FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED MHL073-037 B. WING 05/02/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 230 WINHAVEN STREET WINHAVEN STREET GROUP HOME ROXBORO, NC 27573 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 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 RECEIVED Adults with Developmental Disability. MAY 28 2024 The facility is licensed for 6 and currently has a census of 3. The survey sample consisted of DHSR-MH Licensure Sect audits of 3 current clients. V 106 27G .0201 (A) (8-18) (B) GOVERNING BODY V 106 V106-Direct Support Staff will receive 5/23/24 **POLICIES** training from the Director of Services & Registered Nurse (RN) regarding policy 10A NCAC 27G .0201 GOVERNING BODY for reporting critical POLICIES incidents to include medication errors. (a) The governing body responsible for each Program Coordinators (PC) will monitor facility or service shall develop and implement medication administration records written policies for the following: (8) use of medications by clients in accordance (MARs) weekly and RN's will monitor with the rules in this Section: monthly to ensure all medication orders (9) reporting of any incident, unusual occurrence are being followed according to agency or medication error: policy. Any medication errors (10) voluntary non-compensated work performed discovered will be reported immediately by a client: to the doctor by the RN and Clinical (11) client fee assessment and collection Director. 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

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continuing education;

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(17) safety precautions and requirements for

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED						
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V 106	Continued From pa	age 1	V 106								
V 100	facility areas included areas; and (18) client grievand for review and disp	ding special client activity ce policy, including procedures cosition of client grievances. governing body shall be									
	en e										
	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:										
	Reporting Policy re - "employees procedure for reportincidents are defined.	should follow the established orting critical incidents. Critical ned as: medication errorsstaf cident will complete a medication	f n								
	revealed: - admitted 10/1 - diagnoses: Se Cerebral Palsy Ur Hypertension, Mix Incontinence - a physician's	9/24 of client #2's record 13/99 evere Intellectual Disabilities, nspecified, Essential (Primary) xed Hyperlipidemia, Overflow order dated 4/23/24 for igrams (incontinence)									
	Medication Admir revealed:	24 of client #2's April 2024 nistration Record (MAR) tation of administration of 4/24/24-4/27/24		Mur & DY Curicoo O	nior \$121/24						

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: _ COMPLETED. B. WING MHL073-037 05/02/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 230 WINHAVEN STREET WINHAVEN STREET GROUP HOME ROXBORO, NC 27573 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 106 Continued From page 2 V 106 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 5/23/24 staff did not complete the medication error V118-Direct Support Staff and forms Program Coordinators (PC) will would ensure medication error forms were receive training from the Director of completed Services & Registered Nurse (RN) regarding medication requirements to V 118 27G .0209 (C) Medication Requirements V 118 include implementation of medications according to physician's orders and 10A NCAC 27G .0209 MEDICATION our policy & procedure regarding REQUIREMENTS medication orders. Registered Nurse (c) Medication administration: (RN) will monitor pink sheets after (1) Prescription or non-prescription drugs shall

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druas.

client's physician.

only be administered to a client on the written

(2) Medications shall be self-administered by

clients only when authorized in writing by the

(3) Medications, including injections, shall be

administered only by licensed persons, or by

order of a person authorized by law to prescribe

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If continuation sheet 3 of 7

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appointments to ensure all medication

according to physicians orders. Direct

Support Staff will notify the RN and

PC immediately of any new orders

transcriptions not completed by her.

after appointments. The RN will

quality check and date new

order changes are implemented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLE DATE					
V 118	unlicensed person pharmacist or othe privileged to prepa (4) A Medication A all drugs administe current. Medication recorded immedia MAR is to include (A) client's name; (B) name, strength (C) instructions for (D) date and time (E) name or initial drug. (5) Client requests checks shall be re-	s trained by a registered nurse, or legally qualified person and re and administer medications. It does not considered to each client must be kepted to after administration. The	t							
	Based on record interviews the fac medications on th 2 of 3 audited clie The following are did not receive m	met as evidenced by: reviews, observation and ility failed to administer he written order of a physician for ents (#2 & #3). The findings are examples of how client #2 & # edications ordered by their								
	revealed: - admitted 10/ - diagnoses: S	0/24 of client #2's record 13/99 severe Intellectual Disabilities, nspecified, Essential (Primary)		Mun & Dy an	inital Omi	5/21/24				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: __ MHL073-037 B. WING 05/02/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 230 WINHAVEN STREET WINHAVEN STREET GROUP HOME ROXBORO, NC 27573 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 118 Continued From page 4 V 118 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 Mr 8 Dy Clinice Our 5,21/24 were side effects she (facility's nurse) believed client #2 left for

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out of town on 4/23/24 and returned 4/27/24

Division of Health Service Regulation (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: _ 05/02/2024 MHL073-037 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 230 WINHAVEN STREET WINHAVEN STREET GROUP HOME ROXBORO, NC 27573 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 118 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 Me & D& Cliniae Dint 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

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FORM APPROVED Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING MHL073-037 05/02/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 230 WINHAVEN STREET WINHAVEN STREET GROUP HOME ROXBORO, NC 27573 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 118 Continued From page 6 V 118 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

Division of Health Service Regulation

Mun & Dr Unal Direk 5/21/24