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	MHL059-103	A. BUILDING: _____ B. WING _____	R 07/25/2024

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V 000	INITIAL COMMENTS A limited follow up survey for the Type A1 was completed on July 25, 2024. This was a limited follow up survey, only 10A NCAC 27G .0209 Medication Requirements (V118) was reviewed for compliance. A deficiency was 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 3. The survey sample consisted of audits of 3 current clients.	V 000	V118 RECEIVED AUG 19 2024 DHSR-MH Licensure Sect All medication issues found at the first visit was corrected. The second visit found a new set of errors. CCHC made AFL and her QP retake medication administration training. CCHC nurse has also completed a home visit to ensure everything was correct regarding medications, scripts, and MARS. CCHC QP will conduct quarterly medication inspections to ensure that AFL is staying on top of their MARS. CCHC nurse will do monthly audits of the MARS.	8/15/2024
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;	V 118		

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V 118	Continued From page 1 (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 observations, record reviews and interviews, 1 of 1 staff (Alternative Family Living (AFL) Provider) failed to demonstrate competency in medication administration and failed to keep MARs current affecting 3 of 3 clients (Clients #1, #2 and #3). The findings are: Observation at the facility and interview with the AFL Provider on 7/23/24 at 9:45am-9:55 am revealed: -At 9:45 am, Division of Health Service Regulation (DHSR) surveyor requested to review the clients' MARs. The AFL Provider entered the laundry room area which exits to the bedrooms. -At 9:55 am, the AFL Provider had not returned to the kitchen with the MARs and DHSR surveyor entered the laundry room and called out to the AFL Provider who then appeared with the MARs in her hand stating "What is today's date? I forgot what date it is. I thought today was the 22nd (7/22/24)." Review on 7/24/24 and 7/25/24 of the AFL Provider"s record revealed: -Date of Hire: 11-20-16.	V 118		

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V 118	Continued From page 2 -Most recent medication administration training on 11-30-23. Review on 7/23/24 of Client #1's record revealed: -Date of Admission: 1/26/23. -Diagnoses: Mild Intellectual Disabilities; Chronic Pain Syndrome; Cerebral Palsy; Mild Intermittent Asthma; Overflow Incontinence; Post Traumatic Stress Disorder; Transsexualism; Major Depressive Disorder without Psychotic Features; Dysphagia. -Physician's orders included: 1/8/24: -Propranolol hydrochloride (HCL) 60 milligrams (mg) 1 tablet by mouth (PO) three times daily (TID) (antihypertensive). 4/10/24: -Cetirizine HCL 10 mg 1 tablet PO daily (antihistamine). 4/11/24: -Spironolactone 100 mg 1 tablet PO twice daily (BID) (fluid retention). -Vitamin D 1.25 mg 1 capsule PO once weekly for 12 weeks (nutrient). 4/29/24: -Sertraline HCL 100 mg 2 tablets PO daily (antidepressant). 5/14/24: -Oxybutynin chloride extended release (ER) 5 mg 1 tablet PO daily (overactive bladder). 5/15/24: -Oxcarbazepine 150 mg 1 tablet PO each morning and 2 tablets PO at bedtime (HS) (anticonvulsant). 5/16/24: -Estradiol 2 mg 1 tablet PO BID (hormone replacement). 6/30/24: -Ipratropium bromide/albuterol nebulizer 0.5 mg/2.5 mg per 3 milliliters (ml) solution TID	V 118		

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V 118	Continued From page 3 for 14 days (bronchodilator). -Physician's order for Mirtazapine 30 mg 1 tablet PO at HS (antidepressant) dated 6/13/24 with the following 2 pharmacy labels photo-copied onto the order: - Mirtazapine 15 mg, 30 tablets dispensed on 6/7/24 with instructions to take 1 tablet PO at HS. "Old Order Sent more 15mg = 2tabs = 30mg to use up current pack" was handwritten beside the photo-copied label. - Mirtazapine 30 mg, zero tablets dispensed on 6/13/24 with instructions to take 1 tablet PO at HS. "This will be in next set up" was handwritten beside the photo-copied label. -No current physician's order for lorazepam. -"Escript (electronic prescription) Renewal Req. (request) Response" dated 6/10/24 for Lorazepam 0.5 mg 1-2 tablet PO as needed (PRN) for severe anxiety: -Date Written: 4/18/23. -Original Fill Date: 5/12/23. -Last Fill Date: 5/12/23. -Stop Date: 10/15/23. -"Medication has been discontinued." Review on 7/23/24 at 9:55 am of Client #1's MARs for 7/7/24-7/23/24 revealed: -Cetirizine, Sertraline HCL, and Oxybutynin chloride ER were not documented as administered at 8:00 am on 7/23/24. -Estradiol was not documented as administered at 8:00 pm on 7/22/24, or 8:00 am on 7/23/24. -Propranolol HCL was not documented as administered at 2:00 pm on 7/22/24, 8:00 pm on 7/22/24, or 8:00 am on 7/23/24. -Estradiol, oxcarbazepine, and spironolactone were not documented as administered at 8:00 pm on 7/22/24, or 8:00 am on 7/23/24. -Vitamin D was last initialed as having been administered on 7/15/24 and was not	V 118		

