STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL097-068	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD 60 HOME	258 OLD HIGHWAY 60 WILKESBORO, NC 28697

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V 000	INITIAL COMMENTS An annual survey was completed on 5/3/24. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 3 and has a current census of 3. The survey sample consisted of audits of 3 current clients. Two sister facilities are identified in this report. The sister facilities will be identified as sister facility A and sister facility B. Sister facility clients will be identified using the letter of the facility and a numerical identifier.	V 000		
V 116	27G .0209 (A) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (a) Medication dispensing: (1) Medications shall be dispensed only on the written order of a physician or other practitioner licensed to prescribe. (2) Dispensing shall be restricted to registered pharmacists, physicians, or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy. If a permit to operate a pharmacy is Not required, a nurse or other designated person may assist a physician or other health care practitioner with dispensing so long as the final label, Container, and its contents are physically checked and approved by the authorized person prior to dispensing. (3) Methadone For take-home purposes may be supplied to a client of a methadone treatment service in a properly labeled container by a	V 116		

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	MHL097-068	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 116	Continued From page 1 registered nurse employed by the service, pursuant to the requirements of 10 NCAC 26E .0306 SUPPLYING OF METHADONE IN TREATMENT PROGRAMS BY RN. Supplying of methadone is not considered dispensing. (4) Other than for emergency use, facilities shall not possess a stock of prescription legend drugs for the purpose of dispensing without hiring a pharmacist and obtaining a permit from the NC Board of Pharmacy. Physicians may keep a small locked supply of prescription drug samples. Samples shall be dispensed, packaged, and labeled in accordance with state law and this Rule. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure medication dispensing was restricted to registered pharmacists, physicians, or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy affecting 1 of 3 clients (Client #3). The findings are: Review on 4/26/24 of Client #3's record revealed: -admission date 12/21/23. -diagnoses of Mild Intellectual Developmental Disability (IDD), Major Depressive Disorder, Antisocial Personality Disorder, Speech Impairment, Chronic Obstructive Pulmonary Disease, Gastroesophageal Reflux Disease, Hyperlipidemia, and Allergic Rhinitis. Review on 4/26/24 of Client #3's physician orders	V 116		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 116	Continued From page 2	V 116		

revealed:
-2/16/24 - Lorazepam (Anxiety) 1 milligram (mg) - 1 tablet PRN (as needed).

Observation on 4/25/24 at 3:33 p.m. of Client #3's medications revealed:
-Lorazepam 1 mg with directions to administer 1 tablet PRN - dispensed 4/19/24.

Review on 4/26/24 of nursing notifications provided by the facility's Registered Nurse (RN) Supervisor revealed:
-4/15/24 at 8:00 p.m. - "[Client #3] is having behaviors, and they have no PRN meds (Lorazepam) advised to back off and just let him be, stop arguing with him."

Interviews on 4/26/24, 4/30/24, and 5/1/24 with the facility's RN Supervisor revealed:
-she was not aware Client #3 was out of his Lorazepam, staff were "supposed to let us (nursing) know when it's (PRN medication) down to so many pills ...give me 3 days heads up to let me re-order ..."
-the dispense date for Lorazepam observed on 4/25/24 was "correct ...it (Client #3's Lorazepam) did not come in until the 19th (4/19/24)."
-there was Lorazepam in her office "fixin' to be destroyed so I sent him (Client #3) a couple (on 4/16/24) so he could have something...I can't remember if it was his (Client #3's) to be destroyed ...controls take a minute to get in."

Observation and interview on 5/2/24 at 11:35 a.m. with the facility's RN Supervisor revealed:
-she provided two bubble packs of Lorazepam as what she used for Client #3 on 4/16/24.
-neither bubble pack was pharmacy dispensed for Client #3.
-one bubble pack was Lorazepam 0.5 mg and

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	MHL097-068	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD 60 HOME	258 OLD HIGHWAY 60 WILKESBORO, NC 28697

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V 116	Continued From page 3 belonged to Deceased Client #A1. Portions of the bubble pack were cut out. She stated she cut the Lorazepam out of the bubble pack to keep the medication in the packaging. Each pouch was numbered 1 through 31. Pouches that were cut out were #'s 5, 6, 7, 8, 10, 11, 12, 13, 14, and 15 (10 pills). -the second bubble pack was Lorazepam 1 mg and belonged to Client #B1. Pouches that were cut out were #'s 21 and 22. -a "Controlled Drug Record" sheet of paper was wrapped around both bubble packs with a rubber band. The controlled sheet had Client #3's name at the top, Lorazepam 1 mg, "Take 1 tablet (1 mg) by mouth as needed for behaviors lasting longer than 5 minutes. May take up to three doses in 24 hours." A sticky note was on the front of the "Controlled Drug Record" that the RN Supervisor said she wrote. "4/16/2024 Lorazepam 1 mg ...used 2 doses from [Client #B1] ...used 10 doses of [Deceased Client #A1] ...Both sent to [Client #3] for PRN Use." -"I don't know what else I am supposed to do ... [Client #3] was having a behavior and about to knock staff's head off ...I was trying to help staff and [Client #3] ...I guess I should have just let him (Client #3) beat staff." This deficiency is cross referenced into 10A NCAC 27G.0209 Medication Requirements (V118) for a Type A1 rule violation and must be corrected within 23 days.	V 116		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL097-068	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD 60 HOME	258 OLD HIGHWAY 60 WILKESBORO, NC 28697

