

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL092-678</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>08/28/2024</b>
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NAME OF PROVIDER OR SUPPLIER  
**THE BRUSON GROUP /NEW BEGINNINGS HE/**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**4513 FOX ROAD  
RALEIGH, NC 27616**

**RECEIVED  
SEP 27 2024**

(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
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**DHSR-MH-DRUGS-Inject**

V 000	INITIAL COMMENTS  An annual survey was completed on 8/28/24 . A deficiency was cited.  This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents.  This facility is licensed for 6 and has a current census of 3. The survey sample consisted of audits of 3 current clients.	V 000	<b>Kyle</b>  Measures put in place to <b>correct</b> the deficient area of practice and how we identified other areas of the facility having the potential to be affected by the same deficient practice and what corrective actions will be taken	<b>V118 27G.0209 ( C ) Medication Requirements</b>  Our agency took immediate action to ensure the quality of all homes. We held a board meeting and reviewed the DHSR deficiencies in its entirety. Different scenarios were discussed, and preventative measures/interventions were reviewed and voted on for approval by the Board. <ul style="list-style-type: none"> <li>Upon learning from DHSR a client's MAR was not initialed by the staff that provided the medication/injection to the client a protective measure was immediately implemented by the Director to correct and avoid this action from reoccurring again. An additional medication form was created for both the client and the staff to sign to ensure credibility when a client may have mental health diagnosis and cannot process whether or not the medication has been injected. This form shall include a witness of the medication being injected. The client's monthly pre-scheduled medication will also be inserted into the management google calendar as a reminder for staff to ensure best practice and accountability.</li> </ul>
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	Measures put in place to <b>prevent</b> the problem from occurring again	Upon learning of the deficiency, our agency placed the following preventative measures in place. An additional medication form was created for both the client and the staff to sign to ensure credibility when a client may have mental health diagnosis and cannot process whether or not the medication has

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

*Sonia Ward, Director* TITLE: **Director** (X6) DATE: **9/20/2024**

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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 record review and interview the facility failed to administer medications on the written order of a physician for 1 of 3 clients (#3). The findings are:  Review on 8/28/24 of client #3's record revealed: - admitted 12/29/21 - diagnoses: Schizophrenia, Moderate Intellectual Developmental Disorder and Anxiety Disorder - physician's order dated: 6/17/24: Abilify 400mg monthly intramuscular (nineteenth (19th) of each month) (Schizophrenia)  Observation on 8/28/24 at 3pm of client #3's medications revealed: - no Abilify  Review on 8/28/24 of client #3's August 2024 MAR revealed: - a blank space on 8/19/24 with no documentation of staff initials as the Abilify was administered  During interview on 8/28/24 at 3pm the Qualified Professional (QP) reported: - she or staff #3 administered client #3's Abilify injection	V 118	been injected. This form shall include a witness of the medication being injected. The client's monthly pre-scheduled medication will also be inserted into the management google calendar as a reminder for staff to ensure best practice and accountability.  <b>Who will monitor the situation to ensure it will not occur again</b> The Executive Director, Director and our Quality Management/Quality Improvement Director, and or a designated qualified staff will continue to monitor the implementation to ensure that the deficiency will not occur again.  <b>How often the monitoring will take place</b> Our agency shall monitor this amendment daily to remain in compliance.  <b>Dates the corrective action will be completed</b> The corrective action was completed on 8/29/24, once informed by staff of DHSR's findings	
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V 118	<p>Continued From page 2</p> <ul style="list-style-type: none"> <li>- thought staff #3 administered the Abilify injection on 8/19/24</li> </ul> <p>During interview on 8/28/24 staff #3 reported:</p> <ul style="list-style-type: none"> <li>- she did not administer client #3's monthly Abilify injection</li> </ul> <p>During interview on 8/28/24 client #3 reported:</p> <ul style="list-style-type: none"> <li>- "I have behaviors"</li> <li>- received an injection on the 19th of each month</li> <li>- the QP would administer the injection in her arm</li> <li>- "did not get the shot this month"</li> <li>- "I hope she didn't forget"</li> </ul> <p>During interview on 8/28/24 at 5:45pm the QP reported:</p> <ul style="list-style-type: none"> <li>- thought staff #3 administered client #3's Abilify injection this month</li> <li>- "it could have been me ...I cannot recall"</li> <li>- "she (client #3) got the shot"</li> <li>- the Abilify injection was for her Schizophrenia due to her hearing voices</li> <li>- the injection was more effective than the pill</li> </ul>	V 118		

# Medication Injection Form

Client Name: Jane Doe Medical Record #: 123456

I verify that by signing below that I have received my monthly medication injection from the below staff. I understand that this measure was created to ensure best practice and that I receive my injection as written by my prescriber.

Date

1	Client Name	
2	TBGI Witness (1)	
3	TBGI Witness (2)	

Date

1	Client Name	
2	TBGI Witness (1)	
3	TBGI Witness (2)	

Date

1	Client Name	
2	TBGI Witness (1)	
3	TBGI Witness (2)	

Date

1	Client Name	
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