STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G264	A. BUILDING _____ B. WING _____	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTLAND GROUP HOME	2307 HARTLAND ROAD MORGANTON, NC 28655

(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) COMPLETION DATE
W 312	DRUG USAGE CFR(s): 483.450(e)(2) be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: The facility failed to assure drugs used to control the behaviors of 1 of 3 sampled clients (#2) was used only as an integral part of the client's individual program plan (IPP) to reduce the behaviors for which the drugs are used as evidenced by interview and record verification. The finding is: Review of client #2's IPP dated 5/2/24, substantiated by review of client #2's physician's orders dated 9/12/24 and interview with the facility nurse, verified the client is currently prescribed Buspar, Depakene and Klonopin for behaviors. Further review of the IPP, substantiated by interview with the facility administrator, revealed the client's behaviors have been minor since the client's admission on 4/3/24. However, continue review of the IPP revealed no behavior program has been developed to address the behaviors for which the client is receiving 3 behavior medications.	W 312		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by:	W 340		

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

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W 340	Continued From page 1	W 340		

Nursing services failed to assure staff were adequately trained in appropriate hygiene methods required while administering medications to 5 of 5 clients in the group home (#1, #2, #3, #4 and #5) as evidenced by observation and interview. The finding is:

Morning observations in the group home on 9/18/24 revealed Staff A to begin administration of medication to the clients starting with client #5. Staff A was observed to prompt client #5 to the medication room at 6:50 AM. Staff A then prepared for administration which included putting disposable gloves on both hands. Further observations revealed Staff A had some trouble putting the gloves on and was observed to rip the right glove at the wrist when she was pulling it on.

Continued observations revealed Staff A wore the gloves throughout the administration of medication to client #5. She also was observed to pick up the client's Cogentin tablet that had fallen on the client's chair and place it in the medication cup which was administered to the client along with his other medications at 6:56 AM.

Subsequent observations revealed Staff A to continue wearing the same disposable gloves after finishing client #5's medications through client #4's and client #3's medications, as noted by Staff A continuing to have the same torn glove on her right hand. Client #4's medication pass which was observed, included Staff A administering cream to client #5's back with the same gloves, assisting the client to punch medications into her hand while wearing the gloves and wiping down the chair where client #5 was sitting after client #5 had a toileting accident

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W 340	Continued From page 2 during a seizure. Staff A was then observed to get client #3 for her medications which was not observed but Staff A was observed to be wearing the same gloves when client #3 and Staff A exited the office at 7:30 AM.	W 340		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: The facility failed to assure medications administered to 2 of 2 clients observed during the medication pass (#4 and #5) were administered without error as evidenced by observations, interview and record verification. The finding is: Observations of the morning medication pass on 9/18/24 revealed Staff A to administer medications to client #5 at 6:56 AM and client #4 at 7:14 AM. Further observations revealed during the the observed medication pass, client #5 did not receive any topical medications and client #4 only received a topical medication applied to his back. Review of client #5's physician's orders dated 9/13/24 revealed the client to be prescribed Geri-Hydrolac 12% lotion to be applied under the client's arms twice daily at 7:00 AM and 8:00 PM. Review of client #4's physician's orders also dated 9/13/24, revealed the client to be prescribed Lotrimin AF 1% cream to be applied to both feet twice daily at 7:00 AM and 8:00 PM. Interview with the facility nurse verified that both topical medications should have been administered to the clients as prescribed during	W 369		

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W 369	Continued From page 3 the observed morning medication pass on 9/18/24.	W 369		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: The facility failed to assure medications for 5 of 5 clients in the group home (#1, #2, #3, #4 and #5) were locked except when being prepared for administration as evidenced by observation and interview. The finding is: Morning observations in the group home on 9/18/24 revealed staff A to administer medications to client #5 at 6:56 AM. Staff A was observed to exit to office where medications are administered at 6:58 AM leaving the medication closet open with the keys in the door, the medication box containing client #4's medications sitting on the desk and the office door open. Staff A was then observed to assist client #4 from the living room to the office to start administering his medications. Further observations of Staff A during the morning medication administration revealed Staff A to follow the same process of leaving the office with the clients' medications unlocked and accessible after each administration. Continued observations revealed Staff A to leave the office at 7:22 AM, 7:30 AM, 7:42 AM, 8:00 AM and again at 8:01 AM without assuring the medications were locked. Interview with the facility nurse revealed the clients' medications should be locked in the medication closet	W 382		

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W 382	Continued From page 4 whenever staff trained to administer medications are in the office to administer medications.	W 382		