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V 118	Continued From page 4 documented as administered on 7/22/24. -Ipratropium bromide/albuterol nebulizer was documented as being initiated at 2:00 pm on 7/3/24 and was not documented as administered at 8:00 am, nor 8:00 pm on 7/16/24, or 8:00 am on 7/17/24. -Lorazepam had not been discontinued from the MAR. -Mirtazapine was handwritten onto the MAR as a 15 mg tablet with instructions to take 2 tablets PO at HS and documentation of 2 tablets being administered at HS from 7/1/24-7/22/24. Observation on 7/23/24 at 11:30 am and 7/24/24 at 3:04 pm of Client #1's medications revealed: -A blister pack dispensed on 7/10/24 contained a variety of 9 prescription medications. The medications were divided into sealed compartments by dosing times (AM, PM, and HS). Each of the HS dosing compartments contained a total of 8 tablets which included 2 prazosin, 2 oxcarbazepine, 1 estradiol, 1 spironolactone,1 propranolol and 1 mirtazapine. The mirtazapine was dispensed as a 30 mg tablet with instructions to take 1 PO at HS. -No evidence of any other pharmacy packs, or bottles of mirtazapine in the facility. -A bottle of vitamin D with a prescription label indicating 12 capsules were dispensed on 5/6/24 with instructions to take 1 PO once weekly for 12 weeks. There were 6 oval shaped blue-green colored capsules remaining in the bottle. Interview on 7/25/24 with local pharmacy technician #1 revealed: -The last time vitamin D was dispensed for Client #1 was on 5/6/24. -A total of 12 vitamin D capsules were dispensed. Interview on 7/25/24 with local pharmacy	V 118		

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V 118	Continued From page 5 technician #2 revealed: -Vitamin D was previously dispensed to Client #1 on 8-1-23, 10-3-23, and 12-18-23. -12 capsules were dispensed each time. -12 capsules were a 3 months' supply. Review on 7/23/24 of Client #2's record revealed: -Date of Admission: 10/1/20. -Diagnoses: Severe Intellectual Disabilities; Bipolar Disorder, Current Episode, Manic without Psychotic Features; Intermittent Explosive Disorder; Cerebral Palsy; Acne; Nonrheumatic Mitral Valve Prolapse; Allergic Rhinitis; Unspecified Dementia without Behavioral Disturbance; Unspecified Abnormalities of Gait and Mobility. -Physician's orders included: 4/4/24: -Olanzapine 10 mg 1 tablet PO BID (antipsychotic). 4/5/24: - Cetirizine HCL 10 mg 1 tablet PO daily. - Multivitamin 1 tablet PO daily (nutrient). -Escitalopram 10 mg 1 tablet PO each morning with a 20 mg tablet (antidepressant). -Escitalopram 20 mg 1 tablet PO each morning with a 10 mg tablet. -Vascepa 1 gram (gm) 2 capsules PO BID (cardiovascular disease). 4/28/24: -Ciclopirox 8% topical solution apply to affected area once daily. On the 7th day, wipe off with alcohol and trim nails and repeat (fungal infections). 5/3/24: -Buspirone HCL 15 mg 2 tablets PO BID (anxiety). -Diphenhydramine HCL 25 mg 1 capsule PO each morning and 2 capsules PO at	V 118		