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V 118	Continued From page 4 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 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 observation, record review, and interview, the facility failed to ensure medications were administered on the written order of a physician and that MARs were kept current affecting 3 of 3 clients (Clients #1, #2, and #3). The findings are:	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL097-068	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD 60 HOME	258 OLD HIGHWAY 60 WILKESBORO, NC 28697

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V 118	Continued From page 5 Cross Reference: 10A NCAC 27G.0209 Medication Requirements (V116). Based on observation, record review, and interview, the facility failed to ensure medication dispensing was restricted to registered pharmacists, physicians, or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy affecting 1 of 3 clients (Client #3). Finding #1: Review on 4/26/24 of Client #1's record revealed: -admission date 7/21/17. -diagnoses of Mild Intellectual Developmental Disability (IDD), Anxiety Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Depressive Disorder, Obsessive Compulsive Disorder, Hypocholesterolemia, Hypertension (HTN), Vitamin D Deficiency, Allergic Rhinitis, and Unspecified Neurocognitive Disorder with Behavior Disturbance. Review on 4/26/24 of Client #1's physician orders by Physician #1 revealed: -2/16/24 - Clindamycin/Benzoyl Gel 1-5% (Acne) - "Apply topically to affected area every night at bedtime." Review on 4/26/24 of Client #1's physician order by Physician #1's Family Nurse Practitioner (FNP) revealed: -3/1/24 - "Oragel topical oral analgesic Apply small amount to sore on right side of tongue Three times Daily." Review on 4/29/24 of a local dentist's "Consultation Form" for Client #1 dated 3/18/24 revealed:	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL097-068	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD 60 HOME	258 OLD HIGHWAY 60 WILKESBORO, NC 28697

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V 118	Continued From page 6	V 118		

-"Right lower jaw broken/sharp tooth is rubbing on the right side of his (Client #1's) tongue causing a painful sore."
-"Findings/Recommendations...left lower tooth extracted."

Observation on 4/25/24 at 3:10 p.m. of Client #1's medications revealed:
-Clindamycin/Benzoyl Gel and Orajel topical were not in the facility.

Review on 4/26/24 of Client #1's MARs from 4/1/24 through 4/26/24 revealed:
-32 times Orajel was initialed and circled:
-4/8/24 - 7:50 p.m.
-4/9/24 - 3:04 p.m., 7:55 p.m.
-4/10/24 - 3:41 p.m., 7:45 p.m.
-4/11/24 - 4:01 p.m., 8:06 p.m.
-4/12/24 - 3:17 p.m., 7:07 p.m.
-4/14/24 - 8:26 a.m., 3:20 p.m., 9:07 p.m.
-4/15/24 - 7:48 p.m.
-4/16/24 - 8:30 a.m., 3:52 p.m.
-4/17/24 - 3:18 p.m., 7:51 p.m.
-4/18/24 - 7:35 a.m., 5:01 p.m., 7:28 p.m.
-4/19/24 - 7:26 a.m., 9:21 p.m.
-4/20/24 - 3:05 p.m., 7:41 p.m.
-4/21/24 - 3:46 p.m.
-4/22/24 - 7:35 p.m.
-4/23/24 - 7:46 p.m.
-4/24/24 - 7:57 a.m., 3:02 p.m., 7:46 p.m.
-4/25/24 - 4:31 p.m., 8:00 p.m.
-10 times Clindamycin/Benzoyl Gel was initialed and circled:
-4/14/24, 4/15/24, 4/16/24, 4/17/24, 4/18/24, 4/20/24, 4/22/24, 4/23/24, 4/24/24, and 4/25/24.
-4/19/24 and 4/21/24 were initialed as administered.
-exceptions reflected for Orajel and Clindamycin/Benzoyl Gel for the above dates were "MEDICATION UNAVAILABLE/NURSE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 118	Continued From page 7 AWARE." Interview and review on 4/26/24 of nursing notifications provided by the facility's Registered Nurse (RN) Supervisor revealed: -4/8/24 at 7:41 p.m. - "...[Client #1] is out of Orajel, but it's still on the MAR. Nurse (on-call nurse) advised to chart with the exception 'Medication unavailable' and inquired if [Client #1] was c/o (complaining of) tooth pain. [Staff #2] states that he is not. Nurse recommended using Peridex mouthwash as directed. Nurse also advised if [Client #1] did c/o toothache later, to call nursing, understanding voiced." -no documentation in the nursing notifications Client #1's Clindamycin/Benzoyl Gel was not available. Interview on 4/30/24 with Client #1 revealed: -after his tooth was removed (3/18/24), "No, it (the sore on his tongue) didn't hurt anymore." Interview on 4/30/24 with Staff #1 revealed: -Client #1 "had a little sore on his tongue...he told everybody he had a hole in his tongue." -she "...told them (nursing) she could go to the store and get Orajel, but they (nursing) said '...can't go get it...'" -"After his tooth was taken out it didn't bother him anymore, so I guess it (Orajel) just stayed on his (Client #1's) MAR." Interviews on 4/26/24, 4/30/24 5/1/24 and 5/2/24 with the facility's RN Supervisor revealed: -Client #1's Orajel was still on his MAR as she "thought he (Client #1) might need it a little bit...so I left it (Orajel) alone for a while ...wish they (staff) told me he wasn't having any more pain and I would have ensured it was taken off (the MAR)..." -was not aware Client #1 needed	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL097-068	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD 60 HOME	258 OLD HIGHWAY 60 WILKESBORO, NC 28697

