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NEW BEGINNINGS HOME	6619 FARRINGTON LANE CHARLOTTE, NC 28227

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V 000	INITIAL COMMENTS A complaint survey was completed on January 23, 2024. The complaint was substantiated (intake #NC00210918). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living. This facility is licensed for 2 and currently has a census of 1. The survey sample consisted of audits of 1 current client.	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 (E) name or initials of person administering the	V 118		

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V 118	Continued From page 1 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 the MARs were kept current affecting 1 of 1 client (Client #1). The findings are: CROSS REFERENCE: 10A NCAC 27G .0209 Medication Requirements (h) Medication Errors (V123). Based on record review and interviews, the facility failed to ensure all medication administration errors were immediately reported to a pharmacist or physician affecting 1 of 1 client (Client #1). Review on 12/22/23 of Client #1's medical records revealed: -Client #1 was hospitalized on the following dates: 11/16/23- 11/17/23 for altered mental status. 11/19/23- 11/27/23 for altered mental status and given antibiotics intravenously for a urinary tract infection (UTI). 11/29/23- 11/30/23 for altered mental status. 12/1/23- 12/4/23 for altered mental status and prescribed Amoxicillin- Clavulanate for her UTI. 12/7/23- 12/12/23 for altered mental status and given another prescription for Amoxicillin-Clavulanate for an infection.	V 118		

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V 118	Continued From page 2 12/16/23-12/17/23 and 12/19/23 for altered mental status. Review on 12/19/23 of Client #1' MARs dated December 2023 revealed: -Clobazam 20 mg- no documentation of administration for the second dose on 12/8/23, 12/13/23- 12/15/23, and 12/19/23, and no documentation of administration on 12/9/23-12/12/23, and 12/16/23. -Clonazepam 1mg- no documentation of administration for the second dose on 12/8/23, 12/13/23 and 12/14/23, and no documentation of administration 12/9/23- 12/12/23 and 12/15-12/19. -D3 Super Strength- no documentation of administration on 12/9/23- 12/12/23, 12/16/23, 12/17/23 and 12/19/23. -Divalproex 250 mg- no documentation of administration of second dose on 12/4/23-12/8/23, and 12/14/23 and 12/19/23, and no documentation of administration on 12/9/23-12/13/23,12/15/23, and 12/18/23. -Prazosin 1 mg- no documentation of administration on 12/8/23- 12/13/23, 12/17/23 and 12/18/23, and two doses were administered on 12/14/23. -Gabapentin 300 mg- no documentation of administration for second dose on 12/8/23, no documentation of administration 12/9/23-12/13/23, 12/17/23 and 12/18/23, and no documentation of administration for the first dose on 12/15/23, 12/16/23, and 12/19/23. -Trazadone 50 mg- no documentation of administration on 12/9/23- 12/12/23, 12/17/23 and 12/18/23. -Lacosamide 150 mg- no documentation of administration on 12/9/23- 12/12/23, 12/17/23 and 12/18/23. -Lacosamide 200 mg- no documentation of	V 118		

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administration on 12/9/23- 12/12/23.
-Docusate 100 mg- no documentation of administration of the second dose on 12/8/23, 12/13/23 and 12/17/23, no documentation of administration on 2/9/23- 12/12/23 and 12/18/23 and 12/19 am.
-Amoxicillin- Clavulanate 875mg-125 mg- no documentation of administration 12/12/23 and 12/19/23, documentation of one dose administered on 12/13/23, documentation of four doses administered on 12/14/23, documentation of two doses administered on 12/17/23.
-Lybalvi- no documentation of administration on 12/9/23- 12/13/23, and 12/17/23 and 12/18/23.
-Omeprazole- no documentation of administration on 12/9/23- 12/12/23, and 12/15/23.
-Metformin- no documentation of administration on 12/9/23- 12/12,23 and 12/15/23.
-Zonisamide- no documentation of administration on 12/9/23- 12/12/23, and 12/15/23.

Observation on 12/19/23 at approximately 11:00 am of Client #1's medications revealed:Amoxicillin- Clavulanate
-A pill bottle for a quantity of 21 Amoxicillin-Clavulanate 500 mg (milligrams)-125 mg pills.
-The dispense date for the Amoxicillin-Clavulanate was 12/12/23.
-The dosage instructions for the Amoxicillin-Clavulanate were to take 1 tablet every 8 hours for 7 days.
-There was still 13 Amoxicillin- Clavulanate pills in the bottle on 12/19/23.

Interview on 12/19/23 with Staff #1 revealed:
-Completed medication administration training.
-Only been working with the Client #1 for a week.
-"She (Client #1) missed some of her medication due to being in and out the hospital so much."
-"Sometimes it was hard to wake [Client #1] up to

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take her medicine."
-"I did not report missed medication because I thought they gave it to her at the hospital."

Interview on 12/21/23 with Staff #2 revealed:
-He initialed the MARs when he administered medication to Client #1.
-Documented "CNA" on the MARs to reflect "client was not around for her medication."
-"I always document the MARs. I don't know who left it blank or did not give them to her."
-"I'm just the crisis worker helping out."

Interview on 12/22/23 with the Program Director revealed:
-Client #1 was at the facility for emergency respite services.
-Was not aware of the missed medication or blank MARs.
-"I had not been over there to look at the MARs, and nobody reported anything to me."
-Staff #1 will be retrained in medication administration.
-"I will have a nurse go to the house (facility) and make sure the MARs are filled out correctly."

