| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| DAYMARK GUILFORD RESIDENTIAL TREATMENT FA | 5209 WEST WENDOVER AVENUE HIGH POINT, NC 27265 |

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| V 000 | INITIAL COMMENTS<br><br>An annual and follow up survey was completed on 4 /1/24. Deficiencies were cited.<br><br>This facility is licensed for the following service categories: 10A NCAC 27G .3400 Residential Treatment/Rehabilitation for Individuals with Substance Abuse Disorders and 10A NCAC 27G .5600E Supervised Living for Adults with Substance Abuse Dependency.<br><br>The facility is licensed for 56 and currently has a census of 27. The .3400 has a current census of 21 and the 5600E has a current census of 6. The survey sample consisted of audits of 4 current clients in the 3400 and 4 current clients in the 5600E and 12 former clients from the 3400 and 5600E. | V 000 | | |
| V 117 | 27G .0209 (B) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(b) Medication packaging and labeling:<br>(1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible;<br>(2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate;<br>(3) The packaging label of each prescription drug dispensed must include the following:<br>(A) the client's name;<br>(B) the prescriber's name; | V 117 | | |

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| V 117 | Continued From page 1<br>(C) the current dispensing date;<br>(D) clear directions for self-administration;<br>(E) the name, strength, quantity, and expiration date of the prescribed drug; and<br>(F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interview, the labeling of each prescribed drug was not maintained with the required information affecting 1 of 8 audited current clients (Client #2) and 2 of 12 audited former clients (FC #11 and #12). The findings are:<br><br>Observations on 3/27/24 between 3:40 pm-4:40 pm and on 3/28/24 at approximately 2:30 pm of the facility's stock medications revealed:<br>-The medications were stored in a bottom drawer of 2 separate medication carts.<br>-Former Client (FC #11)'s medicine bottle of Hydroxyzine 25 milligrams (mg) (anxiety) had a white label marked "stock med" (medicine) handwritten and placed over FC #11's name, the prescriber's name, the dispensing date, the directions for administration, the expiration date, and the name, address, and phone number of the dispensing pharmacy.<br>-A bubble pack of Trazadone Hydrochloride (HCl) 50 mg (depression and anxiety) tablets (tab) had a white label marked "stock med" handwritten and placed over the client's name, the | V 117 | | |

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| V 117 | Continued From page 2 | V 117 | | |

prescriber's name, and the directions for administration. The package was marked "d/c" (discontinued) in blue-colored ink.
-A bubble pack of Fluoxetine HCl 20 mg capsule (cap) (depression) was marked with "Total 40 mg" beside the prescribed 20 mg dosage amount and had a white label marked "stock med" handwritten and placed over the client's name, the dispensing date, and the directions for administration,
-FC #12's medicine bottle of Sertraline HCl 50 mg (depression) tab had a black-colored mark over FC#12's name.
-A medicine bottle of Hydroxyzine (Atarax) 25 mg had a white label placed over client's name, dispensing date, and directions for administration and was marked "Stock medicine" and "Do not put in client's bag."
- A second medicine bottle of Hydroxyzine HCl 25 mg tab had a white label placed over the client's name, dispensing date, and directions for administration. The white label was marked with "stock medicine" and "Do not put in client's bag."
-A bubble pack of Hydroxyzine 25 mg had the top upper right corner cut off which removed the client's name and dispensing date. This pack was marked "Stock Medication Only."
-A bubble pack of Mirtazapine 15 mg tab (depression) had a white label marked "Stock medicine" and "Do not put in client's bag" was placed over client's name, dispensing date, and directions for administration.
- A medicine bottle of Melatonin 3 mg tab (sleep) had a white label marked "Stock medicine, Do not put in client's bag" and "Return to Stock bag." This label was placed over the client's name, dispensing date, and directions for administration.
-A medicine bottle of Sertraline HCl 50 mg had a white label marked "Stock medicine" placed over the client's name, dispensing date, and directions

