, hitting, verbal aggression towards staff and consumers, and throwing dishes;" -Health Care Appointment Summary dated 5/23/23 included, "Increased anxiety;" -Health Care Appointment Summary dated 6/22/23 included, "New/Changed Medication: None - they need to be reconciled with group home...Follow Up Instructions: Verify meds (medications) are being given as prescribed. Med list attached;" -After Visit Summary dated 7/4/23 from a local hospital included, "Reason for Visit: Behavioral Problem...Diagnoses: Psychosis and Agitation...All medications must be taken as prescribed;" -Health Care Appointment Summary dated 7/17/23 included documentation by facility staff of, "Anxiety and agitation. Please send updated medication list. Difficulty with medication management" and documentation by the medical provider of "Follow Up Instructions/Orders: Set up psychiatry;" -After Visit Summary dated 9/4/23 from a local hospital included, "Reason for Visit: Altered Mental Status...All medications must be taken as prescribed;" -Health Care Appointment Summary dated 9/14/23 included, "Unintentional Weight Loss, Loss of Appetite, Increased Falls, Unclear Speech;" -Hospital Admission notes dated 9/17/23 and Discharge Summary dated 9/29/23 included,	V 118		

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V 118	Continued From page 5 "Arrival: 9/16/23...Complaint: Anxiety...Comment: Pt (patient) arrives with home health (facility staff) reports that x (unknown) months pt has not been acting her normal states that she has been having some episodes of self harm although pt denies HI/SI (homicidal ideation/suicidal ideation) also reports that pt is having difficulty with getting all of her medication...has been out of her Divalproex, Paliperidone, Benztropine, Clonazepam and Quetiapine for a few weeks and is having escalating bizarre behaviors, has been somewhat more physically violent hitting at her caretakers, refusing to eat or drink, is here with home health care workers that are familiar with her...presented to the ED (emergency department) due to decompensation for the past few months with episodes of self-harm due to inability to get medications...collateral (facility staff) from group home (facility) states that the patient's psychiatrist left a few months ago and patient was unable to get some of her medications continued...has an appointment with [mental health doctor] on 9/27/23 but without her medications has been exhibiting more erratic behavior, been difficult to understand, was self-harming and has been more agitated and aggressive with staff;" -Shift Event and Behavior Logs included: date 5/6/23 verbal aggression checked and "refused to take a shower" was handwritten, date 5/9/23 verbal aggression, cursing and yelling checked and "crying" handwritten, date 5/20/23 verbal aggression checked, date 5/21/23 verbal aggression checked and "crying - Threatening to kill herself" handwritten, dates 7/1/23 and 7/2/23 kicking underlined and "kicking in the air while sitting down on the couch, crying out loud and threaten to kill everyone in the house (facility)" handwritten, date 7/2/23 physical aggression, verbal aggression and inappropriate behavior	V 118		

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checked and "hitting roommate" handwritten, date 7/21/23 verbal aggression checked and "Threaten to beat peers up" handwritten;
-Behavior Chart for February 2023 included 20 entries of behaviors such as cursing, defiance, yelling and aggression;
-Behavior Chart for May 2023 included 47 entries of behaviors such as cursing, defiance, yelling and aggression;
-Behavior Chart for July 2023 included 35 entries of behaviors such as cursing, defiance, yelling and aggression;
-Orders dated 4/6/22 for Omeprazole (heart burn) DR (delayed release) 20mg (milligram), take 1 capsule by mouth (po) daily at 8:00am and Asmanex Twisthaler (used for asthma) 110mcg (micrograms), inhale 1 puff into lungs at bedtime 8:00pm;
-Order dated 4/7/22 for Urea 40% Cream (dryness), apply 1 application topically 3 times a day 8:00am, 2:00pm and 8:00pm;
-Order dated 6/9/22 for Mometasone Furoate 1% Cream (irritated skin), apply to affected areas daily 8:00am;
-Order dated 7/19/22 for Paliperidone ER (extended release) (Schizoaffective Disorder)1.5mg, take 1 tablet po daily with the 3mg tablet 12:00pm;
-Order dated 7/28/22 for Nudexta (involuntary outbursts of crying) 20-10 mg, take 1 capsule po twice daily 8:00am and 8:00pm;
-Order dated 10/6/22 for Paliperidone ER 3mg, take 1 tablet po twice daily 12:00pm and 8:00pm;
-Order dated 11/8/22 for Melatonin (regulates sleep) 10mg, take 1 tablet po in the evening after dinner 8:00pm;
-Order dated 2/10/23 for Ketoconazole 2% cream (athlete's foot and skin fungus on feet), apply to affected areas daily 8:00am;
-Orders dated 3/22/23 for Clonazepam (anxiety)

