STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-072	A. BUILDING: _____ B. WING _____	02/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRASTY GABLES	131 WALNUT ROAD CLYDE, NC 28721

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on 2/13/24. The complaint was unsubstantiated (Intake #NC00212313). A deficiency was 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 2. The survey sample consisted of audits of 2 current clients.	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	V 118		

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V 118	Continued From page 1 (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure medications were administered on the written order of a physician and medications administered were recorded on the client's MAR immediately after administration affecting 1 of 2 clients (Client #1). The findings are: Review on 2/6/24 of Client #1's record revealed: -admission date 1/2/24. -diagnoses of Autism Spectrum Disorder, Seizure Disorder, Epilepsy, Moderate Intellectual Developmental Disorder, Anxiety Disorder unspecified, Obsessive Compulsive Disorder, and Eczema. -1/9/24 - Emergency Medical Services report - client "was reportedly seizing when he was discovered, had fallen, and presumed to have hit his head on the bedside table...transported routinely to [local] ED (Emergency Department)...." -1/9/24 - Emergency MD (Medical Doctor) Note - "...25-year-old male who had a seizure at a group home...He suffered some abrasions during the seizure...Patient also had a 2nd seizure during this episode (in the ED)...."	V 118		

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V 118	Continued From page 2 -ED physician's progress notes from 1/9/24 through 2/6/24 indicated the client had seizures on 1/9/24 (2 times), 1/13/24, 1/31/24 and 2/1/24. -1/13/24 - ED physician's progress note - "The patient did have a generalized tonic-clonic seizure in the ER (Emergency Room) today that required intramuscular benzodiazepines and subsequent IV (intravenous) Keppra (Myoclonic Seizures). I believe that this is because he (Client #1) has not been receiving his home seizure medicine and I have started him on oral Keppra twice a day today..." Review on 2/6/24 of Client #1's MAR for January 2024 revealed: -Lacosamide (seizures) 200 milligrams (mg)- 1 tablet 2 times a day. -Fycompa (seizures) 6 mg - 1 tablet 2 times a day. -Oxcarbazepine (seizures) 600 mg - 2 tablets 2 times a day. -Montelukast Sodium (allergies/asthma) 10 mg - 1 tablet at bedtime. -Guanfacine (Attention-Deficit Hyperactivity Disorder (ADHD)) HCL (hydrochloride) ER (extended release) 2 mg - 1 tablet at bedtime. -Trazodone (Depression) HCL 150 mg - 1 tablet at bedtime. -Guanfacine (ADHD) HCL 1 mg - 1 tablet 2 times a day. -Lithium Carbonate (mood disorder) ER 450 mg - 1 tablet 2 times a day. -Opzelura (Eczema) 1.5% Topical Cream - apply topically to affected areas 2 times a day. -Tacrolimus (Eczema) 0.1% Topical Ointment - apply topically to affected areas 2 times a day. -Mupirocin (Eczema) 2 % Topical Ointment - apply topically daily. -Fluticasone Propionate (allergies) 50 mcg (micrograms) - instill 2 sprays each nostril 1 times	V 118		

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V 118	Continued From page 3 a day. -Haloperidol (agitation) 5 mg - 1 tablet 1 time a day PRN (as needed). -Lorazepam (moderate to severe agitation) 0.5 mg - 1 to 2 tablets 2 times a day PRN. -Trazodone HCL 50 mg - 1 tablet at bedtime PRN. -two medications initialed on 1/8/24 to indicate they were administered were Lorazepam 0.5 mg and Trazodone HCL 50 mg PRN . -there were no initials on 1/8/24 to indicate any of the remaining medications listed above were administered. Review on 2/6/24 of facility records revealed no physician orders for Client #1. Attempted interviews on 2/5/24 and 2/7/24 with Client #1 were unsuccessful as he only repeated the last word that was said . Interviews on 2/5/24 and 2/7/24 with the Registered Nurse (RN) from the local hospital revealed: -she assessed Client #1 on 1/9/24 when he presented to the ED. -he "came here (hospital) with nothing...no meds (medications)...no (physician) orders.." -Client #1 had a second seizure while waiting in the hallway of the ED. -"If he (Client #1) doesn't get his seizure medications at the exact time he is supposed to, he will have a seizure...have to give it the exact same time every day." -the hospital pharmacy did not have one of his seizure medications, Fycompa, available. -on 1/9/24 (Friday), she notified Client #1's dad/guardian they were in need of the medication. -he said he would call the facility to ask for the	V 118		

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V 118	Continued From page 4 Fycompa to be brought to the hospital. -"Someone (from the facility) came and dropped the pills (Fycompa) off at the front desk (of the hospital)...he was without them (Fycompa) for a couple of days (while in the hospital)." Interviews on 2/7/24 and 2/8/24 with the attending physician at the local ED revealed: -it "absolutely would have caused a seizure if there was a day he (Client #1) didn't get his medications...We (hospital staff) were late one day by an hour or two and he had a seizure. His seizure disorder is pretty severe." -it was suspected Client #1 was not receiving his seizure medications due to the results of his laboratory tests on 1/9/24. -his "Oxcarbazepine was undetectable when he got here (ED)...which means it's (the medication) not in his system." -the other seizure medications, Lacosamide and Fycompa, did not have lab values that could be tested. Interviews on 2/5/24 and 2/7/24 with Client #1's Alternative Family Living (AFL) provider revealed: -when Client #1 arrived at the facility, 1/2/24, she received his medications and MARs; "I never got (physician) orders...ever." -he "only had that 1 seizure" on the morning of 1/9/24. -on 1/12/24 (Monday) she received a text from the facility's Adult Services Coordinator/Qualified Professional (ASC/QP), asking her to take Client #1's medications to the hospital, so she did that day. -"He (Client #1) did have his meds (on 1/8/24)...I promise you. I didn't fill it (MAR) out that day." Review on 2/5/24 of a text on the AFL provider's mobile phone dated 1/12/24 from the facility's	V 118		