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for administration.
-A bubble pack of Sertraline HCl 50 mg tab had a white label marked with "Stock Medication, Do Not put in client's bag", and "Return to Stock bag." This label was placed over the client's name, dispensing date, and directions for administration.
- A bubble pack of Divalproex Sodium 500 mg DR (delayed release)tab(seizures) had client's name marked out with black ink.
-A bubble pack of Trazodone HCl 100 mg tab (depression) had a white label marked "Stock medicine, Do Not put in client's bag", and "Return to Stock bag" placed over client's name, dispensing date, and directions for administration.
-A bubble pack of Amlodipine Besylate 10 mg tab (high blood pressure) had client's name and dispensing date cut off the top of the package.
-A plastic bag of Fluoxetine 20 mg cap had a white label marked "Stock medicine, Do No put in client's bag" and "Return to Stock bag" placed over client's name, dispensing date, and directions for administration.

Observation on 3/26/24 at 12:31 pm of Client #2's medications revealed:
-No Levetiracetam 500 milligrams (mg) prescribed to Client #2 present at the facility.

Review on 3/26/24 of Client #2's record revealed:
-Admission date of 2/4/24.
-Diagnoses of Alcohol Use Disorder, Substance-induced Depressive Disorder, Substance-induced Anxiety Disorder, Essential Hypertension, and History of Seizures.
-2/5/24 physician-ordered Levetiracetam 500 mg, 1 tablet twice daily(seizures).

Review on 3/26/24 of Client #2's February 2024 and March 2024 MARs revealed:

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-He was administered Levetiracetam 500 mg beginning at 8 pm on 2/5/24 and twice daily from 2/6/24-2/29/24.
-For March 2024, he was administered Levetiracetam 500 mg at 8 am and 8 pm dose times from 3/1/24-8 am on 3/26/24.
-No documentation he was administered Levetiracetam or related anti-seizure medication from the facility's stock medications.

Interview on 3/25/24 with Client #2 revealed:
-He was on a daily anti-seizure medication.
-His last seizure was in 10/2023.
-He identified no problems with his medications since his admission.

Interview on 3/27/24 with the Licensed Practical Nurse (LPN) revealed:
-Her involvement with client medications was entering delivered medications onto client MARs.
-The facility had been waiting since 3/22/24 (4 days) on Client #2's refill for the Levetiracetam which was delivered the previous evening on 3/25/24; he was administered his 8 am dose this morning (3/26/24).
-There was one Levetiracetam (tablet) in stock medications Client #2 was administered on the previous day.

Interview on 3/27/24 with Staff #1 revealed:
-She was a shift coordinator and a residential worker.
-She had worked at the facility in her position for 2 years.
-Stock medications were prescribed client medications that were discontinued by a medical provider, or prescribed medications from discharged clients they left at the facility.

Interview on 3/27/24 with the Residential Team

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| V 117 | Continued From page 5<br><br>Lead revealed:<br>-He had worked at the facility for almost 2 years.<br>-Stock medications were discontinued medications of current clients and medications of discharged clients who did not return within 10 days of their discharge date to pick their medications up.<br><br>Interview on 3/27/24 with the Regional Program Director revealed:<br>-The medications clients left behind at the facility after 30 days were "looked at as [facility] property."<br><br>This deficiency is cross referenced into 10A NCAC 27G .0209 (c) Medication Requirements (V118) for a Type B rule violation and must be corrected within 45 days. | V 117 | | |
| V 118 | 27G .0209 (C) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(c) Medication administration:<br>(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.<br>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.<br>(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.<br>(4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be | V 118 | | |