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.25mg take 1 tablet po daily 8:00am and Quetiapine Fumarate (anti-psychotic) 25mg, take 1 tablet po at bedtime 8:00pm;
-Order dated 4/9/23 for Trazodone (anxiety) 150mg, take 2 tablets po at bedtime 8:00pm;
-Order dated 4/23/23 for Fish Oil 1,000mg, take 2 capsules po daily 8am;
-Order dated 4/24/23 for Polyethylene Glycol (constipation) 3350, Mix 1 packet in 8 oz. (ounces) of liquid daily 8:00am;
-Order dated 5/23/23 for Hydroxyzine HCL (hydrochloride) (anxiety) 50mg, take 1 tablet po at bedtime 8:00pm;
-Orders dated 6/9/23 for Clonazepam .5mg, take 1 tablet po daily 8:00am and Trazodone 50mg, take 1 tablet po at bedtime 8:00pm;
-Order dated 6/27/23 for Benztropine MES (Mesylate) (anti-tremor) .5mg, take 1 tablet po daily 8:00am;
-Orders dated 9/29/23 to discontinue Flovent HFA (Hydrofluoroalkane) (asthma) 110mcg, inhale 2 puffs twice daily 8:00am and 8:00pm, and Mometasone Furoate 1% Cream, apply to affected areas daily 8:00am and new orders for Paliperidone ER 9mg, take 1 tablet po at bedtime 8:00pm, Baclofen (muscle relaxant) 10mg, take 1 tablet po twice daily 8:00am and 8:00pm, Divalproex DR (manic phases) 125mg, take 6 capsules po twice daily 8:00am and 8:00pm and Aspirin (anti-inflammatory) 81mg, take 1 tablet po daily at 8:00am.

Review on 5/23/23 of client #1's MAR for May 1st - 23rd 2023 revealed:
-Clonazepam and Omeprazole had an N documented for 21 of 23 doses and "need" was handwritten on the back of the MAR 7 times;
-Quetiapine Fumarate had a handwritten note of, "Notified?" beside the medication administration instructions, had no documentation for 1 of 22

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doses, 8 of 22 doses had a line drawn through the date and an N was documented for 13 of 22 doses;
-Paliperidone 3mg had an N documented for 9 of 45 doses and "Medication needed" was handwritten once on the back of the MAR;
-Paliperidone 1.5mg had an N documented for 6 of 23 doses;
-Urea Cream had no documentation for 2 of 68 doses.

Observation on 5/23/23 at approximately 4:09pm of client #1's medications revealed Clonazepam, Omeprazole, Paliperidone 1.5mg and 3mg, Urea Cream, Asmanex Twisthaler and Quetiapine Fumarate were not available at the facility.

Review on 5/25/23 of the pharmacy delivery sheets for client #1 signed and dated 4/26/23 by the Associate Professional revealed:
-"Medications NOT Sent with this Delivery: Fish Oil, Linzess, Omeprazole, and Quetiapine;"
-"All medications listed above require refills/new prescriptions before we can send these out. We have reached out the Doctor on several occasions, but have had no luck in receiving these refills."

Review on 11/7/23 of client #1's MAR for June 2023 revealed:
-Clonazepam .25mg had an N documented for 9 of 9 doses;
-Fish Oil had an N documented for 1 of 30 doses;
-Paliperidone 1.5mg had an N documented for 6 of 30 doses;
-Paliperidone 3mg had an N documented for 30 of 60 doses;
-Quetiapine Fumarate had an N documented for 25 of 30 doses;
-Trazodone 150mg had an N documented for 1 of

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V 118	Continued From page 9 30 doses; -Clonazepam .5mg had an N documented for 2 of 19 doses; -Urea Cream had no documentation for 4 of 90 doses; -Mometasone Furoate had no documentation for 30 doses administered at 8:00pm; -Polyethylene Glycol had no documentation for 1 of 30 doses. Review on 11/7/23 of client #1's MAR for July 2023 revealed: -Benztropine had an N documented for 27 of 31 doses; -Clonazepam .5mg had an N documented for 6 of 31 doses; -Paliperidone 1.5mg had an N documented for 10 of 31 doses; -Paliperidone 3mg had an N documented for 43 of 62 doses and no documentation for 1 of 62 doses; -Divalproex had an N documented for 6 of 62 doses and no documentation for 1 of 62 doses; -Flovent had an N documented for 62 of 62 doses; -Asmanex Twisthaler had an N documented for 24 of 31 doses; -Quetiapine Fumarate had an N documented for 2 of 31 doses; -Trazodone 50mg had an N documented for 31 of 31 doses; -Baclofen had no documentation for 1 of 62 doses; -Quetiapine Fumarate had no documentation for 1 of 31 doses; -Mometasone Furoate had documentation of staff initials for 29 doses administered at 8:00pm. Review on 11/7/23 of client #1's MAR for August 2023 revealed:	V 118		

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-Benztropine had an N documented for 1 of 31 doses;
-Paliperidone 1.5mg had an N documented for 7 of 31 doses;
-Paliperidone 3mg had an N documented for 35 of 62 doses;
-Clonazepam had an N documented for 22 of 62 doses and no documentation for 1 of 62 doses;
-Divalproex and Flovent had an N documented for 60 of 62 doses;
-Asmanex Twisthaler and Quetiapine Fumarate had an N documented for 29 of 31 doses;
-Mometasone Furoate had documentation of staff initials for 31 doses administered at 8:00pm.