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V 118	Continued From page 8	V 118		

Clindamycin/Benzoyl Gel refilled.
-the staff were to notify her when clients ran out of their medications.
-"They (staff) may have told me (Client #1 ran out Clindamycin/Benzoyl Gel) and I may have forgotten (to reorder)...or they may have forgotten to tell me..."
-4/19/24 and 4/21/24 Clindamycin/Benzoyl Gel was "probably checked off (as administered) and didn't give (administer) it would be my guess...may initial the med (medication) (as administered) so they (staff) can advance to the next med on the MAR..."

Finding #2:

Review on 4/26/24 of Client #2's record revealed:
-admission date 12/21/13.
-diagnoses of Mild IDD, ADHD, Schizoaffective Disorder Depressive Type, HTN, and Severe Obstructive Sleep Apnea.

Review on 4/29/24 of Client #2's physician's orders by Physician #2 on 1/9/24 revealed:
-"... D/C (discontinue) Vraylar (antipsychotic) 3 mg (milligrams) PO (by mouth) daily."
-"...Start Vraylar 1.5 mg PO Daily."
-"...Special instructions: Take additional dose of Vraylar 3 mg PO for each of the Days starting 10 days prior to Invega Injection (Schizoaffective Disorder)."

Review on 4/29/24 of Client #2's physician's order by Physician #1's FNP dated 3/28/24 revealed:
-"...Per [Physician #2's] suggestion 1) Discontinue Vraylar 1.5 mg PO Daily. 2) Continue Vraylar 3 mg PO Daily for only the 10 days prior to scheduled invega injection."

Review on 4/29/24 of Client #2's "Medical Note"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL097-068	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD 60 HOME	258 OLD HIGHWAY 60 WILKESBORO, NC 28697

(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 118	Continued From page 9	V 118		

by Physician #2 dated 4/3/24 revealed:
-"Medical Decision Making:...continue with Vraylar 3 mg 1 capsule p.o. daily and Vraylar 1.5 mg capsule 1 daily..."
-"Medications:...Vraylar 1.5 mg capsule take 1 capsule by oral route every day...Vraylar 3 mg capsule take 1 capsule by oral route every day beginning 10 days before each Invega sustenna injection and stop after 10 days..."
-it was unclear if Vraylar 3 mg was to be given daily, or only 10 days prior to the client's Invega injection.

Observation on 4/25/24 at 3:55 p.m. of Client #2's medications revealed:
-no Vraylar, 1.5 mg or 3 mg.

Review on 4/26/24 of Client #2's MARs from 2/1/24 through 4/26/24 revealed:
-2/1/24 through 3/31/24 - Vraylar 1.5 mg - 1 capsule daily - initialed as administered daily.
-2/1/24 through 3/31/24 - Vraylar 3 mg "Take 1 capsule by mouth once every day beginning 10 days before each Invega ..." was initialed as administered daily, with exceptions on 3/20/24 and 3/25/24 "MEDICATION UNAVAILABLE/NURSE AWARE."
-4/1/24 through 4/25/24 - Vraylar 3 mg "Take 1 capsule by mouth once every day beginning 10 days before each Invega ..." was initialed as administered daily with exceptions on 4/16/24, 4/17/24, 4/18/24, 4/21/24, 4/23/24, 4/24/24 and 4/25/24 "MEDICATION UNAVAILABLE/NURSE AWARE."

Interview on 4/29/24 with Physician #1's FNP revealed:
-she did not write the clarification order 3/28/24 to discontinue Client #2's Vraylar 1.5 mg daily.
-"I have nothing to do with that ...that would have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL097-068	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD 60 HOME	258 OLD HIGHWAY 60 WILKESBORO, NC 28697

(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 118	Continued From page 10	V 118		

been his (Client #2's) psych (psychiatric) doctor (Physician #2)..."

Interview on 4/30/24 with Physician #2's RN revealed:
-she referenced Client #2's electronic medical record during the interview.
-located physician orders for 1/9/24, 3/6/24 and 4/3/24 for Vraylar which were all the same.
-Client #2 was to receive Vraylar 1.5 mg daily and 3 mg daily for 10 days prior to his Invega injection.
-could not locate where Physician #2 discontinued Vraylar 1.5 mg daily.
-Client #2 took Vraylar "to help control his mood and psychosis."
-spoke with Physician #2 (4/30/24) who said, "It was fine that [Client #2] was getting (Vraylar) 3 mg daily and that (Vraylar) 1.5 mg was discontinued... Her (Physician #2's) concern was his behavior before his next Invega shot. All she (Physician #2) would ask is if the facility changed it (Vraylar dosages) to let her know...that's what she would want...she will see him (Client #2) 5/28/24 and will discuss this then."

