STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL001-086	A. BUILDING: _____ B. WING _____	R-C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAW RIVER GROUP HOME	2150 HAW RIVER-HOPEDALE ROAD HAW RIVER, NC 27258

(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 A complaint and follow up survey was completed on July 30, 2024. The complaint was substantiated (intake #NC00219675). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. The facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 4 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	V 118	V118 : On 7/16/2024, RSL RN completed an immediate RSL universal medical monitoring training for all residential administrative staff. By 8/21/2024, medical monitoring will consist of ensuring staff are following the appropriate medication order, the appropriate dose, with the appropriate individual. RSL RN will also retrain Haw River staff on medication pass and documentation on MAR. After training is completed, all residential admin will complete a universal medical monitoring observation at least twice a week then fade to monthly as needed. A copy of monitoring documentation will be forwarded to Directors of Residential.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Director Residential Services | 8/12/24

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-1 clonidine 0.1 milligram (mg).
-1 fenofibrate.
-1 fiber-lax.
-1 levetiracetam 750 mg.
-1 lorazepam 1 mg.
-1 sodium chloride 1 gram.
-1 vitamin B12 mg.

-The patient also is on a clonidine patch for his high blood pressure control. This was removed once it was realized that he had gotten the other medication. The patient himself denies any symptoms currently. He states he does not feel dizzy or lightheaded, denies any acute pain, difficulty breathing, palpitations, weakness or nausea."

Review on 7/30/24 of a Medication Error report dated 6/26/24 revealed:
-Report completed by the Qualified Professional and Staff #5.
-Type of Error: Wrong Medication.
-Describe what happened-include medication names and doses: "Staff administered [Client #3}'s medication to [Client #1]. 2 carbamazepine 400 mg, 1 clonidine 0.1 mg, 1 fenofibrate 145 mg, 1 fiber-lax, 1 levetiracetam 750 mg, 1 lorazepam 1 mg, 1 sodium chloride 1 gram, 1 vitamin B12 mg.
-Notifications: Pharmacist.
-Level Determination: Level 1. Error does not threaten person's health or safety.
-Staff Committing Error: [Staff #5].
-Further Action Needed: "Individual was taken to the ER for further results of medication error. No further action needed. Staff was told to be sure to follow proper protocol they learned in med pass to prevent further errors. Staff was also told that during med training that they should focus in giving meds and to do one individual at a time to prevent errors. Staff was also to make sure that

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only one individual should be in the med room at a time and that should be the one to whom you are giving meds to. Nurse was also contacted about med error and staff will be retrained on administering meds."
-Note from the Nurse: "RN has developed a remedial class to be implemented. Additional training will take place 7/16/- 17/2024 to assist in med admin and monitoring."

Review on 7/30/24 of Client #2's record revealed:
-Admission date of 8/17/17.
-Diagnoses of Autism Spectrum Disorder, Obsessive Compulsive Disorder, Attention Deficit Hyperactive Disorder and Asthma.
-Physician orders dated 11/14/23.
-Amantadine 100 mg- Take two capsules twice daily.
-Clonidine 0.1 mg- Take two tablets twice daily.
-Olanzapine 15 mg- Take one tablet twice daily.
-Divalproex 250 mg- Take one tablet daily at night.

Observation on 7/30/24 at about 12:05 pm of Client #2's medications revealed:
-All medications aforementioned were available.

Review on 7/30/24 of Client #2's MARs for June 2024 through July 2024 revealed:
-July:
-Amantadine 100 mg- Was not initialed as given by staff on 7/26 (evening) and 7/29 (evening).
-Clonidine 0.1 mg- Was not initialed as given by staff on 7/29 (evening).
-Olanzapine 15 mg- Was not initialed as given by staff on 7/29 (evening).
-Divalproex 250 mg- Was not initialed as

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given by staff on 7/29 (evening).

-Due to the failure to accurately document medication administration, it could not be determined if the client received his medications as ordered by the physician.

