STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL073-037	A. BUILDING: _____ B. WING _____	05/02/2024

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WINHAVEN STREET GROUP HOME	230 WINHAVEN STREET ROXBORO, NC 27573

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V 000	INITIAL COMMENTS An annual survey was completed on 5/2/24. Deficiencies were cited. This facility is licensed for the following service: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. The facility is licensed for 6 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.	V 000		
V 106	27G .0201 (A) (8-18) (B) GOVERNING BODY POLICIES 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (8) use of medications by clients in accordance with the rules in this Section; (9) reporting of any incident, unusual occurrence or medication error; (10) voluntary non-compensated work performed by a client; (11) client fee assessment and collection practices; (12) medical preparedness plan to be utilized in a medical emergency; (13) authorization for and follow up of lab tests; (14) transportation, including the accessibility of emergency information for a client; (15) services of volunteers, including supervision and requirements for maintaining client confidentiality; (16) areas in which staff, including nonprofessional staff, receive training and continuing education; (17) safety precautions and requirements for	V 106		

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V 106	Continued From page 1 facility areas including special client activity areas; and (18) client grievance policy, including procedures for review and disposition of client grievances. (b) Minutes of the governing body shall be permanently maintained. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to implement their policy regarding incident reports. The findings are: Review on 5/2/24 of the facility's Incident Reporting Policy revealed: - "...employees should follow the established procedure for reporting critical incidents. Critical incidents are defined as: medication errors...staff involved in the incident will complete a medication error form immediately..." A. Review on 4/29/24 of client #2's record revealed: - admitted 10/13/99 - diagnoses: Severe Intellectual Disabilities, Cerebral Palsy Unspecified, Essential (Primary) Hypertension, Mixed Hyperlipidemia, Overflow Incontinence - a physician's order dated 4/23/24 for Solifenacin 5 milligrams (incontinence) Review on 4/29/24 of client #2's April 2024 Medication Administration Record (MAR) revealed: - no documentation of administration of Solifenacin from 4/24/24-4/27/24	V 106		

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V 106	Continued From page 2 B. Review on 4/29/24 of client #3's record revealed: - admitted 4/21/08 - diagnoses: Moderate Intellectual Disabilities, Down's Syndrome Unspecified, Allergic Rhinitis due to pollen, Constipation Unspecified, Gastro-Esophageal reflux disease without esophagitis, Mixed Hyperlipidemia, Adjustment Disorder Unspecified - a physician's order dated 2/8/24 for Miralax (constipation) Review on 4/29/24 of client #3's February 2024 MAR revealed: - no documentation of administration of Miralax from 2/8/24-2/14/24 Interview on 5/2/24 the Managing Director reported: - staff did not complete the medication error forms - would ensure medication error forms were completed	V 106		
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	V 118		

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V 118	Continued From page 3 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 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, observation and interviews the facility failed to administer medications on the written order of a physician for 2 of 3 audited clients (#2 & #3). The findings are: The following are examples of how client #2 & #3 did not receive medications ordered by their physicians: I. Review on 4/29/24 of client #2's record revealed: - admitted 10/13/99 - diagnoses: Severe Intellectual Disabilities, Cerebral Palsy Unspecified, Essential (Primary)	V 118		

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V 118	Continued From page 4 Hypertension, Mixed Hyperlipidemia, Overflow Incontinence - a physician's order dated 4/23/24 for Solifenacin 5 milligrams (mg) (incontinence) 1 tablet by mouth daily Observation on 4/29/24 at 2:35pm of client #2's medication revealed: - a dispense date of 4/24/24 for Solifenacin 5mg Review on 4/29/24 of client #2's April 2024 MAR revealed: - no documentation of administration of Solifenacin from 4/24/24-4/27/24 - no notation of refusals Interview on 4/29/24 client #2 reported: - he did not remember refusing to start Solifenacin - "I don't remember that, happened so long ago." Interview on 4/29/24 staff #1 reported: - been at the facility since March of 2023 - client #2 was out of town when the nurse brought the Solifenacin to the facility - the medicine came on a Thursday or Friday while client #2 was out of town - the nurse brought enough to last until the end of the month before a bubble pack could be used - she (staff #1) administered the medicine on Sunday when client #2 returned Interview on 5/2/24 the facility's nurse reported: - client #2 wanted to wait to start Solifenacin until he returned from out of town, in case there were side effects - she (facility's nurse) believed client #2 left for out of town on 4/23/24 and returned 4/27/24	V 118		

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V 118	Continued From page 5 - thought client #2 could make that decision since he was his own guardian Interview on 4/29/24 the Managing Director reported: - she met with client #2 at the facility the night before he left to go out of town - she provided education to client #2 on Solifenacin and potential side effects - client #2 made the choice to wait until he returned from out of town to start medication - client #2 was able to make that decision because he was his own guardian II. Review on 4/29/24 of client #3's record revealed: - admitted 4/21/08 - diagnoses: Moderate Intellectual Disabilities, Down's Syndrome Unspecified, Allergic Rhinitis due to pollen, Constipation Unspecified, Gastro-Esophageal reflux disease without esophagitis, Mixed Hyperlipidemia, Adjustment Disorder Unspecified - a physician's order dated 2/8/24 for Miralax (constipation) 1 scoop mixed with 8 oz fluids once a day Review on 4/29/24 of client #3's February 2024 MAR revealed: - no documentation of administration of Miralax from 2/8/24-2/14/24 Interview on 4/29/24 client #3's guardian reported: - he consented for client #3 to use all medications, including Miralax Interview on 4/29/24 staff #1 reported: - been at the facility since March of 2023 - did not recall why client #3 started Miralax on	V 118		

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V 118	Continued From page 6 2/15/24 - it was "so long ago" Interview on 5/2/24 the facility's nurse reported: - been with the agency for 9 years - she was responsible for making sure all MARs and medications were accurate - she picked up medications from the pharmacy and dropped them off at the facilities - anything prescribed in the middle of the month, staff picked up that medication and added it to the MAR - she was not sure why staff did not administer client #3's Miralax on 2/8/24 - found out today (5/2/24) the Miralax was not given until 2/15/24 Interview on 4/29/24 the Qualified Professional (QP) reported: - not sure why client #3 was delayed in taking Miralax - it may have been an issue with getting consent from his guardians - she would look into it - no incident reports or medication errors had been completed for client #3	V 118		