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V 118	Continued From page 6 HS (antihistamine). 5/14/24: -Polyethylene glycol 3350 Dissolve 17 grams in 4-8 ounces (oz) of liquid and drink once daily (laxative). -Metoprolol Tartrate 100 mg 1 tablet PO BID (antihypertensive). 6/3/24: -Chlorpromazine HCL 100 mg 1 tablet PO TID (antipsychotic). Review on 7/23/24 at 9:55 am of Client #2's MARs for 7/7/24-7/23/24 revealed: -Polyethylene glycol, cetirizine, multivitamin, escitalopram 10 mg, and escitalopram 20 mg were not documented as administered at 8:00 am on 7/23/24. -Olanzapine, buspirone HCL, diphenhydramine HCL, and metoprolol tartrate were not documented as administered at 8:00 pm on 7/22/24, or 8:00 am on 7/23/24. -Vascepa was not documented as administered at 5:00 pm on 7/22/24, or 8:00 am on 7/23/24. -Chlorpromazine HCL was not documented as administered at 2:00 pm or 8:00 pm on 7/22/24, or 8:00 am on 7/23/24. -Ciclopirox 8% topical solution had a handwritten "n" above the AFL Provider's initials on 7/12/24 and a handwritten "x" above the AFL Provider's initials on 7/19/24. There was no documentation on the MAR to indicate the meaning of each handwritten letter. Review on 7/23/24 of Client #3's record revealed: -Date of Admission: 4/1/20. -Diagnoses: Mild Intellectual Disabilities; Congenital Malformation Syndrome, Predominantly Associated with Short Stature; Type II Diabetes Mellitus; Obstructive Sleep Apnea; Prader Willi Syndrome; Hypertension;	V 118		

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V 118	Continued From page 7 Hyperlipidemia; Hypogonadism, Male; Osteoporosis; Autism. -Physician's orders included: 12/8/23: -Testosterone cypionate 200 mg/ml inject 1/2 ml (100 mg) into the muscle (IM) every 2 weeks (hormone replacement). 2/21/24: -Ozempic 0.5 mg/dose (2 ml) inject 0.5 mg subcutaneously (SQ) once per week (diabetes). 3/19/24: -Naltrexone HCL 50 mg 1 tablet PO daily (opiate antagonist). -Loratadine 10 mg 1 tablet PO daily (antihistamine). -Furosemide 40 mg 1 tablet PO daily (diuretic). -Lisinopril 2.5 mg 1 tablet PO daily (antihypertensive). -Atorvastatin calcium 40 mg 1 tablet PO daily (cholesterol). 4/4/24: -Fluvoxamine Maleate 100 mg 1/2 tablet PO daily (mood stabilizer). 4/26/24: -Certavite Senior Antioxidant 1 tablet PO daily (nutrient). -Vitamin D 50 micrograms (mcg) 1 PO daily (nutrient). 4/30/24: -Levothyroxine sodium 100 mcg 1 tablet PO daily (hypothyroidism). 6/19/24: - Lisdexamfetamine dimesylate 30 mg 1 capsule PO each morning (stimulant). -A letter dated 6-7-24 with a fax received date of 6-11-24 signed by a local endocrinologist "To Whom It May Concern ...[Client #3] is under my care for treatment of type 2 diabetes and	V 118		

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V 118	Continued From page 8 hypogonadism. He may administer his own medications and monitor his glucose under supervision ..." Review on 7/23/24 at 9:55 am of Client #3's MARs for 7/7/24-7/23/24 revealed: -Lisdexamfetamine, naltrexone, loratadine, furosemide, lisinopril, atorvastatin, fluvoxamine. Certavite, vitamin D, and levothyroxine were not documented as administered at 8:00 am on 7/23/24. -Testosterone cypionate was documented as being administered by the AFL Provider on 7/8/24 and 7/22/24. -Ozempic was documented as being administered by the AFL Provider on 7/8/24, 7/15/24 and 7/22/24. Interview on 7/24/24 with Client #1 revealed: -All her medications were administered by the AFL Provider. Interview on 7/24/24 with Client #2 revealed: -Unable to provide information regarding the administration of medications. -Would not answer questions and repetitively stated, "want to go to mall." Observation and interview on 7/24/24 at 2:12 pm with Client #3 revealed: -Education on how to self-administer injections had not been provided by the facility. -He no longer self-administered his injections, "[AFL Provider] does them. I'm not allowed to do them anymore. Nobody said a reason why ...My insulin shots (Ozempic), she (AFL Provider) gets the needle out of the packet and wipes that with a alcohol swipe and then puts a needle on it and she wipes my arm off and injects it in my arm and it's the same on the testosterone shot too."	V 118		