Review on 11/7/23 of client #1's MAR for September 2023 revealed:
-Divalproex had an N documented for 50 of 60 doses;
-Flovent had an N documented for 21 of 58 doses and documentation of staff initials for 1 dose after the medication was discontinued;
-Paliperidone 3mg had an N documented for 58 of 60 doses;
-Paliperidone 1.5mg had an N documented for 9 of 30 doses and no documentation for 21 of 30 doses;
-Benztropine had an N documented for 28 of 30 doses;
-Quetiapine Fumarate had an N documented for 30 of 30 doses;
-Baclofen had no documentation for 2 of 60 doses;
-Mometasone Furoate had no documentation for 2 of 29 doses at 8:00am, documentation of staff initials for 29 doses administered at 8:00pm and staff initials documented for 2 doses after the medication was discontinued;
-Urea Cream had no documentation for 2 of 90 doses.

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Review on 11/7/23 of client #1's MAR for October 2023 revealed:
-Asmanex Twisthaler had an N documented for 31 of 31 doses;
-Paliperidone 9mg had an N documented for 5 of 31 doses;
-Urea Cream had no documentation for 5 of 5 doses.

Review on 11/3/23 of client #1's MAR for November 1st - 3rd 2023 revealed:
-Aspirin had no documentation for 2 of 3 doses;
-Atorvastatin, Fish Oil, Linzess, Omeprazole and Vitamin D had no documentation for 1 of 3 doses;
-Paliperidone, Polyethylene Glycol and Spiriva had no documentation for 3 of 3 doses.

Observation on 11/3/23 at approximately 4:25pm of client #1's medications revealed Urea Cream, Asmanex Twisthaler and Paliperidone 9mg were not available at the facility.

Interview on 10/18/23 with client #1's guardian revealed:
-Client #1 had been transported to a local hospital on 6/12/23 due to agitation;
-"She (client #1) was reportedly out of meds at that time;"
-Client #1 was transported to a local hospital on 7/6/23 due to a fall;
-The client was again transported to a local hospital 9/4/23 due to agitation and was discharged on 9/5/23;
-Informed by hospital staff during admission 9/16/23 - 9/29/23 that the client had not received medications as ordered while at the facility;
-Hospital staff were informed by facility staff that client hadn't received medications as ordered for the previous 4 months;

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-"The group home had reportedly been contacting the pharmacy to obtain refills, however had been unsuccessful in getting the refills needed for [client #1], thus has now resulted in her hospitalization."

Interview on 11/2/23 with the Residential Group Home Manager revealed..."We (facility staff) noticed the change in [client #1]. Her slurred speech. They (medical providers) kept saying nothing was wrong. I was like, we have to commit her. I was like, I'm literally watching her deteriorate. They (hospital) kept her for 2 weeks. She gained some weight. Healthwise, she's doing a lot better. It might have just been 1 of however many of the pills that she was missing (at the facility)."

Finding #2: The facility failed to document the MAR immediately after administration of medication for client #1.

Review on 5/23/23 at approximately 4:09pm of client #1's MAR for May 1st - 23rd 2023 revealed:
-Paliperidone 1.5mg had staff initials documented for 5/24/23 - 5/26/23;
-Paliperidone 3mg, Nudexta, Urea Cream, Asmanex Twisthaler, Hydroxyzine, Melatonin and Trazodone had staff initials documented for 5/23/23 8:00pm.

Finding #3: The facility failed to administer medications as ordered to client #2.

Reviews on 5/23/23, 11/2/23 and 11/7/23 of client #2's record revealed:
-Admission date 4/2021;
-Age 40;
-Declared incompetent and a guardian appointed on 7/29/10;

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V 118	Continued From page 13 -Diagnoses included Moderate IDD, Major Depressive Disorder, Bipolar Disorder, Adjustment Disorder, Suicidal Ideations, Diabetes, Acid Reflux, Essential Hypertension, Morbid Obesity, Sleep Apnea, Dyspnea, Heart Failure with Reduced Ejection Fraction, Fungal Infection, Dry Skin Dermatitis and a History of Tracheotomy Dependency; -FL-2 dated 2/10/22 included a check beside "Verbally Abusive;" -Hospital Admission dated 5/27/23 included, "Admission date 5/24/23...Chief Complaint: Shortness of breath increased since October 2022...Problem: Acute respiratory failure with hypoxia...lives at a group home and is not able to obtain her medications on a regular basis;" -Health Care Appointment Summary dated 7/11/23 included, "therapy to address interpersonal negotiations and issues of anger and frustration;" -Health Care Appointment Summary dated 7/19/23 included, "therapy...more agitated;" -Health Care Appointment Summary dated 8/2/23 included, "therapy...weight 328 pounds...reports agitation with other residents...states they (other clients) are lying;" -Health Care Appointment Summary dated 8/21/23 included, "previously seen 6/9/23 for complaints of chest pain and symptoms typical for heart failure;" -Discharge Summary dated 10/5/23 included, "Admit date: 9/28/23, Surgeries/Procedures: Heart Catheterization, Instructions: Take all of your medication as prescribed;" -Treatment Plan dated 11/26/22 included, "has significant behavioral support needs...these behaviors include physical and verbal aggression, elopement, stealing, property destruction/misuse and inappropriate sexual behaviors;" -Order dated 2/12/21 for Mupirocin (used for skin	V 118		