Interviews on 4/26/24, 4/30/24 5/1/24 and 5/2/24 with the facility's RN Supervisor revealed:
-Client #2's Vraylar 1.5 mg was discontinued by Physician #2 in March 2024, and she would get the physician order.
-asked Physician #1's FNP to write the order on 3/28/24 to discontinue the Vraylar 1.5 mg because Physician #2 was difficult to reach.
-did not understand how staff documented on the MAR they administered Vraylar 3 mg daily or that the medication was unavailable.
-the pharmacy only sent 10 capsules of Vraylar 3 mg a month to take prior to his Invega injection, "They (staff) wouldn't even have a pill to give

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL097-068	A. BUILDING: _____ B. WING _____	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD 60 HOME	258 OLD HIGHWAY 60 WILKESBORO, NC 28697

(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 118	Continued From page 11	V 118		

(administer)... it (Vraylar) shouldn't even be showing up on the MAR (after the 10 days administered)."
-staff "May initial the med (Vraylar) so they can advance to the next med on the MAR."
-"Right now the only Vraylar he (Client #2) should be getting is the 10 pills prior to his Invega shot."

The order from Physician #2 to discontinue Vraylar 1.5 mg was not received prior to exit.

Finding #3:

Review on 4/26/24 of Client #3's physician orders revealed:
-2/16/24 - discontinue Gemfibrozil (Hyperlipidemia) 600 mg - 1 tablet 2 times a day.
-2/16/24 - Lorazepam (Anxiety Disorder) 1 mg - 1 tablet PRN (as needed).
-3/7/24 - Prednisone (inflammation) 20 mg - 1 tablet daily for 5 days.

Review on 4/26/24 of Client #3's MARs from 2/1/24 through 4/26/24 revealed:
-Gemfibrozil 600 mg - initialed as administered 2/17/24 through 4/4/24 (47 days after discontinued).
-Prednisone 20 mg - was not listed for March 2024 as administered for 5 days.
-Lorazepam 1 mg - was not initialed as administered in February or March 2024; initialed as last administered on 4/5/24.

Review on 5/1/24 of e-mail correspondence with Physician #1 and the Division of Health Service Regulation surveyor dated 5/1/24 revealed:
-Physician #1 was not aware Client #3's Gemfibrozil which he discontinued 2/16/24, was continued to be administered until 4/4/24.
-"The effect is delay in change of medical therapy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL097-068	A. BUILDING: _____ B. WING _____	05/03/2024

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OLD 60 HOME	258 OLD HIGHWAY 60 WILKESBORO, NC 28697

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V 118	Continued From page 12	V 118		

to minimize an identified, potential interaction risk or side effect. Client (#3) did not develop sign or symptoms (due to continued Gemfibrozil)."

Review on 4/26/24 of nursing notifications provided by the facility's RN Supervisor revealed:
-4/15/24 at 8:00 p.m. - "[Client #3] is having behaviors, and they have no PRN meds (Lorazepam) advised to back off and just let him be, stop arguing with him."
-9:35 p.m. - "[Client #3] is refusing to wear O2 (oxygen) and let [Staff #3] check his O2. Explained that [Client #3] has been acting out all day and just to leave him alone for now and let him try to calm down some."
-9:43 p.m. - "[Client #3] is threating [Staff #3], breaking stuff. Explained again he has the right to break his stuff and to protect himself if needed."
-10:40 p.m. - [Client #3] has threatened [Staff #3] with a screwdriver he has gotten possession of the screwdriver. Explained for him (Staff #3) to lock the screwdriver in the med room and to let [Client #3] go back to his room and try and calm down."
-4/16/24 at 5:57 a.m. "[Client #3] has gotten up in a bad mood this morning ..."

Interviews on 4/26/24, 4/30/24 5/1/24 and 5/2/24 with the facility's RN Supervisor revealed:
-Client #3's Prednisone 20 mg was not on the March MAR since it was only administered for 5 days.
-staff "would have had to document (administration of Prednisone) on paper because it (Prednisone) didn't make it on the MAR," she would look for the paper MAR.
-Client #3's Gemfibrozil continued to be administered despite the physician's discontinue order because "I guess the pharmacy missed it (being discontinued) and I missed it ...the

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V 118	Continued From page 13 pharmacy continued to send the med (Gemfibrozil)." The paper MAR for Client #3's Prednisone was not received prior to exit. Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician. Review on 5/3/24 of the Plan of Protection dated 5/3/24 written by the Vice President of Operations revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? The licensed RN (RN Supervisor) assigned to provide care for individuals residing at Old 60 Home will be suspended immediately. The RN (another RN) will ensure that individuals' physician order(s) for administration of Vraylar/Orajel are clarified and accurately transcribed in the EMAR (electronic) system for staff to properly administer. By: The RN will ensure that individuals' medications (Vraylar/Lorazepam/Orajel/Clindamycin Topical) are available to administer. The RN will ensure that only medications dispensed for the individual are administered to the individual as prescribed. The RN and LPN (Licensed Practical Nurse) will destroy all medications to include those discontinued and expired per company/pharmacy protocol. Describe your plans to make sure the above happens. The RN (RN Supervisor) assigned to Old 60 Home was suspended by The Regional Vice President and Administrator on 05.02.24. The coordination of care of the individuals in the Old	V 118		

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	MHL097-068	A. BUILDING: _____ B. WING _____	05/03/2024