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V 118	Continued From page 9 -Aware of a new physician's order which allows him to self-administer medications, "I feel safer if [AFL Provider] does it because every time I give my testosterone shot, I always hit a blood vein and when I pull the needle out it shoots blood." -His testosterone injection and his Ozempic injection were administered late this week. "[AFL Provider] told me that on Tuesday (7/23/24) I had to take 2 of them (injections) because of a accident that we (Client #3 and AFL Provider) forgot on Monday (7/22/24). I took the insulin shot (Ozempic) and testosterone. Normally I don't take both together ...It was Tuesday when I got home Tuesday evening. She (AFL Provider) put my insulin shot in this arm (points to left shoulder) and my testosterone shot in this arm (points to right shoulder). It was late. It should have been done on Monday, but [AFL Provider] forgot. It was late ..." Interview on 7/23/24 and 7/24/24 with the AFL Provider revealed: -Used to keep the clients' MARs with their medications. "I haven't been doing that and I think I will go back to keeping them in the drawer of the med (medication) cabinet. I was used to working in a group home with a med cart, but in this home living environment we don't have med carts." -After the last survey had been conducted (June 2024), the Qualified Professional (QP) "went over some things with me and that kind of thing. [QP] said 'make sure the MARs are signed' as I give meds." -She had not seen the statement of deficiencies (SOD) from the previous survey conducted in June 2024. -"The mistakes I make are my own stupidity." -Had not received any additional training since the last survey. -Client #1's vitamin D, "I could have dumped	V 118		

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V 118	Continued From page 10 them out of another bottle and combined the bottles, so I didn't have too many bottles. She (Client #1)) could have told me to do that ... I don't know what happened with that. I would say I don't know, unless she (Client #1) already had some here (at the facility) and then I maybe poured them in the bottle and maybe mixed the 2 meds together, but I know I shouldn't do that. I usually don't, that's not a practice I do. I don't know why I done it. There's no excuse. There were probably 2 bottles of the same medicine, and I probably just mixed it." -Wrote the wrong mirtazapine information on Client #1's MAR. "I can't remember, but I guess I did. It would've had to been me. It's (mirtazapine) in a bubble pack, so she's getting the right meds. It's my mistake." -A registered nurse (RN) employed by the licensee was supposed to provide education to Client #3 for self-administering his injections. "She (RN) only works a few days each month, so she will probably be working next week for sure, and she will call him (Client #3) and have him go up there (licensee office) and review with him how to do his sugar, and how to give the insulin (Ozempic) and hormone (testosterone) shot ...I talked to her last week. She wanted me to talk to her about setting up [Client #3's] training on his meds that she was going to do ..." -Client #3 self-administered his Ozempic and testosterone injections. "He does it, I watch him. He checks his own sugar and gives his own injections and I watch him. For the insulin (Ozempic) he rubs the top of the bottle with alcohol, he rolls his sleeve up and wipes and then I check the amount and he injects it, and it's the same with the hormone (testosterone) shot ...the doctor gave him a paper saying he can do it." -After Client #3 self-administered his medication, she would sign the MARs.	V 118		

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V 118	Continued From page 11 -Client #3's testosterone and Ozempic injections were not administered late this week. "He got them Monday night (7/22/24), I mean Monday morning. He gets them on Mondays. We talked about the injections last night (Tuesday 7/23/24) to make sure he understood everything we do because I have to go over it with him. That's how come I stay with him when he does all that because I have to make sure he draws up the right amount ... There shouldn't be any reason to think they were given last night. No. He forgets and he will get it confused and if he is asked questions, he might say something different ...because he does get confused and will tell you one thing when he's meaning to tell something else. He gets stuff backwards all the time." Interview on 7/25/24 with the QP revealed: -Was responsible for oversight of the facility. -Had not seen the SOD from the previous survey conducted in June 2024, "but I saw the Plan of Protection. [Chief Executive Officer (CEO)] usually handles all that." -In June 2024 "I met with the nurse who works here (licensee office) ...she is only here like twice a month. She helped me print off brand new scripts (physician's orders) for the MARs to make sure it matched up. I then went to [AFL Provider's] house (facility) and matched the current MARs to the scripts that I brought out there and they were all accounted for ... I matched the MARs and scripts and meds and made sure she (AFL Provider) had everything she needed ...[AFL Provider] had to repeatedly call [Client #3's] doctor to get the paper for his self-administration of meds, so then that letter was faxed here, and [AFL Provider] was given a copy and we uploaded it into his (Client #3's) file ..." -Had not made any other visits to the facility	V 118		