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V 118	Continued From page 14 lesions) 2% Ointment, apply topically 3 times daily to affected area 8:00am, 2:00pm and 8:00pm; -Orders dated 4/6/22 for Potassium (low potassium) CL (Chloride) ER 20meq (milliequivalent), take 1 tablet po twice daily 8:00am and 8:00pm, Furosemide (used for fluid retention) 40mg, take 1 tablet po daily 8:00am and Cetirizine (used for allergies) HCL 10mg, take 1 tablet po daily 8:00am; -Order dated 6/6/22 for Trazodone (antidepressant) 50mg, take 1 tablet po at bedtime 8:00pm; -Order dated 6/7/22 for Docusate Sodium (used for constipation) 100mg, take 1 capsule po twice daily 8:00am and 8:00pm; -Order dated 7/25/22 for Trintellix (used for Major Depressive Disorder) 20mg, take 1 tablet po every morning 8:00am; -Orders dated 10/3/22 for Clotrimazole-Betamethasone (used for fungal infection), apply topically twice daily 8:00am and 8:00pm and Triamcinolone (used for fungal infection) .5% Cream, apply topically twice daily 8:00am and 8:00pm; -Order dated 10/27/22 for Invega (antipsychotic) 6mg, take 2 tablets po at 9:00pm; -Orders dated 2/10/23 for Vitamin D (vitamin deficiency) 50,000 units, take 1 capsule po weekly on Thursdays, Ferosul (low iron levels) 325mg, take 1 tablet po twice daily 8:00am and 8:00pm, Ketoconazole (used for fungal infection) .5% Cream, apply to affected areas daily 8:00am, Omeprazole (used for acid reflux) DR 20mg, take 2 capsules po daily 8:00am, Ammonium Lactate (used for dry skin) 12% Lotion, apply to affected areas daily 8:00am, Centrum Multigummies (supplement), chew 1 gummy daily 8:00am, Fluticasone (used for allergies) 50mcg Nasal Spray, use 1 spray in each nostril daily 8:00am,	V 118		

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Metformin Hydrochloride (used for diabetes) 500mg, take 1 tablet po daily with breakfast 8:00am, Clonazepam (used for anxiety) .5mg, take 1 tablet po three times daily 8:00am, 2:00pm and 8:00pm, Melatonin (used for sleep) 10mg, take 1 capsule po at bedtime 8:00pm and Famotidine (acid reflux) 20mg, take 1 tablet po daily 8:00am;
-Order dated 3/2/23 for Metoprolol Tartrate (used for hypertension) 25mg, take 1 1/2 tablets po twice daily 8:00am and 8:00pm;
-Order dated 7/11/23 for Diclofenac Sodium (used for inflammation) DR 75mg, take 1 tablet po in the morning 8:00am and at bedtime 8:00pm;
-Order dated 7/18/23 for Lamotrigine (treat Bipolar Disorder) 25mg, take 1 tablet po daily for 7 days then 2 tablets daily 8:00am;
-Orders dated 8/20/23 for Aspirin (blood thinner) 81mg, take 1 tablet po daily 8:00am, Carvedilol (heart failure) 6.25mg, take 1 tablet po twice daily 8:00am and 8:00pm and Lisinopril (heart failure) 5mg, take 1 tablet po daily 8:00am;
-Orders dated 10/5/23 to discontinue Lisinopril (used for hypertension) 5mg, take 1 tablet po daily 8:00am and Carvedilol 6.25mg, take 1 tablet po twice daily 8:00am and 8:00pm.

Interview on 5/25/23 with staff #2 revealed client #2 was hospitalized on 5/24/23 due to breathing difficulties.

Requests for Client #1's hospital records were made on 5/25/23, 6/13/23, 6/14/23, 6/30/23, 7/3/23, 7/6/23, and 8/1/23. Incomplete and unreadable electronic hospital records were received on 8/4/23 and 8/14/23 requiring the assistance of Information Technology staff to make the record readable. Client #2's hospital records were available in a readable format on

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10/18/23.