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V 118	Continued From page 14 60 home was reassigned to another RN on 05.02.24. The RN (another RN) will review and obtain clarifying orders from the individual's physician regarding the individual's Vraylar order. Nursing will ensure that the Vraylar order is accurately transcribed in the electronic medication record to ensure certified staff can administer correctly. By: 5/3/24 The RN will review and obtain clarifying orders from the individuals' physician order in regard to the individual's Orajel order to include a stop date. Nursing will ensure that the Orajel order is accurately transcribed in the electronic medication record to ensure certified staff can administer correctly. By: 5/3/24 The RN will in-service all medication certified staff in the home to notify nursing immediately when a medication is not available for administration. By: 5/3/24 The RN will in-service all medication certified staff in the home to document exceptions including unavailable medications appropriately within the electronic medication administration record. By: 5/3/24 The RN will in-service all medication certified staff in the home to notify nursing when PRN medications are within 5 days of depletion. All medication with the exception of PRN medications are on a cycle refill. PRN medications are dispensed as requested by pharmacy. If the pharmacy cannot refill a medication to arrive within 48 hours, nursing will ask the pharmacy to call it into the backup Pharmacy. By: 5/3/24 The Corporate Director of Nursing will in-service nursing personnel to order all medications from the contracted pharmacy and/or from the backup pharmacy to ensure that medications are available to administer to individuals as	V 118		

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V 118	Continued From page 15 prescribed. By: 5/3/24 The Corporate Director of Nursing will in-service nursing staff on proper procedures of destroying expired and discontinued medications per company/pharmacy protocol. By: 5/3/24 The Corporate Director of Nursing will in-service nursing staff to not borrow medications from other individuals for administration as this is considered dispensing which is not within nursing scope of practice. by: 5/3/24 The RN will in-service med certified staff to administer only those medications that have been prescribed to the specific individual as ordered by the physician. By: 5/3/24 The RN or LPN will review electronic medication record daily to ensure that documentation of administration is accurate and consistent for 8 weeks and then on monthly basis. Ongoing Nursing, Administrator or the Qualified Professional will conduct an assessment of the medication cart weekly to ensure all medications are available and ordered from the pharmacy as required; ensure that no discontinued or expired medications are available for administration; and ensure that medications are not being borrowed from other individuals for administration for 8 weeks and then on a monthly basis. Ongoing." Clients #1, #2, and #3 had diagnoses of Mild IDD, Anxiety Disorder, ADHD, Schizoaffective Disorder, Major Depressive Disorder, Obsessive Compulsive Disorder, Antisocial Personality Disorder, Unspecified Neurocognitive Disorder with Behavior Disturbance, Hypocholesterolemia, HTN, Vitamin D Deficiency, Allergic Rhinitis, Severe Obstructive Sleep Apnea, Speech Impairment, Chronic Obstructive Pulmonary Disease, Gastroesophageal Reflux Disease, and Hyperlipidemia. Client #1 had physician orders for Orajel, for a sore on his tongue, and	V 118		

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V 118	Continued From page 16 Clindamycin/Benzoyl gel for acne. There were 32 times from 4/8/24 through 4/25/24 where his Orajel was not available and 10 times from 4/14/24 through 4/25/24 where his acne gel was not available to administer. The RN Supervisor was notified on 4/8/24, Client #1 did not have Orajel and did not know if she was contacted about him being out of his Clindamycin/Benzoyl. Client #2 continued to be administered Vraylar, 1.5 mg, for 3 days, after the discontinuation order on 3/28/24. Vraylar, 3 mg, was administered daily in February and March 2024, and for 15 days in April 2024, even though the order was to administer only 10 days prior to getting his monthly Invega injection. Seven days in April 2024, which were not consecutive, had exceptions noted that Vraylar 3 mg, was not administered due to the medication being unavailable. The RN Supervisor thought staff initialed as administered so they could advance on the electronic MAR to the next medication to administer. The pharmacy only dispensed 10 pills a month of Vraylar, staff could not have had it to administer on the days outside of this. Client #3 had a discontinue order for his Hyperlipidemia medication, Gemfibrozil, on 2/16/24. Gemfibrozil continued to be administered to Client #3 for 47 more days before being discontinued. Client #3 was administered Prednisone 20 mg for 5 days, on 3/7/24, which was not on the electronic MAR or a handwritten MAR. There was no documentation if Client #3 received the 5 days of Prednisone. Client #3 had a physician order for Lorazepam 1 mg, as needed for behaviors. On 4/15/24, Client #3 was having a behavior, and staff reported he did not have any Lorazepam to administer. Client #3's behaviors continued to escalate throughout the evening where he destroyed property and threatened staff with a screwdriver. The RN Supervisor had Lorazepam	V 118		

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V 118	Continued From page 17 in her office to be destroyed. The Lorazepam belonged to 2 different clients from sister facilities. The RN Supervisor cut out 10 pills from 1 bubble pack, 2 pills from the other bubble pack, and dispensed them for Client #3. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 118		
V 291	27G .5603 Supervised Living - Operations 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	V 291		

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V 291	Continued From page 18 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 observation, record review and interview, the facility failed to ensure coordination of care was maintained between the facility, Registered Nurse (RN) and physician's who were responsible for treatment/habilitation affecting 3 of 3 clients (Clients #1, #2 and #3). The findings are: Finding #1: Review on 4/26/24 of Client #1's record revealed: -admission date 7/21/17. -diagnoses of Mild Intellectual Developmental Disability (IDD), Anxiety Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Depressive Disorder, Obsessive Compulsive Disorder, Hypocholesterolemia, Hypertension (HTN), Vitamin D Deficiency, Allergic Rhinitis, and Unspecified Neurocognitive Disorder with Behavior Disturbance. Review on 4/26/24 of Client #1's physician's orders by Physician #1 dated 2/16/24 revealed: -"Blood Pressure & Pulse Daily Before Giving Meds (medications) - Notify RN (Registered Nurse) if SBP (systolic blood pressure) is Greater Than 150 or DBP (diastolic blood pressure) is Greater Than 90." Review on 4/26/24 of Client #1's MARs from 2/1/24 through 4/26/24 revealed: -the following dates Client #1's DBP was greater	V 291		