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| V 118 | Continued From page 6<br>recorded immediately after administration. The MAR is to include the following:<br>(A) client's name;<br>(B) name, strength, and quantity of the drug;<br>(C) instructions for administering the drug;<br>(D) date and time the drug is administered; and<br>(E) name or initials of person administering the drug.<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to ensure prescription drugs were administered to a client on the written order of a person authorized to prescribe drugs affecting of 4 of 8 audited current clients (Client #1, #2, #7, and #22) and 12 of 12 audited former clients ( FC #8, #9, #10, #11, #12, #13, #16, #17, #18, and #19). The findings are:<br><br>Cross Reference: 10A NCAC 27G .0209 (b) Medication Labeling (V117)<br>Based on observation, record review and interview, the labeling of each prescribed drug was not maintained with the required information affecting 1 of 8 audited current clients (Client #2) and 2 of 12 audited former clients (FC #11 and #12).<br><br>Cross Reference: 10A NCAC 27G .0209 (d) Medication disposal (V119) | V 118 | | |

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| V 118 | Continued From page 7<br><br>Based on observation, record review and interview, the facility failed to properly dispose of current clients' discontinued medications and failed to dispose of former clients' prescribed medications affecting 1 of 8 audited current clients (Client #22) and 6 of 12 former audited clients (FC #8, #9, #10, #11, #12, and #13).<br><br>Cross Reference: 10A NCAC 27G .0209 (h) Medication errors (V123)<br>Based on record review and interview, the facility failed to ensure all medication administration errors were reported immediately to a physician or pharmacist affecting 4 of 8 audited current clients (Client #1, #2, #7 and #22) and 9 of 12 audited former clients (FC #8, #9, #10, #11, #12, #13, #16, #17, #18 and #19).<br><br>Review on 3/22/24 of the Plan of Protection dated 3/22/24 by the Regional Program Director revealed:<br>"What immediate action will the facility take to ensure the safety of the consumers in your care?<br>Effective immediately, all responsible staff will no longer dispense or use "stock" meds that belong to previous clients<br>Effective immediately, all responsible staff will follow appropriate steps for refilling client medications as identified in agency policy and procedures (i.e. notifying pharmacy in timely manner of refills; calling doctors' offices for samples; scheduling clients with the mobile med unit)<br>Effective immediately, all staff responsible for passing medications will review the Daymark Recovery Services Procedures on Dispensing of Medications<br>Effective immediately, all staff responsible for passing medications will review the NCDHHS guidelines for dispensing medications | V 118 | | |

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| V 118 | Continued From page 8<br><br>Effective immediately, all staff will notify the appropriate parties when clients have a missed medication dose as identified in the above policies and procedures. (i.e. notifying the clients physician or pharmacy of a missed dose)<br><br>Describe your plans to make sure the above happens.<br>Effective 3/28/2024, Program Director will oversee the immediate discard of any stock medications that belong to previous clients<br>Effective 3/28/2024, Program Director scheduled a meeting w/all staff on 4/3/24, to cover the above policies, procedures and guidelines for passing medications.<br>Effective 3/28/2024, Program Director will have all staff responsible for passing medications scheduled to complete additional Medication Administration Training"<br><br>The current and former clients at this facility had substance use disorders and co-occurring mental and physical health disorders including Alcohol Use Disorder, Cocaine Use Disorder, Generalized Anxiety, and History of Seizures. Residential staff were responsible for administering client medications. The residential staff used current clients' discontinued prescribed medications and discharged clients' prescribed medications to administer to current clients who were awaiting prescription refills from the pharmacy. These medications were defined by staff as stock medications. There was no documentation that indicated which clients received the stock medications. At least 13 stock medications had pharmacy labels which had been altered and obstructed information from a client's name, dosage strength, dispense date, and dispensing instructions to handwritten dosage strength, directions for administration, | V 118 | | |

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| V 118 | Continued From page 9<br>and were identified as a stock medication. At least 7 of 15 stock medications were held at the facility after 30 days from a client's 30 discharge date. Staff had no knowledge how long these medication labeling and medication administration practices had been occurring. There were at least 5 incidents between 1/1/24-3/25/24 where there was a lack of immediate notification to a physician or pharmacist when a client missed or refused a medication.<br><br>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 119 | 27G .0209 (D) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(d) Medication disposal:<br>(1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion.<br>(2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction.<br>(3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. | V 119 | | |

