STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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DIERING HOME	2 VILLAGE WAY BLACK MOUNTAIN, NC 28711

(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 000	INITIAL COMMENTS An annual and follow up survey was completed on 5/30/24. Deficiencies were 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 3 and has a current census of 2. The survey sample consisted of audits of 2 current clients.	V 000		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (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; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (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	V 117		

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V 117	Continued From page 1 practitioner. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the packaging and labeling were affixed to each prescription drug dispensed affecting 2 of 2 clients (Clients #1 and #2). The findings are: Review on 5/29/24 of Client #1's record revealed: -admission date of 8/17/15. -diagnoses of Moderate Intellectual Developmental Disability (IDD), Autism Spectrum Disorder, Schizophrenia Disorder, Post-Traumatic Stress Disorder, and Hypothyroidism. -1/30/23 - physician's order for Retin-A 0.025% topical cream (acne) - apply to face, back and shoulders nightly. Observation on 5/30/24 at 9:35 a.m. of Client #1's medications revealed: -2 containers of Retin-A 0.025% topical cream in the medication box. -there was no pharmacy labeled box or packaging with the medication. Review on 5/29/24 of Client #2's record revealed: -admission date of 8/17/15. -diagnoses of Mild IDD, Autism Spectrum Disorder, Bipolar Disorder unspecified, Major Depressive Disorder, Unspecified Mood Disorder, Post Traumatic Stress Disorder, Conversion Disorder with Seizures or Convulsions, Somatization Disorder, Borderline Personality	V 117		

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V 117	Continued From page 2 Disorder, Other Chronic Pain, Other Muscle Spasm, Cerebral Palsy, Anxiety Disorder, Attention Deficit Hyperactivity Disorder, Acne unspecified, and Sleep Disorder. -8/25/23 - physician's order for Nikki (birth control) - 3-0.02 milligrams (mg) - 1 tablet daily. Observation on 5/30/24 at 10:06 a.m. of Client #2's medications revealed: -Nikki - 3-0.02 mg - had a blank white card where the bubble pack of medication slide into. -the plastic wrapper was in the medication box with the medication name but did not have the client's name or pharmacy label attached. Interview on 5/30/24 with the AFL provider revealed: -the pharmacy box that belonged to Client #1's Retin cream had torn and she threw it away. -Client #2's Nikki medication came like this, the pharmacy did not put a label on the medication.	V 117		
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.	V 118		

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V 118	Continued From page 3 (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 2 of 2 clients (Clients #1 and #2). The findings are: Review on 5/29/24 of Client #1's record revealed: -admission date of 8/17/15. -diagnoses of Moderate Intellectual Developmental Disability (IDD), Autism Spectrum Disorder, Schizophrenia Disorder, Post-Traumatic Stress Disorder, and Hypothyroidism. Review on 5/29/24 of Client #1's physician's orders revealed: -9/9/22 -Vitamin D 50 micrograms (mcg)	V 118		

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(nutrient)- 1 tablet daily.
-1/30/23-Retin-A 0.025% topical cream (acne) - apply to face, back and shoulders nightly.
-Clindamycin Phosphate 1% (acne) - apply once a day to affected area in the morning.
-4/6/23 -Ketoconazole 2% shampoo (dandruff) - "apply to scalp while in shower 3 x week or until clear for 3 weeks then use once weekly for maintenance dose."
-11/27/23 -Levothyroxine Sodium (Hypothyroidism) 50 mcg - 1 tablet daily.
-12/1/23 -Melatonin (sleep supplement) 3 milligrams (mg) - 1 tablet at bedtime (HS).
-2/29/24 -Invega (Schizophrenia) 6 mg - 1 tablet once daily.
-Olanzapine (Schizophrenia) 10 mg - 1 tablet at HS
-Lithium Carbonate (mood stabilizer) 600 mg - 1 capsule 2 times a day.
-Oxcarbazepine (mood stabilizer) 300 mg - 1 tablet every morning and 3 tablets at HS.
-Guanfacine HCL (hydrochloride) (high blood pressure) 1 mg - 1 tablet 2 times a day

Review on 5/29/24 of Client #1's MARs from 3/1/24 through 5/29/24 revealed:
-the following medications were not initialed to indicate they were administered on 4/6/24 and 4/7/24:
-Vitamin D 50 mcg - 1 tablet daily.
-Retin-A 0.025% topical cream - apply to face, back and shoulders nightly.
-Clindamycin Phosphate 1% - apply once a day to affected area in the morning.
-Levothyroxine Sodium 50 mcg - 1 tablet daily.
-Melatonin 3 mg - 1 tablet at HS.
-Invega 6 mg - 1 tablet once daily.
-Olanzapine 10 mg - 1 tablet at HS
-Lithium Carbonate 600 mg - 1 capsule 2

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times a day.
-Oxcarbazepine 300 mg - 1 tablet every morning and 3 tablets at HS.
-Guanfacine HCL 1 mg - 1 tablet 2 times a day
-Ketoconazole 2% shampoo - "apply to scalp while in shower 3 x week or until clear for 3 weeks then use once weekly for maintenance dose." was blank for all months reviewed.
-Clindamycin Phosphate 1% - apply once a day to affected area in the morning- was blank for 5/2/24 through 5/29/24.