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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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 12 except for one other time on 7/18/24, but the AFL Provider "wasn't there and I left some papers in her mailbox for her." -"I'm just trusting that [AFL Provider], with what we just went through, would keep an accurate record. The QPs are supposed to go through the meds now, so as of July 1st (2024), we have been doing that. QPs have been told to check meds, MARs, and scripts quarterly." -"[AFL Provider] has been in contact with the nurse (RN) and will have the nurse review the Ozempic shot, and hormone (testosterone) shot process with [Client #3]." -Client #3 self-administered his Ozempic and testosterone injections. "[Client #3] does it, but [AFL Provider] watches him. That's what [AFL Provider] told me, that she watches him draw it out and she checks when he draws it out. [Client #3] ...he injects it." -She was not aware of the documentation expectation for a client self-administering medication. "No. I would just look for a signature on the MAR that the med had been administered." Interview on 7/25/24 with the CEO revealed: -QPs were required to compare medications with the MARs and physician's orders quarterly. "Ever since all this happened ... I had followed up with [QP] and asked that she was following through with the compliance ...That was on June 14th (2024). I sent everybody the updated QP quarterly med requirements on July 2nd (2024). Prior, on June 4th (2024) I requested for the QPs to ensure all meds, MARs and scripts were corrected. On July 5th (2024) [QP] sent a text that everything had been addressed. On July 9th (2024), I asked if [Client #3] had training with the nurse (RN) and the nurse asked me about how I wanted her to document it ...she asked me how	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL059-103	A. BUILDING: _____ B. WING _____	R 07/25/2024

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PITTMAN HOME	267 MOODYTOWN ROAD MARION, NC 28752

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V 118	Continued From page 13 she should document it, so I figured it was done ...She was supposed to type up a document and save it in his chart that it was done ...[Client #3] never showed up for the training, so he has not been trained ...I am going to have [AFL Provider] bring everything to the office tomorrow morning and will have her complete face to face med training again." Due to the failure to accurately document medication administration, it could not be determined if clients received their medication as ordered by the physician. Review on 7/25/24 of a Plan of Protection completed and signed by the CEO on 7/25/24 revealed: " What immediate action will the facility take to ensure the safety of the consumers in your care? AFL staff is to bring in all medications, scripts, and medication records first thing 7/26/2024 at 9am. Staff will be meeting with the CEO and administrative staff to ensure everything is accurate. AFL staff and QP will be required to follow through with additional medication administration training. Describe your plans to make sure the above happens. CEO has already requested a formal sit down with AFL staff for 7/26/2024 at 9am to ensure proper medication protocols are followed. CEO has scheduled a medication administration class for AFL staff and QP for 7/26/2024 at 11AM. Unannounced visits will be required at a minimum of two times a week at various times to ensure medication protocols are being followed. These visits will continue to occur until the CEO feels that staff have successfully maintained a safe environment regarding medications."	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 118	Continued From page 14 This deficiency constitutes a re-cited deficiency. The facility served 3 clients with diagnoses including, but not limited to Mild to Severe Intellectual Disabilities; Chronic Pain Syndrome; Cerebral Palsy; Mild Intermittent Asthma; Overflow Incontinence; Post Traumatic Stress Disorder; Transsexualism; Major Depressive Disorder without Psychotic Features; Dysphagia; Bipolar Disorder; Intermittent Explosive Disorder and Unspecified Dementia. Clients #1, #2, and #3 were prescribed a variety of medications which included controlled and psychotropic medications such as lisdexamfetamine dimesylate, oxcarbazepine, buspirone, chlorpromazine, fluvoxamine, escitalopram, sertraline and Olanzapine. The MARs for Clients #1, #2, and #3 were not maintained to accurately reflect which medications had been administered and it was unclear if clients received their medications as prescribed. Over a period of 16 days (7/7/24-7/23/24), Client #1, #2 and #3's MARs had 47 doses of medications which had not been initialed as administered. Client #1's MAR had inaccurate instructions to administer two 15 mg tablets of mirtazapine at HS instead of one 30 mg tablet as ordered by the physician and dispensed by the pharmacy. There were no 15 mg tablets of mirtazapine available at the facility, yet the MAR was initialed as 2 tablets having been administered each night from 7/1/24-7/22/24. Client #1's MAR inaccurately listed lorazepam as an active PRN medication for severe anxiety even though it had been discontinued since 10/15/23. Client #1's vitamin D was last dispensed on 5/6/24 with12 capsules to be administered weekly for 12 weeks. On 7/23/24 and 7/24/24 there were 6 capsules remaining in the prescription bottle instead o 1 capsule which would have been expected if the medication had	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 118	Continued From page 15 been administered as ordered. Client #2's MAR had no clear documentation of ciclopirox 8% solution being removed with alcohol every 7 days as ordered. It could not be determined whether Client #3 was self-administering his injections of Ozempic and testosterone, or if the injections were being administered by the AFL Provider. The Ozempic and testosterone injections were initialed as being administered by the AFL Provider on the MAR. Additionally, there was conflicting information on whether Client #3's MAR reflected the actual dates the Ozempic and testosterone injections had been administered. This deficiency constitutes a Continuing Type A1 rule violation originally cited for serious neglect for failure to correct within 23 days.	V 118		