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| V 119 | Continued From page 10<br>(4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to properly dispose of current clients' discontinued medications and failed to dispose of former clients' prescribed medications affecting 1 of 8 audited current clients (Client #22) and 6 of 12 former audited clients (FC #8, #9, #10, #11, #12, and #13). The findings are:<br><br>Observations on 3/27/24 between 3:40 pm-4:40 pm and on 3/28/24 at approximately 2:30 pm of the facility's stock medications revealed:<br>-Client #22 had a bubble pack of Gabapentin 300 milligrams (mg)(epileptic seizures) capsule (cap) filled on 3/22/24 with a white label placed on left top that covered the dispensing instructions with "Stock Med"(medicine) handwritten in black ink. 15 of 31 capsules remained in the pack.<br>-Former Client (FC #8) had a bubble pack of Quetiapine Fumarate 50 mg(major depressive disorder) tablet (tab), take 1 tab at bedtime, filled on 12/14/23. 8 of 31 tablets remained in the pack. One of 9 blister trays in this pack contained 2 tablets.<br>-FC #9 had a bubble pack of Fluoxetine Hydrochloride (HCl) (depression)20 mg cap, take | V 119 | | |

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| V 119 | Continued From page 11<br>1 cap daily, filled on 12/15/23. 12 out of 30 capsules remained in the pack.<br>-FC #10 had 2 bubble packs of Gabapentin 100 mg cap, take 1 cap 3 times daily with the first pack filled on 10/14/23. 12 of 30 capsules remained in the pack.<br>-The second pack of Gabapentin 100 mg, take 1 cap 3 times daily, filled on 10/18/23. 10 out of 60 capsules remained in the pack. A red-colored handwritten instruction on the left top corner of this bubble pack read "11-1-23@ 0845 Take 200 mg P.O. TID" with circled initials.<br>-FC #11 had a pill bottle of Hydroxyzine 25 mg (anxiety) filled with a white label marked "stock med" written in red-colored ink was placed over the client's name, the prescriber's name, date filled, quantity filled, and the directions for administration. 1 tablet remained in the pill bottle.<br>-FC #12 had a pill bottle of Sertraline HCl 50 mg (depression), take ½ tab daily with the client's name, drug quantity, and date filled marked over with black colored ink. 5-7 tablets remained in the bottle.<br>-FC #13 had a pill bottle of Ondansetron 4 mg disintegrating tablet (nausea and vomiting), take one tablet every 6 hours as needed, filled on 8/20/23 for 10 pills and an unknown quantity in bottle.<br>-A bubble pack of Trazadone Hydrochloride (HCl) 50 mg (depression and anxiety) tab, filled on 8/11/23 had a white label marked "stock med" written in red-colored ink and placed over the client's name, the prescriber's name, and the directions for administration. The package was marked "d/c" (discontinued) in blue-colored ink. 23 tablets out of 30 remained in the pack.<br>-A bubble pack of Fluoxetine HCl 20 mg cap (depression), filled on 8/11/23, had black-colored handwritten instruction that read " Total 40 mg" beside the 20 mg dosage amount with a white | V 119 | | |

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| V 119 | Continued From page 12 | V 119 | | |

label marked "Stock Med" in red colored ink and placed over the client's name, the dispensing date, and the pharmacy's dispensing instructions. 7 out of 30 capsules remained in the pack.

Review on 4/1/24 of Client #22's record revealed:
-Admission 2/15/24.
-Diagnosis of Alcohol Dependence.

Review on 4/1/24 of FC #8's record revealed:
-Admission date of 12/14/23.
-Discharged date of 1/13/24.
-Diagnosis of Stimulant Use Disorder.

Review on 4/1/24 of FC #9's record revealed:
-Admission date of 12/7/23.
-Discharged date of 1/5/24.
-Diagnoses of Alcohol Use Disorder and Cocaine Use Disorder.

Review on 4/1/24 of FC #10's record revealed:
-Admission date of 10/17/23.
-Discharged date of 12/11/23.
-Diagnosis of Alcohol Use Disorder.