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V 291	Continued From page 19 than 90: -2/6/24 -92, -2/7/24 -93, -2/8/24 - 94, -2/9/24 - 96, -2/10/24 - 98, -2/11/24 - 97, -2/12/24 - 98, -2/13/24 - 97, -2/14/24 - 98, -2/15/24 - 97, -2/16/24 - 98, -2/17/24 - 97, -2/18/24 - 98, -2/19/24 - 96, -2/20/24 - 91, -2/23/24 - 93, -2/24/24 - 95, -2/25/24 - 98, -2/26/24 - 97, -2/27/24 - 98, -2/28/24 - 97, -2/29/24 - 98, -3/3/24 - 92, -3/6/24 - 91, -3/22/24 - 94, -3/23/24 - 92, -3/24/24 - 94, -3/25/24 - 92, -3/26/24 - 96, -3/27/24 - 93, -3/28/24 - 92, -3/29/24 - 91, -3/31/24 - 95, -4/1/24 - 97, -4/2/24 - 96. -no documentation nursing was notified the 35 times his DBP was greater than 90. Review on 5/1/24 of e-mail correspondence with	V 291		

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V 291	Continued From page 20 Physician #1 and the Division of Health Service Regulation surveyor dated 5/1/24 revealed: -he had not been contacted regarding Client #1's DBP readings being above 90 in February, March or April 2024. -"In my medical opinion, changes in anti-hypertensive medications for this client are not based on a single BP reading: the trend or repeated, multiple readings are more effective at guiding therapy; thus, no serious sequelae." Interviews on 4/26/24, 4/30/24 5/1/24 and 5/2/24 with the facility's RN Supervisor revealed: -she did not recall being notified of Client #1's low DBP readings and this was not documented anywhere. Finding #2: Review on 4/26/24 of Client #2's record revealed: -admission date 12/21/13. -diagnoses of Mild IDD, ADHD, Schizoaffective Disorder Depressive Type, HTN, and Severe Obstructive Sleep Apnea. Review on 4/29/24 of Client #2's physician's orders by Physician #2 on 1/9/24 revealed: -" ... D/C (discontinue) Vraylar (antipsychotic) 3 mg (milligrams) PO (by mouth) daily." -" ...Start Vraylar 1.5 mg PO Daily." -" ...Special instructions: Take additional dose of Vraylar 3 mg PO for each of the Days starting 10 days prior to Invega Injection (Schizoaffective Disorder)." Review on 4/29/24 of Client #2's physician's order by Physician #1's FNP dated 3/28/24 revealed: -" ...Per [Physician #2] suggestion 1) Discontinue Vraylar 1.5 mg PO Daily. 2) Continue Vraylar 3 mg PO Daily for only the 10 days prior to	V 291		

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V 291	Continued From page 21 scheduled invega injection." Review on 4/29/24 of Client #2's "Medical Note" by Physician #2 dated 4/3/24 revealed: -"Medical Decision Making: ...continue with Vraylar 3 mg 1 capsule p.o. daily and Vraylar 1.5 mg capsule 1 daily ..." -"Medications: ...Vraylar 1.5 mg capsule take 1 capsule by oral route every day ...Vraylar 3 mg capsule take 1 capsule by oral route every day beginning 10 days before each Invega sustenna injection and stop after 10 days ..." -it was unclear if Vraylar 3 mg was to be given daily, or only 10 days prior to the client's Invega injection. Observation on 4/25/24 at 3:55 p.m. of Client #2's medications revealed: -no Vraylar, 1.5 mg or 3 mg. Review on 4/26/24 of Client #2's MARs from 2/1/24 through 4/26/24 revealed: -2/1/24 through 3/31/24 - Vraylar 1.5 mg - 1 capsule daily - initialed as administered daily. -2/1/24 through 3/31/24 - Vraylar 3 mg "Take 1 capsule by mouth once every day beginning 10 days before each Invega ..." was initialed as administered daily, with exceptions on 3/20/24 and 3/25/24 "MEDICATION UNAVAILABLE/NURSE AWARE." -4/1/24 through 4/25/24 - Vraylar 3 mg "Take 1 capsule by mouth once every day beginning 10 days before each Invega ..." was initialed as administered daily with exceptions on 4/4/24 - "WITHHELD PER DR/RN ORDERS" and on 4/16/24, 4/17/24, 4/18/24, 4/21/24, 4/23/24, 4/24/24 and 4/25/24 "MEDICATION UNAVAILABLE/NURSE AWARE." Interview on 4/29/24 with Physician #1's FNP	V 291		