Review on 5/23/23 of client #2's MAR for May 1st - 23rd 2023 revealed:
-Vitamin D had an N documented for 3 of 4 doses, a handwritten note of "notified" beside the administration instructions and "need" was documented once on the back of the MAR;
-Ferosul had an N documented for 33 of 45 doses, no documentation or a line drawn through the date for 11 of 45 doses and "need" was documented 8 times on the back of the MAR;
-Potassium had "notified" handwritten beside the medication administration instructions, had an N documented for 33 of 45 doses, no documentation or a line drawn through the date for 11 of 45 doses and "need" was documented 8 times on the back of the MAR;
-Furosemide had an N documented for 23 of 23 doses and "need" was handwritten 7 times on the back of the MAR;
-Omeprazole, Trintellix, Centrum Multigummies and Cetirizine had an N documented for 23 of 23 doses, "notified was handwritten beside the administration instructions and "need" was handwritten 7 times on the back of the MAR;
-Clotrimazole-Betamethasone had no documentation for 10 of 45 doses;
-Docusate Sodium had no documentation for 12 of 45 doses;
-Triamcinolone had no documentation for 2 of 4 doses.

Observation on 5/23/23 at approximately 3:25pm of client #2's medications revealed Vitamin D, Clotrimazole-Betamethasone, Ferosul, Potassium, Triamcinolone Cream, Furosemide, Ketoconazole Cream, Omeprazole, Trintellix, Ammonium Lactate, Centrum Multigummies, Cetirizine, Fluticasone and Mupirocin Ointment

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were not available at the facility.

Review on 5/25/23 of the pharmacy delivery sheets for client #2 signed and dated 4/26/23 by the Associate Professional revealed:
-"Medications NOT Sent with this Delivery: Centrum Multigummies, Cetirizine, Ferosul, Furosemide, Omeprazole, Potassium, Trintellix and Vitamin D;"
-"All medications listed above require refills/new prescriptions before we can send these out. We have reached out the Doctor on several occasions, but have had no luck in receiving these refills."

Review on 11/7/23 of client #2's MAR for August 2023 revealed:
-Famotidine had an N documented for 1 of 31 doses;
-Furosemide had an N documented for 29 of 31 doses;
-Lamotrigine had an N documented for 28 of 31 doses;
-Trintellix had an N documented for 5 of 31 doses;
-Metoprolol had an N documented for 62 of 62 doses;
-Aspirin and Lisinopril had an N documented for 3 of 10 doses;
-Carvedilol had an N documented for 3 of 21 doses and no documentation for 1 of 21 doses;
-Vitamin D had no documentation for 1 of 5 doss.

Review on 11/7/23 of client #2's MAR for September 2023 revealed:
-Ammonium Lactate had no documentation for 1 of 30 doses;
-Ferosul had no documentation for 1 of 60 doses;
-Clonazepam had no documentation for 1 of 90 doses.

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Review on 11/7/23 of client #2's MAR for October 2023 revealed:
-Fluticasone had an N documented for 31 of 31 doses;
-Metformin had an N documented for 4 of 31 doses;
-Diclofenac Sodium had an N documented for 4 of 62 doses.

Review on 11/3/23 of client #2's MAR for November 1st - 3rd 2023 revealed:
-Fluticasone and Metformin had an N documented for 3 of 3 doses;
-Vitamin D had an N documented for 1 of 1 dose;
-Diclofenac Sodium had an N documented for 5 of 5 doses;
-Clonazepam had no documentation for 3 of 8 doses;
-Lisinopril and Carvedilol had staff initials documented for 3 doses after the medications were discontinued.

Observation on 11/3/23 at approximately 3:25pm of client #2's medications revealed Ammonium Lactate, Fluticasone, Metformin, Vitamin D and Clonazepam were not available at the facility.

Interview on 5/22/23 with client #2 revealed she wasn't always administered her medications as ordered and had been informed by different facility staff that her medications were unavailable.

Interview on 11/7/23 with client #2's Cardiologist revealed it was important for client #2 to take medications as ordered because they helped relax blood vessels and made it easier for the heart to work and lowered blood pressure, slowed down the heart rate so that it didn't have to work

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as hard, helped the heart beat stronger and better and got rid of extra salt and water in the body.

Finding #4: The facility failed to document the MAR immediately after administration of medication for client #2.

Review on 5/23/23 at approximately 3:25pm of client #2's MAR for May 1st - 23rd 2023 revealed:
-Metoprolol Tartrate, Triamcinolone, Melatonin and Trazodone had staff initials documented for 5/23/23 8:00pm;
-Invega had staff initials documented for 5/23/23 9:00pm;
-Clonazepam had staff initials documented for 5/23/23 8:00pm and 2:00pm 5/24/23 - 5/26/23.

Finding #5: The facility failed to ensure medications weren't expired prior to being administered to client #2.

Observation on 11/3/23 at 4:25pm of client #2's container of Ketoconazole cream revealed the medication expired on 10/7/23.

Reviews on 11/3/23 and 11/7/23 of client #2's MARs for the months of October 1st, 2023 - November 7th, 2023 revealed Ketoconazole cream was documented as being administered with facility staff signatures.

Interview on 11/3/23 with staff #3 revealed:
-Not aware that client #2's Ketoconazole cream was expired.
-Unable to locate additional containers of Ketoconazole cream in the facility.