Review on 4/1/24 of FC #11's record revealed:
-Admission date of 11/7/23.
-Discharge date of 11/7/23.
-No diagnoses identified.

Review on 4/1/24 of FC #12's record revealed:
-Admission date of 12/20/23.
-Discharge Date of 2/6/24.
-Diagnoses of Cocaine Use Disorder, Alcohol Use Disorder, and Cannabis Use Disorder

Review on 4/1/24 of FC #13's Record revealed:
-Admission date of 8/24/23
-Discharged date of 3/8/24
-Diagnoses of Opioid Use Disorder,

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| V 119 | Continued From page 13<br>Amphetamine Use Disorder, Stimulant Use Disorder, Sedative Use Disorder, and Cannabis Use Disorder.<br><br>Interview on 4/1/24 with the Support Supervisor revealed:<br>-FC #11 was not officially admitted to the facility. "He must have come in around 11/7/23 and decided that same day not to stay. He either left his medicine here or it was ordered, came in (delivered to the facility) and put in stock medicine is likely what happened."<br><br>Interview on 3/27/24 with the Licensed Practical Nurse (LPN) revealed:<br>-Stock medications were administered by the residential staff to current clients from prescribed medications of discharged clients if the medication and dosage strength matched.<br><br>Interview on 3/27/24 with Staff #1 revealed:<br>-She was a shift coordinator and a residential worker.<br>-She had worked at the facility in her position for 2 years.<br>-Stock medications were prescribed client medications that were discontinued by a medical provider, or prescribed medications from discharged clients they left at the facility.<br>-Stock medications were administered to clients for "no more than 2 days."<br><br>Interview on 3/27/24 with the Residential Team Lead revealed:<br>-He had worked at the facility for almost 2 years.<br>-Stock medications were discontinued medications of current clients and medications of discharged clients who did not return within 10 days of their discharge date to pick their medications up. | V 119 | | |

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| V 119 | Continued From page 14<br>-More than one dose of a stock medication at same dose strength would be pulled from the medication stock and administered to a current client if a client was waiting for their prescribed medication to be delivered from the pharmacy.<br>-He did not know how long the practice of administering stock medications to current clients had been occurring.<br>-He had no knowledge of clients who had experienced adverse effects due to being administered a former client's medication.<br><br>Interview on 3/27/24 with the Regional Program Director revealed:<br>-The medications clients left behind at the facility after 30 days were "looked at as [facility] property."<br>-When a former client's medication was used as stock medication, it could be given to a current client one time to fill a "gap" while waiting for the current client's medication to be delivered.<br>-"If it (stock medication) was going to be used more than two times, we should be calling (the doctor) and asking for a bridge (medication samples) and not using stock meds over and over ...should be a rare occasion."<br>-Staff were to ensure the same milligrams and same brand drug was used from the stock medication as the current client's prescribed medication.<br>-She became interim center director for about 3 weeks beginning 10/31/23 and did not know how long the practice of administering former client medications to current clients had been occurring.<br>-She would ensure the practice of administering discontinued medications and former client medications to current clients was stopped immediately. | V 119 | | |

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| V 119 | Continued From page 15<br>This deficiency is cross referenced into 10A NCAC 27G .0209 (c) Medication Requirements (V118) for a Type B rule violation and must be corrected within 45 days. | V 119 | | |
| V 123 | 27G .0209 (H) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(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.<br>.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure all medication administration errors were reported immediately to a physician or pharmacist affecting 4 of 8 audited current clients (Client #1, #2, #7 and #22) and 9 of 12 audited former clients (FC #8, #9, #10, #11, #12, #13, #16, #17, #18 and #19). The findings are:<br><br>Review on 3/25/24 of Client #1's record revealed:<br>-Admission date of 2/1/24.<br>-Discharge date of 3/26/24.<br>-Diagnoses of Alcohol Abuse Disorder, Generalized Anxiety Disorder and Mood Dysregulation Disorder.<br>-No documentation in his Level I incident report | V 123 | | |

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| V 123 | Continued From page 16 | V 123 | | |

dated 3/17/24 that a physician or a pharmacist was notified about his missed 8 am dose of Allopurinol 100 milligram(mg) (lower uric acid levels in the blood).