Observation and interview on 5/30/24 at 10:23 a.m. with Client #1 revealed:
-he had medicated shampoo, it had a "blue lid" on it, he hadn't used this "in a while."
-walked to his bathroom where the shampoo or the cream for his acne was not found.
-he denied he had dandruff at this time and his face was "all clear right now."
-he visited his mom at times and stayed overnight, "I think I did that in April."

Review on 5/29/24 of Client #2's record revealed:
-admission date of 8/17/15.
-diagnoses of Mild IDD, Autism Spectrum Disorder, Bipolar Disorder unspecified, Major Depressive Disorder, Unspecified Mood Disorder, Post Traumatic Stress Disorder, Conversion Disorder with Seizures or Convulsions, Somatization Disorder, Borderline Personality Disorder, Other Chronic Pain, Other Muscle Spasm, Cerebral Palsy, Anxiety Disorder, Attention Deficit Hyperactivity Disorder, Acne unspecified, and Sleep Disorder.

Review on 5/29/24 of Client #2's physician's orders revealed:
-8/25/23 -Nikki (birth control) - 3-0.02 mg - 1

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V 118	Continued From page 6 tablet daily. -9/15/23 -Gabapentin (epilepsy, pain)100 mg - 1 capsule every morning and 2 capsules at HS. -11/13/23 -Lybalvi (mood stabilizer) 5 mg-10 mg - 1 tablet at HS. -11/17/23 -Vitamin D 50 mcg - 1 tablet every morning. -Magnesium Oxide (dietary supplement) 400 mg - 1 tablet at HS. -Clindamycin Phosphate 1% - 1 apply to affected skin 2 times daily until resolved. -12/8/23 -Prazosin HCL (hypertension) 2 mg - 2 capsules at HS. -2/7/24 -Trazodone HCL (anxiety) 50 mg - 1 tablet at HS. -2/23/24 -Duloxetine HCL (anxiety) 30 mg - 1 capsule 2 times daily. -5/9/24 -Lamotrigine (epilepsy) 25 mg - 1 tablet 2 times daily. Review on 5/29/24 of Client #2's MARs from 3/1/24 through 5/29/24 revealed: -the following medications were not initialed to indicate they were administered on 3/23/24 and 3/24/24: -Nikki - 3-0.02 mg - 1 tablet daily. -Gabapentin 100 mg - 1 capsule every morning and 2 capsules at HS. -Vitamin D 50 mcg - 1 tablet every morning. -Magnesium Oxide 400 mg - 1 tablet at HS. -Clindamycin Phosphate 1% - 1 apply to affected skin 2 times daily until resolved. -Prazosin HCL 2 mg - 2 capsules at HS. -Trazodone HCL 50 mg - 1 tablet at HS. -Duloxetine HCL 30 mg - 1 capsule 2 times daily. -Lamotrigine 25 mg - 1 tablet 2 times daily. -Lybalvi 5 mg-10 mg - 1 tablet at HS was not listed for any of the months reviewed.	V 118		

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V 118	Continued From page 7 Interview on 5/30/24 with the AFL provider revealed: -Client #1 no longer saw the "skin specialist" that prescribed the shampoo and acne creams. -it had been about a year since he had been to the dermatologist. -these medications were still on Client #1's MARs because "the pharmacy doesn't take it off." -a hospital prescribed Client #2's Lybalvi, but she no longer took this medication. -it was difficult to get it discontinued because the hospital physician initiated the order. -the dates in March and April were blank because the client's went to visit their parents. -Client #1 and #2's parents administered the medications on 3/23/24, 3/24/24, 4/6/24 and 4/7/24. -she had never been told to document at the bottom of the MAR as to why the medication was not administered on those days. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 290	27G .5602 Supervised Living - Staff 10A NCAC 27G .5602 STAFF (a) Staff-client ratios above the minimum numbers specified in Paragraphs (b), (c) and (d) of this Rule shall be determined by the facility to enable staff to respond to individualized client needs. (b) A minimum of one staff member shall be present at all times when any adult client is on the premises, except when the client's treatment or habilitation plan documents that the client is capable of remaining in the home or community without supervision. The plan shall be reviewed as needed but not less than annually to ensure	V 290		