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V 291	Continued From page 22 revealed: -she did not write the clarification order 3/28/24 to discontinue Client #2's Vraylar 1.5 mg daily. -"I have nothing to do with that ...that would have been his (Client #2's) psych (psychiatric) doctor (Physician #2) ..." Interview on 4/30/24 with Physician #2's RN revealed: -she referenced Client #2's electronic medical record during the interview. -located physician orders for 1/9/24, 3/6/24 and 4/3/24 for Vraylar which were all the same. -Client #2 was to receive Vraylar 1.5 mg daily and 3 mg daily for 10 days prior to his Invega injection. -could not locate where Physician #2 discontinued Vraylar 1.5 mg daily. -Client #2 took Vraylar "to help control his mood and psychosis." -she spoke with Physician #2 (4/30/24) who said, "It was fine that [Client #2] was getting (Vraylar) 3 mg daily and that (Vraylar) 1.5 mg was discontinued... Her (Physician #2's) concern was his behavior before his next Invega shot. All she (Physician #2) would ask is if the facility changed it (Vraylar dosages) to let her know ...that's what she would want ...she will see him (Client #2) 5/28/24 and will discuss this then." Interviews on 4/26/24, 4/30/24 5/1/24 and 5/2/24 with the facility's RN Supervisor revealed: -Client #2's Vraylar 1.5 mg was discontinued by Physician #2 in March 2024, and she would get the physician order. -her understanding was "Right now the only Vraylar he (Client #2) should be getting is the 10 pills prior to his Invega shot." The order from Physician #2 to discontinue	V 291		

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V 291	Continued From page 23 Vraylar 1.5 mg was not received prior to exit. Finding #3: Review on 4/26/24 of Client #3's record revealed: -admission date 12/21/23. -diagnoses of Mild IDD, Major Depressive Disorder, Antisocial Personality Disorder, Speech Impairment, Chronic Obstructive Pulmonary Disease, Gastroesophageal Reflux Disease, Hyperlipidemia, and Allergic Rhinitis. Review on 4/26/24 of Client #3's physician's orders by Physician #1 dated 2/16/24 revealed: -"Pulse Oximeter Reading ...Check O2 (oxygen) Sat (saturation) three times a day, Notify Nurse if Less than 85%." Review on 4/26/24 of Client #3's physician's orders by Physician #1's Family Nurse Practitioner (FNP) dated 3/12/24 revealed: -" ...Check FSBG (finger stick blood glucose) Before meals at bed time Daily and PRN for s/s (signs and symptoms) of hypo/hyperglycemia ...Notify Nurse for treatment plan if FSBG Lower than 70 or higher than 200." Review on 4/26/24 of Client #3's MARs from 3/1/24 through 4/26/24 revealed: -the following dates Client #3's O2 Sats was less than 85% or client refused: -3/13/24 - 83%, -3/14/24 - 79%, -3/22/24 - 84%, -3/23/24 - 84%, -4/4/24 - 82%, -4/11/24 - refused, -4/15/24 - refused, -4/17/24 - refused, -the following dates Client #3's FSBG was lower	V 291		

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V 291	Continued From page 24 than 70 or higher than 200, or client refused: -3/18/24 - 11:00 a.m., 5:00 p.m. and 8:00 p.m. -refused, -3/22/24 - 225, -3/26/24 - 240, -3/28/24 - refused, -3/30/24 - 201, -4/7/24 - 207, -4/9/24 - refused, -4/15/24 - refused, -4/17/24 - 7:00 a.m., 11:00 a.m., 5:00 p.m., and 8:00 p.m. - refused, -4/18/24 - 11:00 a.m., 5:00 p.m. and 8:00 p.m. - refused, -4/20/24 - refused, -4/22/24 - 64. -no documentation nursing was notified for the 8 times his O2 Sats were less than 85%, or the 19 times his FSBG was lower than 70 or higher than 200, or he refused. Interview on 4/29/24 with Physician's #1's FNP revealed: -she was not notified of any dates/times when Client #3's O2 Sats and FSBG readings were outside of the ordered parameters. Interviews on 4/30/24 and 5/2/24 with the Residential Team Lead revealed: -the vital sign parameters, blood sugars, O2 saturations, blood pressure, for each client were "usually on the QMAR (electronic MAR)." -he would "tell (new) staff what the parameters are or they (new staff) can call nursing and nursing will tell them." -he was to notify nursing if clients' refused treatments or vital signs to be taken. Interview on 4/30/24 with Staff #1 revealed: -she had been working at the facility for	V 291		

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	MHL097-068	A. BUILDING: _____ B. WING _____	05/03/2024

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V 291	Continued From page 25 approximately 4 months. -to determine parameters for blood sugars, O2 saturations, blood pressure, "I use my phone to see what normal range is and also call nursing...I noticed [Client #1's] bottom number (DBP) is lower, like 60, I didn't call nursing...just monitor a little bit...he was fine." Interviews on 4/26/24, 4/30/24 5/1/24 and 5/2/24 with the facility's RN Supervisor revealed: -she does not have documentation of specific dates when staff notified her Client #3's O2 Sats and/or FSBG readings were outside of the ordered parameters. Review on 5/3/24 of the Plan of Protection dated 5/3/24 written by the Vice President of Operations revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? The RN (RN Supervisor) assigned to provide care for individuals residing at Old 60 Home was suspended 5/2/24. All medication certified staff in the home will notify nursing immediately when a medication is not available to administer as ordered (Client's Vraylar and Client's Lorazepam). All certified medication staff will communicate with nursing when a PRN medication (Lorazepam) quantity is within 5 doses of depletion and/or not available for administration. Nursing personnel will order medications from the contracted pharmacy promptly to ensure medications are available as prescribed to the individual for administration. All medications except PRN medications are received routinely on a cycle filled. For PRN's the staff notify nursing that a medication is out or getting ready to runout the responsible nurse is expected. Staff are trained and will be in-service when a PRN	V 291		

