STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-833	A. BUILDING: _____ B. WING _____	R 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE HOMES	926 EDISON ROAD RALEIGH, NC 27610

(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 July 31, 2024. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and has a current census of 4. The survey sample consisted of audits of 3 current clients.	V 000		
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. (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.	V 118		

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V 118	Continued From page 1 (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 the MAR was kept current affecting 1 of 3 audited clients (#1). The findings are: Review on 7/30/24 of client #1's record revealed: - Admitted 6/15/15 - Diagnoses of Paranoid Schizophrenia, Ataxia, Essential Hypertension, Hyperlipidemia, History of Seizure Disorder, History of Depression, Diverticulitis, Epilepsy, Alcohol Dependence Disorder, Gastroesophageal Reflux Disease, Mild Intellectual Developmental Disability & Psychosis - A physician's order dated 2/8/24: Food Supplement Drink (Ensure) one can per day with meals (Supplement) Review on 7/30/24 of client #1's May, June & July 2024 MARs revealed: - Ensure Active Light Oral Liquid Drink one can per day with meals (three per day (TID)) and drink one with each snack if not eating - Staff #1 initialed from May 1st-31st at 8am, 12pm & 5pm indicating the Ensure was administered - Staff #1 initialed from June 1st-30th at 8am, 12pm & 5pm indicating the Ensure was	V 118		

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V 118	Continued From page 2	V 118		

administered
- Staff #1 initialed from July 1st -30th at 8am, 12pm & 5pm & 8am on July 31st indicating the Ensure was administered

Observation at 9:39am on 7/30/24 revealed:
- No Ensure in the facility

Interview on 7/30/24 client #1 reported:
- Was supposed to drink Ensure with his meals, but he hadn't had it in a while
- "Been a long time" since he had an Ensure
- Couldn't recall the last time he had an Ensure

Interviews on 7/30/24 & 7/31/24 staff #1 reported:
- Client #1 didn't have any Ensure in the facility
- Client #1 drank Ensure everyday, but Client #1 ran out of his Ensure two weeks ago
- He initialed the MARs indicating that he administered the Ensure to client #1
- Initialing client #1's MARs indicating he administered the Ensure was "my mistake"
- Was trained to sign the MAR after he administered the clients' medications
- He made a mistake by saying client #1 ran out of Ensure two weeks ago; client #1 ran out of his Ensure on Monday (7/29/24)
- Told the Registered Nurse (RN)/Qualified Professional (QP)/Licensee that client #1 was out of Ensure yesterday (7/30/24)
- The RN/QP/Licensee purchased client #1's Ensure and brought them to the facility today (7/31/24)

Interview on 7/31/24 the RN/QP/Licensee reported:
- Was unaware client #1 had ran out of Ensure
- Was unaware staff #1 signed client #1's MARs indicating he administered client #1 his Ensure

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V 118	Continued From page 3 - Trained staff to sign the clients MARs after administering the clients' medications	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 inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.	V 291		

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V 291	Continued From page 4	V 291		

This Rule is not met as evidenced by:
Review on 7/30/24 of client #1's record revealed:
- Admitted 6/15/15
- Diagnoses of Paranoid Schizophrenia, Ataxia, Essential Hypertension, Hyperlipidemia, History of Seizure Disorder, History of Depression, Diverticulitis, Epilepsy, Alcohol Dependence Disorder, Gastroesophageal reflux disease, Mild Intellectual Developmental Disability & Psychosis
- A physician's order dated 2/8/24: Food Supplement Drink one can per day with meals (Supplement)

Review on 7/30/24 of client #1's May, June & July 2024 MARs revealed:
- Ensure Active Light Oral Liquid Drink one can per day with meals (three per day (TID)) and drink one with each snack if not eating
- Staff #1 initialed from May 1st-31st at 8am, 12pm & 5pm indicating the Ensure was administered
- Staff #1 initialed from June 1st-30th at 8am, 12pm & 5pm indicating the Ensure was administered
- Staff #1 intitialed from July 1st -30th at 8am, 12pm & 5pm & 8am on July 31st indicating the Ensure was administered

Observation at 9:39am on 7/30/24 revealed:
- No Ensure in the facility

Interview on 7/30/24 client #1 reported:
- Was supposed to drink Ensure with his meals, but he hadn't had it in a while
- "Been a long time" since he had an Ensure
- Couldn't recall the last time he had an Ensure
- He ate his food and wasn't losing any weight