Finding #6: The facility failed to ensure medications were administered as ordered for client #3.

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V 118	Continued From page 20 Reviews on 5/23/23, 11/2/23 and 11/7/23 of client #3's record revealed: -Admission date 9/26/19; -Age 22; -Diagnoses included Mild/Moderate IDD, Schizophrenia, Schizoaffective Disorder, Insomnia and Migraines; -Orders dated 2/10/23 for Clozapine (antipsychotic) 100mg, take 1 tablet po every morning 8:00am and 2 tablets po every evening 8:00pm, Lotrimin (foot fungus) 2%, apply 1 application topically twice a day 8:00am and 8:00pm until clear and then as needed and Metformin (anti-diabetic) ER 500mg, take 1 tablet po daily with supper 5:00pm; -Order dated 4/10/23 for Biotin Forte (vitamin B deficiency) 3mg, take 1 tablet po daily 8:00am; -Order dated 6/4/23 for Divalproex Sodium (prevent migraines) ER 500mg, take 2 tablets po once daily 8:00am. Review on 5/23/23 of client #3's MAR for May 1st - 23rd 2023 revealed Clozapine had an N documented for 18 of 23 doses and "Notified Pharm (pharmacy)" was handwritten beside the medication administration instructions. Observation on 5/23/23 at approximately 3:00pm of client #3's medications revealed Clozapine was not available at the facility. Review on 11/7/23 of client #3's MAR for June 2023 revealed: -Biotin had an N documented for 1 of 30 doses; -Clozapine had an N documented for 8 of 60 doses; -Metformin had an N documented for 1 of 30 doses; -Divalproex had an N documented for 1 of 24	V 118		

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V 118	Continued From page 21 doses and no documentation for 1 of 24 doses. Review on 11/7/23 of client #3's MAR for July 2023 revealed: -Clozapine had an N documented for 4 of 62 doses; -Metformin had an N documented for 8 of 31 doses. Review on 11/7/23 of client #3's MAR for August 2023 revealed: -Clozapine had an N documented for 62 of 62 doses; -Divalproex had an N documented for 1 of 31 doses. Review on 11/7/23 of client #3's MAR for September 2023 revealed: -Clozapine had an N documented for 26 of 60 doses and no documentation for 2 of 60 doses; -Divalproex Sodium had an N documented for 5 of 30 doses; -Lotrimin had an N documented for 7 of 60 doses and no documentation for 3 of 60 doses; -Metformin had no documentation for 2 of 30 doses. Review on 11/7/23 of client #3's MAR for October 2023 revealed Clozapine had an N documented for 1 of 62 doses. Observation on 11/3/23 at approximately 3:15pm of client #3's medications revealed Lotrimin was not available. Attempted reviews on 5/23/23, 5/24/23 and 5/25/23 of February 2023 - April 2023 MARs for clients #1, #2 and #3 were not successful as they were requested and not provided prior to exit.	V 118		

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Attempted review on 11/7/23 of June 2023 - July 2023 MARs for client #2 was not successful as they were requested and not provided prior to exit.

Reviews on 5/23/23 and 11/7/23 of personnel files for staff #1, #2 and #3 revealed documentation of completed Medication Administration Training signed by the Owner #1/Registered Nurse (RN).

Interview on 5/23/23 with staff #1 revealed:
-"The pharmacy has been messing up, sending the medication late;"
-"[Client #1] has been acting up, going off lately something terrible;"
-"[Client #1] goes off, f**k you b***h, I'm going to get you like I did that girl, I have 2 men;"
-"It's (client #1 exhibiting behaviors) the pharmacy's fault;"
-There had been issues with the medications, "a few months now;"
-Discussed the medication issues with the Residential Group Home Manager (dates unknown) and was informed, "There is nothing we really can do;"
-The QP had contacted the pharmacy used by the facility and the medical providers regarding the medication issues.

Interviews on 5/23/23 and 5/25/23 with staff #2 revealed:
-Aware that there had been issues with the clients not having medications available;
-"I don't handle that kind of stuff;"
-"The ones (medications) that they (clients) don't have just mark it in the book (MAR) as N, not available."

Interview on 5/23/23 with the AP revealed:
-The Residential Group Home Manager worked

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with the QP and the Owner #1/RN to resolve medication issues;
-The Residential Group Home Manager was on vacation for a couple of weeks and was not available;
-Aware that there were client medications not available;
-"[Owner #1/RN] has been working with [the QP] and they've reached out to the pharmacy;"
-"I don't know what the h**l is going on (regarding the number of medications not available and the documentation errors on the MAR)."

Interview on 5/24/23 with the QP revealed:
-Facility staff were supposed to inform the Residential Group Home Manager of medication issues;
-"She's (the Residential Group Home Manager) supposed to inform me (of medication issues) immediately or [Owner #1] in my absence;"
-Absent from work 5/1/23 - 5/17/23;
-The Owner #1/RN filled in as the QP when she was not available;
-Provided a list of client medications not available when she returned to work on 5/17/23;
-"I called the pharmacy (date unknown) and they stated that they (medications) all needed new scripts. [Client #1] meds (medications) for the missing stuff will be available May 30th when the new rotation begins;"
-Didn't understand why the medical providers for the clients didn't fax the pharmacy with refills;
-"A lot of it (medications not available) was miscommunication with their providers. This just started happening."