Reviews on 3/25/24 and 4/1/24 of Client #7's record revealed:
-Admission date of 1/18/24.
-Diagnoses of Alcohol Use Disorder, Stimulant Use Disorder, and Cannabis Use Disorder.
-No documentation in his Level I incident report dated 1/26/24 that a physician or a pharmacist was notified about his missed 8 am dose of Sertraline .25 mg (depression).

Reviews on 3/25/24 and 4/1/24 of Former Client (FC #16)'s record revealed:
-Admission date of 12/19/23.
-Discharged date of 2/19/24.
-Diagnoses of Alcohol Use Disorder, Opioid Use Disorder, and General Anxiety Disorder.
-No documentation in his Level I incident report dated 2/10/24 that a physician or a pharmacist was notified about his missed 1 pm dose of Buprenorphine Naloxone 2 mg (opioid dependence).

Reviews on 3/25/24 and 4/1/24 of FC# 17's record revealed:
-Admission date of 2/8/24.
-Discharged date of 3/8/24.
-Diagnoses of Cocaine Dependence and Alcohol Use Disorder.
-No documentation in his 3 Level 1 incident reports dated 2/12/24 at 9 pm, 2/13/24 at 8 pm, and 2/14/24 at 8 pm that a physician or a pharmacist was notified about his refused doses of Trazadone. Client # 17's statement in the report was the medicine "caused his legs to swell" (depression).

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| V 123 | Continued From page 17<br><br>Reviews on 3/25/24 and 4/1/24 of FC# 18's record revealed:<br>-Admission date of 2/27/24.<br>-Discharge date of 3/20/24.<br>-Diagnoses of Cocaine Disorder, Alcohol Use Disorder, and Cannabis Use Disorder.<br>-No documentation in his Level 1 incident report dated 3/2/24 that a physician or a pharmacist was notified about his missed 4 pm dose of Ibuprofen. Client #18's statement in the report was this medicine "hurt his stomach".<br><br>Reviews on 3/5/24 and 4/1/24 of FC# 19's record revealed:<br>-Admission date of 1/17/24.<br>-Discharge date of 2/6/24.<br>-Diagnosis of Cocaine Use Disorder, Alcohol Use Disorder, Cannabis Use Disorder, Sedative Hypnotic Anxiolytic Disorder.<br>-No documentation in his Level 1 incident reports dated 1/21/24 that a physician or a pharmacist was notified about his missed 8 pm dose of Methocarbamol.<br>-No documentation in his Level 1 incident reports dated 1/22/24 that a physician or a pharmacist was notified about his missed 8 am dose of Methocarbamol.<br><br>Interview on 3/27/24 with Staff #2 revealed:<br>-She worked as a residential worker.<br>-Her direct supervisor was the Residential Team Lead.<br>-She administered medications to clients.<br>-She completed incident reports when clients missed or refused their medications and placed each report in the Residential Team Lead's door.<br>-She did not notify a doctor or a pharmacist when there was a missed medication administration or a medication refusal because she did not have | V 123 | | |

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| V 123 | Continued From page 18<br>access to speak with a doctor and she had never had to call a pharmacist.<br>-"[Residential Team Lead] and [Shift Coordinator] would handle that (talking to the clients' physicians and the pharmacist).<br><br>Interview on 3/27/24 with the Residential Team Lead revealed:<br>-Residential staff completed incident reports for clients who refused or missed their medication doses.<br>-The incident reports were then submitted to him or the center director for review.<br>-"We don't have to notify the (client's) doctor and that's the client's right."<br><br>This deficiency is cross referenced into 10A NCAC 27G .0209 (c) Medication Requirements (V118) for a Type B rule violation and must be corrected within 45 days. | V 123 | | |
| V 736 | 27G .0303(c) Facility and Grounds Maintenance<br><br>10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS<br>(c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.<br><br>This Rule is not met as evidenced by:<br>Based on interview and observation, the facility was not maintained in a safe, clean, and attractive manner. The findings are:<br><br>Observation of the facility's interior on 3/27/24 between 3:42 pm and 4:45 pm revealed:<br>Cafeteria:<br>-An area of floor tiles of approximately 8 inches x | V 736 | | |