Interviews on 7/30/24 & 7/31/24 staff #1 reported:

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V 291	Continued From page 5 - Client #1 didn't have any Ensure in the facility - Client #1 drunk Ensure everyday, but Client #1 ran out of Ensure two weeks ago - The Registered Nurse (RN)/Qualified Professional (QP)/Licensee was responsible for purchasing client #1's Ensure - Made a mistake by saying client #1 ran out of Ensure two weeks ago; client #1 ran out of his Ensure on Monday (7/29/24) - Told the RN/QP/Licensee that client #1 was out of Ensure yesterday (7/30/24) - The RN/QP/Licensee purchased client #1's Ensure and brought them to the facility today (7/31/24) Interview on 7/31/24 the RN/QP/Licensee reported: - Was unaware client #1 had ran out of Ensure - Staff #1 was supposed to notify her when client #1 had 7 Ensure left so she could purchase more - She could've sent staff #1 money to purchase client #1 more Ensure - Staff #1 "forgets a lot" - Staff #1 called her yesterday (7/30/24) and that client #1's drunk his last Ensure that morning (7/30/24) - She purchased client #1's Ensure and took it to the facility today (7/31/24)	V 291		
V 513	27E .0101 Client Rights - Least Restrictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most	V 513		

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V 513	Continued From page 6 appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort; and (2) employing the intervention by people trained in its use. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to use the least restrictive and most appropriate method. The findings are: Observations at 9:26am on 7/30/24 and at 9:36am and 10:30am on 7/31/24 revealed: - Staff #1 used keys to unlock the kitchen door that was adjacent to the living room area Interview on 7/30/24 client #1 reported: - The kitchen door was locked after meals so clients couldn't go in the kitchen and take food Interview on 7/30/24 client #2 reported: - Staff #1 kept the kitchen door locked after meals so clients couldn't steal food	V 513		

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V 513	Continued From page 7 Interview on 7/30/24 client #4 reported: - The kitchen door was locked after meals so clients couldn't go in the kitchen and eat food Interview on 7/31/24 staff #1 reported: - He "always keep it (kitchen door) locked" due to a former client and client #4 stealing food out of the kitchen - The Registered Nurse (RN)/Qualified Professional (QP)/Licensee told him to keep the kitchen door locked - He kept the kitchen door locked since last year (2023), but couldn't recall exactly when he started - Wanted to keep the clients from having access to knives in the kitchen - "Liked the way it's going now...if they (clients) need anything I'll give it to them" Interview on7/31/24 the RN/QP/Licensee reported: - Was unaware the kitchen door was kept locked - Saw the kitchen door locked during a visit and told staff #1 to leave the door unlocked - Couldn't recall when she told staff #1 to keep the kitchen door unlocked - "Clients can enter the kitchen...they (clients) can go anywhere they want" in the facility - The kitchen door was not supposed to be locked	V 513		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive	V 736		

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V 736	Continued From page 8 odor. This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a clean & attractive manner. The findings are: Observation at 9:39am on 7/30/24 revealed the following: Client #1's room: - 2 out of 3 lightbulbs were not working Spare bedroom: - brown spots splashed on the front of the closet door - water stains on the wall inside the closet - small circular hole in the wall behind the bedroom door - air vent in the lower wall under the window was rusted and dusty Upstairs bathroom: - 2 out of 3 lightbulbs were not working - paint peeling under the light plate cover on the wall - vent in the lower wall very rusty, dirty and coming apart Upstairs hallway: - beeping smoke detector Downstairs bathroom: - toilet paper holder broken and missing Interview on 7/30/24 staff #1 reported: - was responsible for cleaning the facility - the Registered Nurse (RN)/Qualified Professional (QP)/Licensee was responsible for completing repairs in the facility	V 736		

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V 736	Continued From page 9 - was unaware the light bulbs weren't working - he would change the blown light bulbs and the battery in the smoke detector - the RN/QP/Licensee asked if he could repair things in the facility and he repaired the things he could - the stains in the spare bedroom were from a former client Interview on 7/30/24 the RN/QP/Licensee reported: - was responsible for overseeing the repairs in the facility - she repaired some of the issues that were cited in the previous Division of Health Service Regulation survey - staff #1 was responsible for cleaning the facility - was "very particular" with the cleanliness of the facility - planned to repair and paint the walls in the spare bedroom - there was a storage of light bulbs in the facility and she was shocked that staff #1 hadn't replaced the blown light bulbs This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 736		