Interview on 5/24/23 with the Owner #1/RN revealed:
-"What happens if we're missing meds, the manager (Residential Group Home Manager)

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HOME CARE SOLUTIONS AT FOLKSTONE RIDGE	1166 FOLKSTONE RIDGE LANE WINSTON SALEM, NC 27127

(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
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sends a text to let us (the QP and the Owner #1/RN) know meds are missing. [The QP] will call (the pharmacy) and see what's going on."
-"What I'm having a time trying to figure out, I don't know why it took as long as it did to notify [the QP] the meds were missing. I don't know. [The QP] is pretty good. She's on it. She'll send me emails too."
-When the QP was not available, she filled in..."It would have been me, but I didn't know either;"
-"I just think this time the ball was dropped as far as notifying (pharmacy and medical provider). Like I said, usually we're on top of it (medications). It was just a trifecta of terrible events honestly."

Interview on 11/7/23 with the Residential Group Home Manager revealed:
-Responsible for ensuring medications received from the pharmacy were correct;
-Notified the QP if medications were missing and the QP contacted the pharmacy;
-"The pharmacy attempts to contact the doctors, but they aren ' t always successful. Usually a day or 2 if we haven ' t received them, I ' ll contact [the QP]. Trying to get them (medical providers) on the phone is hard too. A lot of them (clients), we ' re getting them switched over to new doctors so hopefully that helps;"
-The Owner/RN was in the building during exit but didn't participate in the exit interview.

Review on 11/7/23 of the Plan of Protection signed and dated by the Owner/RN #1 revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care? All missing medications have been called to the doctors for refills or orders to discontinue. [Client #2] will be provided with a scale for her daily weight.

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-Describe your plans to make sure the above happens. We will continue to get the individuals (clients) to their medical appointments as scheduled. Staff have been instructed to request refills each time they take an individual to an appointment and document it along with the visit. We will ask the pharmacy to notify us when they contact the doctor's offices. Lastly, we are in the process of moving our med management patients to [mental health provider]. This is a lengthy process but we are trying to navigate through it as quickly as possible. We have had management call and go to the doctor's offices due to the need for refills. Almost 10 out of 10 times we never get to speak directly with the doctor and have to leave messages with the assistants. Even then, it may take 2-3 days for the doctor to contact us back about the medications. The scale was purchased for [Client #2] today - 11/7/2023."

Three clients ranging in age from 22 - 64 with diagnoses of Mild/Moderate IDD, Schizoaffective Disorder, Schizophrenia, Intermittent Explosive Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, Bipolar Disorder, Heart Failure, Acid Reflux, Sleep Apnea, Insomnia, Morbid Obesity, Asthma, Diabetes, Hypertension, and Migraines reside in the facility. The Owner/RN, the QP, the AP and the Residential House Manager were aware in May 2023 that clients were not being administered medications as ordered. The continued lack of competency in medication administration continued through November 2023. During the months of June 2023 - October 2023, client #1 was not administered a total of 671 doses of medications because they weren't available and there was no documentation for 44 doses of medication. Of the 715 missed doses of medication, 401 were client #1's antipsychotic's and sedatives. From May

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V 118	Continued From page 26 2023 - October 2023, client #1 was seen by her medical provider 4 times for increased agitation, was seen at a local Emergency Department twice for behavioral issues and was admitted to a local hospital for 13 days where she stabilized after she received her medications as ordered. At each visit, client #1's medical providers expressed the need for facility staff to administer medications as ordered. For the months of August 2023 - September 2023, client #2 was not administered 170 doses of medications because they weren't available and there was no documentation for 5 doses of medication. Of the 175 missed doses of medications, 148 were client #2's antidepressants, beta blockers and diuretics. From May 2023 - October 2023, client #2 was seen by a therapist 3 times for increased anxiety, was hospitalized 3 days for acute respiratory failure and was hospitalized 1 week for heart failure. During June 2023 - October 2023, client #3 was not administered a total of 125 doses of medications due to the medications not being available and there was no documentation for 8 doses of medication. In May 2023, facility staff documented administration of 8 medications for client #1 and 6 medications for client #2 prior to the actual administration of the medications. Client #2 was administered 27 doses of expired medication in October 2023 - November 2023. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days. An administrative penalty of $5,000.00 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 118		

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V 291 27G .5603 Supervised Living - Operations V 291

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, 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, interviews, and observation, the facility failed to ensure service coordination was maintained with other

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professionals responsible for treatment affecting 2 of 3 clients (#1 and #2). The findings are:

Reviews on 5/23/23, 11/2/23 and 11/7/23 of client #1's record revealed:
-Orders dated 6/22/23 and 7/6/23 that included check blood sugar daily;
-After Visit Summary from hospitalization 9/28/23 - 10/5/23 included, "Heart catheterization...Weigh yourself every morning. Call for weight gain > (more than) 3 lbs. (pounds) above your normal/dry weight."