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| V 736 | Continued From page 19<br>8 inches was cracked and stained.<br><br>C-Hall:<br>-Bedroom C-2 had a black-colored rubber trim pulled away from the wall on left side of the shower entrance, stains on the floor in front of the toilet of approximately 1-2 feet in length, dark stains on the shower floor and shower wall surround, rusted vent screen in the ceiling and rusted handrails around the toilet (back and left facing side walls).<br>-Bedroom C-4 had three holes in a row in the left wall behind the bedroom door. One hole was approximately 4 inches x 4 inches, the second hole was 2 inches x 2 inches, and the third hole was about 1 inch x 1.5 inches. There were dark colored stains in the shower on the floor and wall surround, and rusted handrails around the toilet (back and left facing side walls).<br><br>B-Hall:<br>-Bedroom B-2 had 4 holes on the right wall that were each approximately 2 inches x 2 inches, had a black-colored rubber trim pulled away from the wall at shower entrance of approximately 2 inches in length, a stained floor area in front of toilet about 2 feet in length, rusted handrails, and a rusted ceiling vent.<br>-Bedroom B-5 had a hole approximately 4 inches x 4.5 inches in the left wall behind the door.<br>-Bedroom B-10 had a black-colored rubber trim that was about 2-3 inches in length and dislodged from wall around shower entrance. The handrails around toilet appeared rusted, and there was dripping water into the shower from the shower head.<br><br>Women's A-Hall:<br>-Bedroom A-4 (Client#3's bedroom) had sink with that would not drain water and a wall mounted | V 736 | | |

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| V 736 | Continued From page 20 | V 736 | | |

soap dispenser with the body of the dispenser hanging down from the dispenser. There was a black-colored stain on the bathroom floor in front of the shower that was approximately 3-5 inches in length.
-Bedroom A-7 had splitting, damaged caulking around the sink and a brown stain on the tile beneath the sink that was approximately 3 inches x 5 inches in size.

Interview on 3/26/24 with Client #3 revealed:
-She stated her toilet "might get messed up," but was fixed a couple of days ago. She did not identify problems with her sink being clogged or her soap dispenser.

Interview on 3/26/24 with a client (not in audit) who occupied bedroom B-5 revealed:
-He requested an observation of a hole in the left wall behind the door of his room.
-He stated the hole was there when he was admitted on 3/25/24.
-He did not know who or what caused the hole in the wall.

Interview on 3/26/24 with Client #6 revealed:
-He was in Bedroom B-12 and shared a bathroom with a client in B-10.
-Water dripped continuously in their shower.
-"It's been leaking for a year. I've explained to maintenance to shut off the water and change the showerhead or get channel locks and tighten it (showerhead). Sounds like someone is constantly peeing ....I reported it the last time I was here."
-To access repair work, clients were expected to complete a maintenance request form and submit it to the Support Supervisor.
-He did not know why the water problem in the shower had not been fixed.

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| V 736 | Continued From page 21<br><br>Interview on 3/27/24 with Support Supervisor revealed:<br>-The building was old and there was not a full-time maintenance person; "we need someone full-time."<br>-The floor tile in the kitchen was mopped daily by a local contracted cleaning service. She reported, "floors are mopped daily, and this stain has not been removed."<br>-She was unaware of holes in the walls of the clients' rooms and the leaking showerhead.<br>-She had contacted a flooring company and they had started cleaning the floors.<br>-The dislodged trim around the showers in client's room "maybe from water."<br>-She would follow up with the county maintenance and have these repair issues addressed as soon as possible.<br><br>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. | V 736 | | |