| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL092-935 | A. BUILDING: _____ B. WING _____ | R-C 05/21/2024 |

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| V 000 | INITIAL COMMENTS<br><br>A complaint and follow up survey was completed on 5/21/24. The complaint was substantiated (Intake #NC00216344). Deficiencies were cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.<br><br>The facility is licensed for 4 and currently has a census of 3. The survey sample consisted of audits of 2 current clients. | V 000 | | |
| V 112 | 27G .0205 (C-D)<br>Assessment/Treatment/Habilitation Plan<br><br>10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN<br>(c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days.<br>(d) The plan shall include:<br>(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;<br>(2) strategies;<br>(3) staff responsible;<br>(4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both;<br>(5) basis for evaluation or assessment of outcome achievement; and<br>(6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. | V 112 | | |

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| V 112 | Continued From page 1 | V 112 | | |

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to develop and implement strategies for 1 of 2 audited clients (#1). The findings are:

Review on 5/16/24 of client #1's record revealed:
- Admitted: 3/21/20
- Diagnoses: Moderate Intellectual Disability and Traumatic Brain Injury
- Treatment plan dated 12/6/23 revealed:
  - "[client #1] has very little safety awareness. He requires 24/7 support to ensure he doesn't wandering/elopement from his house"
  - no strategies to address clients' behavior of elopement, wandering into neighbor's yards and knocking on neighbors' doors

Review on 5/16/24 of client #3's record revealed:d
- Admitted: 2/29/16
- Diagnoses: Autism, Moderate Mental Retardation, Psychosis, Attention Deficit Hyperactivity Disorder, Cerebral Palsy, and Mood Disorder

Interview on 5/17/24 client #3 reported:
- she had seen client #1 leave the facility
- client #1 went up the street or he went in circles when he left the facility
- staff would go and get him
- he did it a lot

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| V 112 | Continued From page 2<br>- the neighbors had come over to complain but she didn't know what staff they spoke with<br><br>Interview on 5/20/24 staff #1 reported:<br>- worked the weekends<br>- client #1 didn't leave out a lot but there were times he needed a 1:1 staff<br>- back in April 2024, client #1 went a few houses up the street on her shift and when she got to him, she reached her hand out to him and he grabbed it and they went back to the facility<br>- it was always one person per shift and she had mentioned to the manager that client #1 needed a 1:1 staff<br><br>Interview on 5/16/24 the Group Home Manager reported:<br>- about 1 - 2 months ago, staff #1 called her and told her that client #1 had left the facility<br>- she told staff #1 that she had to go and get him<br>- staff #1 went and got him and brought him back to the facility<br>- one neighbor would tell them that client #1 came to their house or rang their doorbell<br>- that same neighbor moved out of the house and new people moved in about a month ago<br>- another neighbor would bring client #1 back<br>- it happened sporadically and no neighbor ever complained about client #1 coming over<br><br>Interview on 5/20/24 client #1's guardian reported:<br>- client #1 had a history of elopement when he was home with her<br>- she was told one time that client #1 went to the neighbors' house but she didn't remember the date<br><br>Interview on 5/20/24 the Chief Executive Officer | V 112 | | |

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| V 112 | Continued From page 3<br>(CEO) reported:<br>- client #1 had a history of elopement and he may walk out in the community to the neighbor's house but would come right back<br>- client #1 would sometimes knock on the neighbor's door<br>- client #1 hadn't been to the neighbor's house in awhile<br>- not sure exactly when client #1 starting leaving the facility and going to the neighbor's house<br>- thought that it was something in his past that triggered him about the neighbor's house and that was why he kept going there<br>- "he tries it when female staff are here (working)"<br>- it was not in his treatment plan because it was so sporadic<br>- she was responsible for short term goals<br>- she just hired a new Qualified Professional and would go over client #1's treatment plan with her to make some adjustments | V 112 | | |
| 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 | V 118 | | |

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| V 118 | Continued From page 4<br>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 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 record review and interview, the facility failed to administer medications on the written order of a physician and failed to keep the MARs current affecting 2 of 2 audited clients (#1, #3). The findings are:<br><br>A. Review on 5/16/24 of client #1's record revealed:<br>- Admitted: 3/21/20<br>- Diagnoses: Moderate Intellectual Developmental Disability and Traumatic Brain Injury<br>- No discontinuation (d/c) order for:<br>- Erythromycin Ointment 5 milligram (mg)/gram (gm), provide in right eye 4 times daily (bacterial infections) | V 118 | | |

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| V 118 | Continued From page 5<br>- No physician order for:<br>- Culturelle 10B Digestive, 1 cap daily, (digestion)<br>- Belsomra tablet (tab) 10mg, 1 tab every evening (insomnia)<br>- Benzoly Peroxide 10% Wash, use to wash affected area twice daily then rinse, (acne)<br>- Ketoconazole 2% cream 60gm, spread topically to affected area once daily (skin infections)<br>- Mupirocin Ointment 2%, spread topically to involved area around mouth 3 times daily (skin infections)<br>- Naltrexone tab 500mg, 1 tab daily<br><br>Review on 5/16/24 of client #1's May 2024 MAR revealed:<br>- all medications listed above were signed off by staff as being administered<br>- Naltrexone tab 50mg and Nalitrexone tab 500mg were both on the MAR and signed off on by staff as being administered<br><br>Interview on 5/16/24 & 5/17/24 the Group Home Manager stated:<br>- she was responsible for checking the MARs<br>- she tried to check them a couple of times per week<br>- there was no Nalitrexone 500mg tabs<br>- Nalitrexone 500mg was written wrong on the MAR and the staff were signing off on the Naltrexone 50mg and the Nalitrexone 500mg in error and she would speak with staff about not signing off on medications that wasn't there<br>- Erythromycin Ointment was written by an urgent care doctor and she was unable to get in touch with them for a refill or to get it discontinued<br><br>B. Review on 5/16/24 of client #3's record | V 118 | | |

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| V 118 | Continued From page 6<br>revealed:<br>- Admitted: 2/29/16<br>- Diagnoses: Autism, Moderate Mental Retardation, Psychosis, Attention Deficit Hyperactivity Disorder, Cerebral Palsy, and Mood Disorder<br>- No physician order or d/c order for:<br>- Sodium Fluoride Cream 5000, brush teeth with a pea-sized amount of paste for 2 minutes and spit twice daily (toothpaste)<br>- Vitamin D2 1.25mg 50,000, 1 capsule every week (supplement)<br>- March 2024 - May 2024 there were no staff initials to show that this medication had been administered to client #3<br><br>Observation on 5/16/24 at approximately 1:10pm revealed:<br>- no Vitamin D2 in client #3's medication box or in the facility<br>- no Sodium Fluoride Cream in client #3's medication box or in the facility<br><br>Interview on 5/16/24 the Group Home Manager stated:<br>- the sodium fluoride cream had expired and client #3's father tried to get her a doctor's appointment but was unsuccessful so they were in the process of trying to find another dentist<br>- she was in the process of working with the pharmacy in getting in touch with the doctor for the Vitamin D2<br>- she would make sure she obtain all d/c and doctor's orders<br><br>Interview on 5/16/24 the Chief Executive Officer stated:<br>- it wasn't fair that they were responsible for the doctor's that they couldn't get in touch with or urgent care not returning their calls for | V 118 | | |

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| V 118 | Continued From page 7<br>discontinued medications or doctor orders<br>- they would get all of the orders for all medications even if they had to go to the urgent care and doctor's offices since they couldn't get through on the phone<br><br>Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.<br><br>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. | V 118 | | |