Reviews on 5/23/23, 11/2/23 and 11/7/23 of client #2's record revealed an order dated 10/28/22 for blood sugar checks twice daily.

Finding #1: The facility failed to check blood sugars as ordered for clients #1 and #2.

Review on 5/23/23 of client #1's MAR for May 1st - 23rd 2023 revealed:
-Documentation included, "Check blood sugar once daily as directed at 8:00am;"
-Results documented for 18 of 23 days.

Review on 11/7/23 of client #1's MARs for June 2023 - October 2023 revealed:
-17 out of 30 days had blood sugar results documented for June 2023;
-No blood sugar results were documented for July 2023 - September 2023;
-8 out of 30 days had R (refused) documented for blood sugar results for September 2023;
-4 out of 31 days had blood sugar results documented for October 2023;
-27 out of 31 days had R documented for blood sugar results for October 2023.

Review on 11/3/23 of client #1's Medication

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Administration Record for November 1st - 3rd 2023 revealed:
-Documentation included, "Check blood sugar once daily as directed at 8:00am;"
-No documentation of results of blood sugar checks.

Interview on 11/3/23 with the Owner #2 revealed:
-Unable to locate client #1's glucometer or documentation sheets in the facility;
-"I don't know where they keep it (glucometer and documentation);"
-Blood sugar results weren't documented on the Medication Administration Record.

Interview on 6/1/23 with a representative of the pharmacy utilized by the facility revealed an order for client #2 dated 5/27/23 to discontinue blood sugar checks.

Review on 5/23/23 of client #2's MAR for the month of May 1st - 23rd 2023 revealed:
-Documentation included, "Check blood sugar twice daily 8:00am and 8:00pm;"
-Results documented for 28 out of 45 times.

Observation on 5/23/23 at 5:00pm of the glucometers in the facility revealed:
- 2 glucometers each in a black cover;
-Neither cover or glucometer was labeled with a name;
-Only 1 of the glucometers turned on;
-13 results were in the history for November 2022;
-4 results were in the history for December 2022;
-2 results were in the history for January 2023;
-1 result was in the history for February 2023;
-4 results were in the history for March 2023;
-5 results were in the history for April 2023
-2 of the 18 results matched what was

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documented on client #1's MAR for the month of May 2023;
-7 of the 28 results matched what was documented on client #2's MAR for the month of May 2023.

Attempted reviews of clients #1 and #2 MAR's for March 2023 - April 2023 requested on 5/23/23, 5/24/23 and 5/25/23 were not provided prior to exit so it wasn't possible to determine whether blood sugar checks were completed and recorded as ordered.

Interview on 5/25/23 with staff #2 revealed:
-Facility staff were required to check client #1's blood sugar every morning;
-"She (client #1) refuses sometimes;"
-Unable to explain why neither of the 2 glucometers located in the facility were labeled with a name, why only 1 glucometer turned on or why the glucometer history didn't match the documentation of the results.

Interview on 5/24/23 with the Qualified Professional revealed she was not aware of any issues with staff not checking clients blood sugar as ordered.

Interview on 5/24/23 with the Owner/Registered Nurse revealed:
-Not aware of issues with the facility staff not checking clients blood sugar as ordered;
-"You know what, I don't think anybody has rechecked the history (glucometer);"
-Not sure why there were 2 glucometers in the facility and only 1 turned on;
-"I don't know if it's a battery issue. It could be that situation. Each one (client) should have their own (glucometer)."

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Finding #2: The facility failed to weigh client #2 as ordered after heart catheterization.

Observation on 11/3/23 from approximately 3:00pm - 3:15pm of the facility revealed no scale.

Interview on 11/3/23 with client #2 revealed:
-"My weight is supposed to be checked every day;"
-Not aware of a scale at the facility.

Interview on 11/7/23 with client #2's Physician Assistant revealed, "Heart failure means that the heart isn't working as well as it should. One effect of this can be extra fluid in the body. This can cause rapid weight gain and can cause swelling in the ankles, feet or legs, or sometimes around the stomach. Fluid can also build up in the lungs, which can cause breathlessness. Weighing every day is one of the best ways of managing conditions at home and can help keep a track of which direction weight is heading."

Interview on 11/3/23 with staff #3 revealed:
-Employed at the facility since July 2023;
-Not aware of a scale in the facility;
-Not aware that client #2 was ordered to have her weight checked daily.

Interview on 11/7/23 with the Residential Group Home Manager revealed:
-Not aware of a scale in the facility;
-Thought client #2 was supposed to be weighed weekly rather than daily;
-"She (client #2) goes to [a weight loss clinic] every week and they usually check it (weight);"
-Not able to provide documentation regarding clients' weight.