Interview on 7/30/24 with Staff #5 revealed:
-Regarding medication error: "On 6/26/24, I came and pulled the wrong client's medications out the box. I felt in a hurry. I felt like I was running late. I was working by myself. I was trying to get in the schedule to get the guys ready and out of the home to their program."
-When she realized her error, she contacted her supervisor and the nurse.
-She was informed to contact emergency services.
-Client #1 went to the local emergency department to be checked.
-Client #1 was checked, did not have any problems and was returned home that same day.
-An incident medication error report was made.
-She was also retrained by the Nurse regarding "Medication Pass."

Interview on 7/30/24 with the Vice President of Operations revealed:
-He knew why the state had received a complaint.
-One individual had received another client's medications in error.
-When the medication error occurred, [Staff #5] noticed the error right away.
-Staff #5 notified her supervisor, pharmacist was contacted, emergency personnel was contacted and attended the home, Client #1 went to the emergency department to be checked. He was fine and returned to the facility later that same day.
-An incident report was made. Staff #5 and others

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V 118	Continued From page 5 in the agency were retrained. -Regarding some medications not being initialed by staff on the MAR: He was not aware of missing initials. -He acknowledged Client #1 received another client's medications which he did not have physician's orders for and the MAR was not being kept current.	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	V 291	V291 : By 8/21/2024 RSL Residential Administrative professionals will ensure that all medical monitoring is completed and documented as ordered. Medical observations will be forwarded to the Directors of Residential Services, then will be sent to RN for review.	

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or legal system is involved or when health or safety issues become a primary concern.

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to coordinate with other qualified professionals who are responsible for the treatment/habilitation for 4 of 4 audited clients (#1 and #3). The findings are:

Review on 7/30/24 of client #1's record revealed:
-Admisison date of 11/15/13.
-Diagnoses of Autism Spectrum Disorder; Generalized Anxiety Disorder; Depression; Intellectual and Developmental Disabilities, Moderate; Epilepsy, Unspecified, Not Intractable, Without Status Epilepticus; Hyperlipidemia; Hypertension; Allergic Rhinitis; Hemorrhoids; Migraines.
-FL2 dated 2/8/24: check blood pressure weekly.

Review on 7/30/24 of client #1's Medication Administration Record (MAR) for the months of June and July of 2024 revealed:
-Check Blood Pressure:
-June =There were no recordings from 6/2-6/30.
-July = Hand written instructions to check them daily. There were no recordings from 7/1-7/10; 7/19-7/23, 7/26-7/31.

Observation on 7/30/24 at about 12:00 pm of the facility's medication room revealed:
-There was a blood pressure monitor on site.

Review on 7/30/24 of client #3's record revealed:
-Admisison date of 4/13/91. .

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V 291	Continued From page 7 -Diagnoses of Moderate Intellectual and Developmental Disabilities; Benign Essential Hypertension; Seizures; Anxiety; B12 Deficiency; Other Hyperlipidemia; Urethra Stricture; Anemia; Psoriasis, Unspecified Allergies. -FL2 dated 8/13/24: check blood pressure weekly. Review on 7/30/24 of client #3's MAR for the months of June and July of 2024 revealed: -Check Blood Pressure Weekly: -June = There were no recordings from 6/2-6/30. -July = There were no recordings from 7/1-7/30. Observation on 7/30/24 at about 12:00 pm of the facility's medication room revealed: -There was a blood pressure monitor on site. Interview on 7/30/24 with the Vice President of Operations revealed: -He was not aware that the blood pressure checks for clients #1 and #3 had not been completed accordingly to instructions on their FL2. -The Qualified Professional (QP) recently resigned from the agency. -The QP was supposed to check to make sure the blood pressure checks were being completed. -That was one of the reasons he resigned. He found out that he was not able to complete all the duties the position entailed. -A new Program Specialist had been hired. New staff among with nurses and new QP would be monitoring to make sure client's blood pressures would be checked. -He acknowledged that staff had not recorded the high blood pressure check readings accordingly to instructions from their FL2 for clients #1 and #3	V 291		

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V 291	Continued From page 8 in their MAR. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 291		