Review on 12/22/2023 of Plan of Protection dated 12/22/2023 written by the Program Director revealed the following:
-"What immediate action will the facility take to ensure the safety of the consumers in your care? [Program Director] will go to the home to ensure all meds are properly on MAR. Each time the consumer is in the hospital or refusing meds, the care provider will right R (refuse) or H (hospital) on the chart. After each med is given the care provider will initial his/her name and sign the bottom of the chart. A QP (Qualified Professional) will go by the home (facility) 3 times a week to ensure all meds are given at proper times. The

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V 118	Continued From page 5 QP will report all findings to [Program Director]. Describe your plans to make sure the above happen: [Licensee's] nurse and [QP] will go by the home (facility) at least 3 times a week to ensure meds are given at proper times, check the MARs, as well as report findings to the director. The [Licensee's] nurse will go out to the home (facility) weekly to ensure the consumer (Client #1) has all of her medications." Client #1 has a diagnoses of Mild Intellectual Disability, Post Traumatic Stress Disorder (PTSD), Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder, Seizure Disorder, and Depression. Client #1 had several hospitalizations due to her mental status and prescribed Amoxicillin- Clavulanate for a UTI/infection. Staff failed to administer 15 medications as prescribed, including the Amoxicillin- Clavulanate, and failed to report medication errors to a pharmacist or doctor for 11 days in December of 2023. This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days.	V 118		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. .	V 123		

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V 123	Continued From page 6 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure medication administration errors were reported immediately to a physician or pharmacist for 1 of 1 client (Client #1). The findings are: Review on 12/19/23 of Client #1's record revealed: -Age 18. -Admission date unknown. -Diagnoses of Mild Intellectual Disability, Post Traumatic Stress Disorder (PTSD), Disruptive Mood Dysregulation Disorder, Attention Deficit Hyperactivity Disorder, Seizure Disorder, and Depression. -Medication orders dated 12/4/23 for the following: Clobazam 20 milligrams (mg)- Take 1 tablet by mouth 2 times daily (seizures). Clonazepam 1mg- Take 1 tablet daily by mouth 2 times daily at 8:00 am and 1:00 pm (seizures). Amoxicillin- Clavulanate 500 mg-125 mg- Take 1 tablet every 8 hours for 7 days (infection). D3 Super Strength 2,000 units- Take 1 capsule daily (vitamin). Divalproex 250 mg- Take 1 tablet by mouth 2 times daily (seizures). Prazosin 1mg - Take 3 capsules by mouth daily at bedtime (PTSD). Gabapentin 300mg - Take 1 capsule 2 times daily (seizures). Trazadone 50 mg- Take 0.5 tablet by mouth once daily at bedtime (depression).	V 123		

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Lacosamide 150 mg- Take 1 tablet by mouth daily at bedtime (seizures).
Lacosamide 200 mg- Take 1 tablet by mouth daily in the morning (seizures).
Docusate 100 mg- Take 1 capsule by mouth 2 times daily (constipation).
Lybalvi 20 mg- 10 mg- Take 1 tablet daily at bedtime (mood).
Omeprazole 20 mg Extended Release- Take 1 capsule by mouth daily (gastroesophageal reflux disease).
Metformin 500 mg- Take 1 tablet by mouth daily in the morning for (weight management).
Zonisamide 50 mg- Take 1 capsule by mouth daily in the morning (seizures).
Fluoxetine 20 mg- Take 1 capsule by mouth daily in the morning (depression).

Review on 12/19/23 of Client #1's MARs dated December 2023 revealed:
-All medications were missing documentation of administration for one or both doses between 12/8/23 and 12/19/23.
-No documentation that medication errors had been reported to a doctor or pharmacist.

Review on 12/19/23 of the facility's incident reports revealed:
-No incident reports for Client #1's missed medications.
-No documentation showing Client #1's missed medication was reported to a doctor or pharmacist.

Observation on 12/22/23 at approximately 2:30 pm of Client #1 revealed:
-She was lying on the couch in the living room.
-Staff #1 was sitting in the living room observing Client #1.
-Client #1 was tired, drowsy and sleepy.

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V 123	Continued From page 8 -Client #1 could not stay awake. Attempted interview on 12/22/23 with Client #1 revealed: -Client #1 could not speak clearly and answer questions. -Client #1 had slurred speech and was incoherent. Interview on 12/19/23 with Staff #1 revealed: -Completed medication administration training. -Only been working with the Client #1 for a week. -"She (Client #1) missed some of her medications due to being in and out the hospital so much." -"Sometimes it was hard to wake [Client #1] up to take her medicine." -"I did not report missed medication because I thought they gave it to her at the hospital." Interview on 12/22/23 with the Program Director revealed: -Client #1 was at the facility for emergency respite services. -Was not aware of the missed medications. -"I had not been over there to look at the MARs, and nobody reported anything to me." -Staff #1 will be retrained in medication administration. -"I will have a nurse go to the house (facility) to check medications and report any missed dosages to her (Client #1) PCP (Primary Care Physician)." This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements/Medication Administration (V118) for a Type B rule violation and must be corrected within 45 days.	V 123		