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V 118	Continued From page 5 ASC/QP revealed: -the ASC/QP asked, "Can you take [Client #1's] meds to hospital." Interview on 2/6/24 with the ASC/QP revealed: -he had a copy of 1 physician order for Client #1, Lorazepam, on his mobile phone. -all of Client #1's physician orders were taken to the hospital (date unknown). -on 1/8/24 it "looks like she (AFL provider) failed to document properly (on the MAR). That will be a med error on her. I will write that corrective up." Review on 2/6/24 of a text on the ASC/QP's mobile phone a copy of an electronic physician's order for Client #1 revealed: -12/8/23 - Lorazepam 0.5 mg - 1 to 2 tablets 2 times a day PRN for moderate to severe agitation. Due to the failure to accurately document medication administration, it could not be determined if Client #1 received his medications as ordered by the physician. Review on 2/13/24 of the Plan of Protection dated 2/13/24 written by the ASC/QP revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? The Adult Services Coordinator (ASC/QP) and Program's Assistant went to Grasty Gables and did an inventory of all medications on site. The staff then checked the MAR against the medication to verify documentation was correct. A formal discussion between the AFL and ADA (Americans with Disabilities Act) Coordinator took place to elaborate on this policy and requirement and fielded any questions. IWC (Irene Wortham Center) (licensee) staff explained in detail why correct documentation and preservation of the	V 118		

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V 118	Continued From page 6 physician's orders is important. This occurred on 02/12/2024. ADA staff will continue, daily, to check with Grasty Gables to ensure that correct documentation is being done. Per Irene Wortham Center Policy: III.03.30, 6: For those clients/residents who self-administer medication but do not record on the MAR, the staff record doses in the MAR. If the consumer refuses to sign his MAR, Grasty Gables staff will appropriately document MAR such as to reflect accurately which medications were administered. This will continue as an on-going basis up until the point where the consumer's Individual Service Plan changes. Daily visual verification of the MAR will continue for one month. On 02/13/2024, the IWC Program's Assistant will be in-serviced on the following topics: 1) Common med errors and how to recognize them. 2) The importance of accurate record keeping. 3) Possible penalties for inaccurate reporting. 4) Abuse and Neglect refresher training. Grasty Gables will be in-serviced by the ADA Coordinator by 02/16/2024 on the topic of maintaining accurate physician's orders, correct MAR data entry, and a new acknowledgement of medication passing policies and procedures. The language of this in-service will be written by Irene Wortham Center RN staff. -Describe your plans to make sure the above happens. ADA coordinator will in-service the Program's	V 118	V118: AFL provider [redacted] will maintain compliance with signing the MAR and administering medication if/when consumer refuses to self-administer and sign the MAR. Compliance met on 03/14/2024	03.07.24

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V 118	Continued From page 7 Assistant describing the expectations and policy(s) written above. The ADA coordinator will work with the Program's Assistant to ensure compliance from Grasty Gables and continue to train Grasty Gable's staff on proper policies and procedures. The ADA Coordinator will personally in-service the above documents and verify visually the MAR daily." Client #1 had diagnoses of Autism Spectrum Disorder, Seizure Disorder, Epilepsy, Moderate Intellectual Developmental Disorder, Anxiety Disorder unspecified, Obsessive Compulsive Disorder, and Eczema. He took medications for seizures, mood disorders, and Attention-Deficit Hyperactivity Disorder. The facility had no physician orders for the client's medications. On 1/8/24 his MAR had no initials to indicate his routine medications were administered. On 1/9/24, Client #1 suffered a seizure and was transported to the local hospital. A Physician and RN at the local hospital stated Client #1's seizure disorder was severe and him missing his seizure medications one day, or not receiving them at the same time every day, would cause the client to have a seizure. When lab values were tested upon arrival to the hospital, the medication Oxcarbazepine was undetectable. The other seizure medications, Lacosamide and Fycompa, had no lab values that could be tested. The hospital was in need of one seizure medication, Fycompa, that was not available in their pharmacy. On 1/9/24 a request was made for the facility to bring this medication to the hospital. The facility did not take the requested medication until 1/12/24. Client #1 went approximately 3 days without his seizure medication, Fycompa. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 118	V118: Programs assistant will check the AFL MAR book daily for Grasty Gables specifically for 30 days via confirmation with the AFL Provider. The Programs assistant will also ensure that medication is being correctly given and recorded in the MAR. 1) Common med errors and how to recognize them. 2) The importance of accurate record keeping. 3) Possible penalties for inaccurate reporting 4) Abuse and Neglect refresher training. Daily checking will be implemented on 02/14/2023 and continue for 30 days, ending on 03/14/2024. Continued monitorings of the AFL homes to ensure compliance with Per Irene Wortham Center Policy: 111.03.30, 6. Compliance was met on 03/14/2024	03.07.24

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