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V 290	Continued From page 8 the client continues to be capable of remaining in the home or community without supervision for specified periods of time. (c) Staff shall be present in a facility in the following client-staff ratios when more than one child or adolescent client is present: (1) children or adolescents with substance abuse disorders shall be served with a minimum of one staff present for every five or fewer minor clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body; or (2) children or adolescents with developmental disabilities shall be served with one staff present for every one to three clients present and two staff present for every four or more clients present. However, only one staff need be present during sleeping hours if specified by the emergency back-up procedures determined by the governing body. (d) In facilities which serve clients whose primary diagnosis is substance abuse dependency: (1) at least one staff member who is on duty shall be trained in alcohol and other drug withdrawal symptoms and symptoms of secondary complications to alcohol and other drug addiction; and (2) the services of a certified substance abuse counselor shall be available on an as-needed basis for each client. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to document in the treatment or habilitation plan when a client was capable of remaining in	V 290		

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V 290	Continued From page 9 the community without staff supervision for 1 of 2 clients (Client #2). The findings are: Review on 5/29/24 of Client #2's record revealed: -admission date of 8/17/15. -diagnoses of Mild IDD, Autism Spectrum Disorder, Bipolar Disorder unspecified, Major Depressive Disorder, Unspecified Mood Disorder, Post Traumatic Stress Disorder, Conversion Disorder with Seizures or Convulsions, Somatization Disorder, Borderline Personality Disorder, Other Chronic Pain, Other Muscle Spasm, Cerebral Palsy, Anxiety Disorder, Attention Deficit Hyperactivity Disorder, Acne unspecified, and Sleep Disorder. -12/5/23 - treatment plan did not address the client's ability to be in the community unsupervised. Interview on 5/30/24 with Client #2 revealed: -she remained home unsupervised about "30 minutes to an hour." -when in the community she "usually" was with her one-on-one worker. Interviews on 5/30/24 with Client #2's mom/guardian and the AFL provider revealed: -the amount of unsupervised time "depends on her (Client #2's) mood." -when in the community, her mom/guardian allowed her to go to one store alone while she went to another. -mom/guardian also approved for Client #2 to walk downtown and get coffee by herself. -both were unsure if this was in her treatment plan, but knew this had been discussed during treatment team meetings. Interview on 5/30/24 with the Qualified Professional revealed:	V 290		

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V 290	Continued From page 10 -she was aware Client #2 walked down the street unsupervised to meet her mom/guardian. -she was unsure if unsupervised time in the community was in the treatment plan, but would ensure this would be added, should the team decide to continue this.	V 290		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required	V 367		

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report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18).
(e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:
(1) medication errors that do not meet the definition of a level II or level III incident;
(2) restrictive interventions that do not meet the definition of a level II or level III incident;
(3) searches of a client or his living area;

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V 367	Continued From page 12 (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report a level II incident in the Incident Response Improvement System (IRIS) within 72 hours of becoming aware of the incident. The findings are: Review on 5/29/24 of Client #2's record revealed: -admission date of 8/17/15. -diagnoses of Mild IDD, Autism Spectrum Disorder, Bipolar Disorder unspecified, Major Depressive Disorder, Unspecified Mood Disorder, Post Traumatic Stress Disorder, Conversion Disorder with Seizures or Convulsions, Somatization Disorder, Borderline Personality Disorder, Other Chronic Pain, Other Muscle Spasm, Cerebral Palsy, Anxiety Disorder, Attention Deficit Hyperactivity Disorder, Acne unspecified, and Sleep Disorder. Review on 5/29/24 of a facility internal incident report dated 4/14/24 revealed:	V 367		

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DIERING HOME	2 VILLAGE WAY BLACK MOUNTAIN, NC 28711

(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 367	Continued From page 13 -4:00 p.m. - Client #2 "wrongly" told the AFL provider "she was getting picked up by [mom/guardian]. This is a normal occurrence as she sometimes spends a few days with mom as a natural support. Instead of walking to the designated pickup site down the road from their home (AFL provider), (Client #2) instead walked to a friend's house..." -Client #2 called her mom/guardian but refused to tell her where she was. -Police were called, located Client #2, and returned her to the AFL provider at 7:00 p.m. Review on 5/29/24 of IRIS revealed: -there were no level II incidents reported regarding Client #2. Interview on 5/30/24 with the Qualified Professional revealed: -she completed the incident report for Client #2 on 4/14/24. -the Quality Manager (QM) determined if incidents needed to be submitted to IRIS. Interview on 5/30/24 with the QM revealed: -he reviewed the first part of the IRIS grid that incidents were reportable if it was an absence of more than 3 hours. -he "neglected" to read the second part about absence that required contacting the police. -he would ensure the incident was submitted into IRIS.	V 367		