STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411234	A. BUILDING: _____ B. WING _____	08/07/2024

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V 000	INITIAL COMMENTS An annual and follow up survey was completed on August 7,2024. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600B Supervised Living for Minors with Developmental Disability. 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 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 medications were administered on the written order of a physician and failed to keep current the MARs affecting 2 of 2 clients (Client # 1 and #2). The findings are: Observation on 8/6/24 at 2:16 pm of Client #1's medications revealed: -No Aripiprazole 2 mg and Senna 8.6 mg present in the facility. Review on 8/7/24 of Client #1's record revealed: -Admission date: 2/1/24. -Diagnoses of Schizophrenia, Autism Spectrum Disorder, Asthma, and Constipation. -1/30/24 physician-prescribed Aripiprazole 2 milligram (mg)- 1 tablet (tab) daily (mood/psychosis). -4/2/24 physician-prescribed Senna 8.6 mg-2 tabs as needed (constipation). Review on 8/6/24 of Client #1's August 2024 MAR revealed: -Aripiprazole 2 mg had a slash (/) marked at the 8 am dosage time from 8/2/24 to 8/6/24. -Senna had a slash mark at the 8 am dosage time from 8/1/24 to 8/6/24.	V 118		

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V 118	Continued From page 2 Review on 8/7/24 of Client #2's record revealed: -Admission date: 7/15/24. -Diagnoses of Autism Spectrum Disorder, Mild Intellectual Developmental Disability (IDD), Post-Traumatic Stress Disorder (PTSD), Attention-Deficit/Hyperactivity Disorder (ADHD)-combined type, Conduct Disorder, Other persistent mood (affective disorder), and Child Neglect. -6/12/24 physician-prescribed medications: -Citalopram 10 milligrams (mg)- 3 tablets (tab) daily (depression). -Quetiapine Fumarate 200 mg- 1 tab at bedtime (anxiety). -Divalproex Sodium 500 mg- 1 tab every 12 hours (mood stabilizer). Review on 8/6/24 of Client #2's July 2024 and August 2024 MARs revealed: -Citalopram was initialed as administered at 8 am and at 8 pm on 7/16/24, 7/17/24, 7/20/24 to 7/24/24, 7/26/24 to 7/30/24, and from 8/1/24 to 8/6/24. -Quetiapine Fumarate was initialed as administered at 8 am and at 8 pm on 7/16/24 to 7/24/24, and from 7/26/24 to 7/30/24, and from 8/1/24 to 8/6/24. There was no documentation this medication was administered on 7/25/24 at the 8 pm dosage time. -Divalproex had no documentation for 8 am dosage time on 7/21/24 and for 8 pm dosage time on 7/25/24. -Divalproex had no documentation of a dosage time prior to the 8 pm dosage time from 8/1/24 to 8/6/24. Interview on 8/6/24 with Staff #1 revealed: -The slash marks on Client #1's August MAR for Aripiprazole and Senna were because	V 118		

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V 118	Continued From page 3	V 118		

Client #1 was out of these medications.
-The Assistant Residential Affairs Director was working with the pharmacy to get these medications refilled.

Interview on 8/6/24 with Staff #2 revealed:
-"I give [Client #2] all his tablets in the morning."
-" I just marked the sheet (MAR) without reading the bottle."
-Client #2 received his medications at his dosage times.

Interview on 8/6/24 with Owner/Director #1 revealed:
-He and Owner/Director #2 would come to the facility today (8/6/24) and review Client #1's and #2's MARs, talk with staff, and have the Qualified Professional (QP) to do a medication count.
-The medication concern would be addressed immediately.

Interview on 8/7/24 with the Assistant Residential Affairs Director revealed:
-The pharmacy refilled Client #1's Aripiprazole and Senna on 7/17/24 and the pharmacy usually "dropped the medicine off here. (the office)."
-"I don't understand why he was out the medicines if he was given 30 pills."
-" I have talked with the pharmacy today and I will go pick his medicine up. He will have it today."

Interview on 8/7/24 with the QP revealed:
-He was at the facility this morning and pill counts of Client #1's and #2's medications were done.
-The MARs had 2 dosage times (8am and 8 pm) for medications that were to be administered once daily.
-The pharmacy was going to start printing and providing the client MARs.
-His interviews with staff revealed staff were

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V 118	Continued From page 4 going by the medicine labels and were initialing the MARs at both the dosage times provided. -He believed the problem was a documentation issue and he would work with the Owners/Directors to correct the medication issues. Interview on 8/7/24 with Owner/Director #2 revealed: -Changes had already been made for staff to stand in the kitchen area in sight of the camera where he would observe the medication administration by staff and ensure Clients #1 and #2 received their medications correctly. -He would ensure the client medications were available for administration as prescribed by the client doctors. -The Assistant Residential Affairs Director was checking the client MARs twice a month and had not been to the facility yet for this month (August). -He was looking into having a nurse check the client MARs frequently to note any errors so that the errors could be addressed. -He would ensure the staff received refresher medication training. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer	V 119		

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V 119	Continued From page 5 system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to dispose of medication in a manner that guarded against diversion or accidental ingestion affecting 2 of 2 clients (Client #1 and #2). The findings are: Observation on 8/6/24 at 1:33 pm of the facility's kitchen floor revealed: -A white, round tablet was laying on the floor about 2 inches away from the baseboard and between the baseboard and dining table. -The tablet had an imprint of "M" on one side and "c37" on the opposite side.	V 119		

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V 119	Continued From page 6 Interview on 8/6/24 with Staff #2 revealed: -Client #1 usually sat at the dining table location where the tablet was found. -He did not know what the medicine tablet was with the imprints on the tablet. -"It doesn't look like one of [Client #2]'s (medications); its likely [Client #1]'s (medication)." Interview and observation on 8/6/24 between 2:00- 3:00 pm with Staff #1 revealed: -The medicine tablet likely belonged to Client #1. -She picked up the medicine tablet off the table and walked away with the tablet.	V 119		