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V 291	Continued From page 26 medication is within 5 doses of running out, nursing will be notified. Nursing will notify the pharmacy. If the pharmacy cannot refill a medication within 48 hours, nursing will ask the pharmacy to call it into the backup pharmacy. (Vraylar/Lorazepam/Orajel/Clindamycin Topical) All certified medication staff will notify nursing immediately when individuals refuse medications/treatments or when treatments administered are not within normal parameters (blood pressure, pulse, fsbs, oxygen saturation level). This will be documented by the responsible nurse on the nursing on call log or client chart. Describe your plans to make sure the above happens. The RN (another RN) assigned to Old 60 Home was suspended by Regional Vice President and Administrator on 05.02.24. The coordination of care of the individuals in the Old 60 Home were reassigned to another RN 05.02.24. The RN will in-service all medication certified staff in the home to notify nursing immediately when a medication is not available for administration. By: 5/3/24 The RN will in-service all medication certified staff in the home to document exceptions including unavailable medications appropriately within the electronic medication administration record. By: 5/3/24 The RN will in-service all medication certified staff in the home to notify nursing when PRN medications are within 5 days of depletion. By: 5/3/24 The Cooperate Director of Nursing will in-service the RN and LPN (Licensed Practical Nurse) to order all medications from the contracted pharmacy and/or from the backup pharmacy to ensure that medications are available to administer to individuals as prescribed. By: 5/3/24 The RN will in-service staff to notify nursing	V 291		

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V 291	Continued From page 27 immediately when individuals refuse prescribed medication/treatments. By: 5/3/24 The RN will in-service staff to notify nursing immediately when treatments to include obtaining vitals such as pulse, blood pressure, oxygen saturation level, and finger stick blood sugars are outside of the normal parameters as indicated in the physician order. By: 5/3/24 The RN will in-service staff on how to properly document treatments to include vital sign parameters and refusals to comply with obtaining ordered treatments within the electronic medication administration. By: 5/3/24 The RN or LPN will review electronic medication records daily to ensure that documentation of administration is accurate and consistent for the next 8 weeks and then on a monthly basis. Ongoing The Qualified Professional, Administrator RN, or LPN will conduct an assessment of the medication cart weekly to ensure all medications are available and ordered from the pharmacy as required for the next 8 weeks and then on a monthly basis. Ongoing" Clients #1, #2, and #3 had diagnoses of Mild IDD, Anxiety Disorder, ADHD, Schizoaffective Disorder, Major Depressive Disorder, Obsessive Compulsive Disorder, Antisocial Personality Disorder, Unspecified Neurocognitive Disorder with Behavior Disturbance, Hypocholesterolemia, HTN, Vitamin D Deficiency, Allergic Rhinitis, Severe Obstructive Sleep Apnea, Speech Impairment, Chronic Obstructive Pulmonary Disease, Gastroesophageal Reflux Disease, and Hyperlipidemia. Client #1 had HTN and physician orders to notify nursing if his blood pressure readings were outside the parameters set as SBP greater than 150 or DBP greater than 90. There were 35 times between 2/6/24 and 4/2/24 when	V 291		

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V 291	Continued From page 28 Client #1's DBP was greater than 90. There was no indication the RN Supervisor was made aware of this trend of high DBP readings and Client #1's physician was not aware of these trends. Client #2 had a physician order for Vraylar to help manage his mood and psychosis. Physician #2 was the prescribing physician for Client #2's Vraylar whose prescription for this remained the same on 1/9/24, 3/6/24 and 4/3/24. Physician #2 prescribed Vraylar 1.5 mg daily and Vraylar 3 mg, 10 days before the client's Invega injection. The RN Supervisor thought Physician #2 discontinued Vraylar, 1.5 mg during his 3/6/24 visit. She did not have clarification orders from Physician #2 to discontinue this and asked Physician #1's FNP to write the order on 3/28/24 to discontinue Client #2's Vraylar, 1.5 mg daily. The FNP denied having anything to do with Client #2's Vraylar and denied writing this order. Physician #2 was not aware Client #2's Vraylar, 1.5 mg, had been discontinued on 3/28/24 or that he received Vraylar, 3 mg daily, and not just 10 days prior to his Invega injection. Client #3 had physician orders to check his O2 saturation and FSBG daily. Staff #1 was unclear on what the parameters were for these vital signs and when nursing should be notified if they fell outside those parameters. Between 3/13/24 and 4/17/24, there were 8 times when Client #3's O2 saturation was below 85% or he refused to have it checked. Between 3/18/24 and 4/22/24, there were 19 times Client #3's FSBG was below 70 or greater than 200 and 7 days he refused to have his blood sugar tested. There was no indication the RN Supervisor was notified when Client #3's O2 saturation and FSBG levels were outside the expected parameters according to the physician orders. Coordination of care was not maintained between nursing, the qualified professional and physician's associated with the clients care due to	V 291		

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V 291	Continued From page 29 the failure to clarify medication orders, and communicate when vital signs were not within the parameters. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 291		