Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-053	A. BUILDING: _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK VISTA GROUP HOME	38 THOMAS PARK DRIVE WAYNESVILLE, NC 28786

(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 An annual survey was completed on September 12, 2024. Deficiencies were cited. This facility is licensed under the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.	V 000		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes. (b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate the facility's response to fire emergencies. (d) Each facility shall have a first aid kit accessible for use.	V 114		

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

Leslie Flowers, Snr Quality Management Drector | 10/24/24

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V 114	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure fire and disaster drills were conducted on each shift at least quarterly. The findings are: Review on 9/11/24 of the facility's fire and disaster drill logs revealed: -A printout of fire-disaster drills completed at the facility for the last 12 months. -No documentation of fire drills during the following shifts and quarters: -October - December 2023: 1st & 3rd shifts. -January - March 2024: 2nd & 3rd shifts. -July - August 2024: 1st & 2nd shifts. -No documentation of disaster drills during the following shifts and quarters: -October - December 2023: 1st, 2nd, 3rd shift. -January - March 2024: 1st, 2nd & 3rd shifts. -April - June 2024: 2nd & 3rd shifts. Interview on 9/11/24 with Staff #2 revealed: -Staff have a list of times when fire and disaster drills are expected to be completed. -"What you see (fire and disaster drill log) is what I got." Interview on 9/11/24 and 9/12/24 with the Qualified Professional (QP) revealed: -Took over as the QP for this facility in July 2024. -Has been working on getting everything up to date since becoming QP of this facility. -She cannot account for what was done prior to her being involved. -"...missing a few (fire and disaster drills) from when the last manager was here."	V 114	V114 Fire Drills were not being completed due to a lack of oversight by a manager. Structured the Residential program to develop Clusters. This provides support to homes with a staff shortage. QM send reminders monthly for drill completion by the 5th of the month. QM will send Program Director and Operations Manager the list of staff who have not completed their drill by the third Wednesday of the month. Operation Manager and Program Director will have one on ones with the managers who have not submitted their drills on this date. and a reminder on the 20th. The third Wednesday of the month during the GH Managers meeting staff will be pulled aside regarding missing drills. QM provide training regarding Drill Compliance with all staff at this home.	11/1/24 11/4/24

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V 118	Continued From page 2	V 118	V118 Staff were not documenting medication. Staff meeting occurred 9/11/24. Facilitated by GH Manager. Agenda items: Meds given on time and documented on the MAR as well as ensuring incident reports are completed. RN complete a training with staff on 11/4/24.	11/4/24
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. (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:	V 118		

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V 118	Continued From page 3 Based on record reviews and interviews, the facility failed to keep the MARs current affecting 3 of 3 audited clients (#1, #2, and #3). The findings are: Review on 9/10/24 of Client #1's record revealed: -Admission Date: 6/6/24. -Diagnoses: Schizoaffective Disorder, Bipolar Type; Post Traumatic Stress Disorder (PTSD); Social Anxiety; Unspecified Intellectual Disabilities; Asthma; and Obesity. -Physician Orders dated 5/3/24 revealed: -Hydroxyzine 25 milligram (mg) tablet (tab) (anxiety), 2 tabs by mouth (PO) three times daily (TID). -Imipramine 10mg tab (overactive bladder), 2 tabs PO twice daily (BID), scheduled at 8:00am and 2:00pm. -Lansoprazole 30mg capsule (cap) (antacid), 1 cap PO every day at 4:00PM. -Buspirone 10mg tab (anxiety), 1 tab PO BID. Review on 9/11/24 of Client #1's MAR dated 7/1/24 to 9/11/24 revealed: -No staff initials to indicate medication was administered on the following dates: -July 2024: -Lansoprazole 30mg cap, 7/4/24,7/10/24, 7/12/24, 7/17/24-7/18/24, and 7/24/24. -Hydroxyzine 25mg tab, 7/26/24, 2:00pm. -August 2024: -Buspirone 10mg tab, 8/30/24, 8:00 PM. -Hydroxyzine 25mg tab, 8/2/24 2:00pm, 8/7/24 2:00pm, 8/9/24 2:00pm, and 8/30/24 2:00pm. -Imipramine 10mg tab, 8/2/24 2:00pm, 8/7/24 2:00pm, 8/9/24 2:00pm, and 8/30/24 2:00pm. -Lansoprazole 30mg cap, 8/1/24, 8/2/24, 8/7/24, 8/14/24, 8/16/24, 8/2/24-8/23/24, and	V 118		

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V 118	Continued From page 4 8/29/24-8/30/24 4:00pm. -September 2024: -Hydroxyzine 25mg tab, 9/3/24 2:00pm and 9/5/24 2:00pm -Imipramine 10mg tab, 9/3/24 2:00pm, and 9/5/24 at 2:00pm. Review on 9/10/24 of Client #2's record revealed: -Admission Date: 6/2/17. -Diagnoses: Schizoaffective Disorder; Type 2 Diabetes; Gastroesophageal Reflux Disease (GERD); Hypertension; Vitamin D Deficiency; Recurrent Genital Herpes; Obesity; and Pseudo-seizures. -Physician Orders included the following: -Aripiprazole 15mg tab (antipsychotic), 1 tab PO daily (QD), dated 12/22/23. -Atorvastatin 80mg tab (Hyperlipidemia), 1 tab PO in the evening (QHS), dated 4/4/24. -Bupropion HCL SR 150mg tab, (Depression), 1 tab QD, dated 2/27/24. -Docusate Sodium 100mg cap (constipation), 1 cap PO BID, dated 5/17/24. -Ezetimibe 100mg tab (cholesterol), 1 tab QD, dated 5/17/24. -Famotidine 20mg tab (GERD), 1 tab PO BID, dated 3/21/24. -Linzess 290 micrograms (mcg) (constipation), 1 cap PO, QD, dated 8/7/23. -Metoprolol ER 25 mg (anxiety), 1 tab PO BID, dated 8/30/23. -Pantoprazole 40mg tab (GERD), 1 tab PO QD, dated 4/10/24. -Psyllium Fiber Capsules (constipation), 2 caps PO QHS, dated 1/24/22 -Risa quad Capsules (probiotic), 1 cap PO QD, dated 7/26/23. -Toviaz ER 8mg tab (incontinence), 1 tab PO, QD, dated 2/28/24. -Trintellix 20mg tab (antidepressant), 1 tab	V 118		

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PO QD, dated 2/28/24.
-Valacyclovir 1 gram (Herpes)1 tab PO, every 8 hours for 7 days, dated 7/25/24.
-Vitamin B-12 500 mcg, tab (low vitamin B), 1 tab PO QD, dated 1/26/24.
-Vitamin D3-5000U tab, (vitamin D deficiency), 1 tab PO QD, dated 4/26/24.
-Westab Plus Tab (prenatal vitamin), 1 tab QD, dated 1/22/24.

Review on 9/11/24 of Client #2's MAR dated 7/1/24 to 9/11/24 revealed:
-no staff initials to indicate the medication was administered on the following dates:
-July 2024:
-Aripiprazole 15mg tab, 7/1/24 and 7/7/24.
-Atorvastatin 80mg tab, 7/7/24 and 7/19/24.
-Bupropion HCL SR 150mg tab, 7/1/24.
-Docusate Sodium 100mg cap, 7/1/24 9:00am, 7/7/24 8:00pm, and 7/19/24 8:00pm.
-Ezetimibe 100mg tab, 7/1/24.
-Famotidine 20mg tab, 7/1/24, 8:00am, 7/7/24 8:00PM, and 7/19/24 8:00pm.
-Linzess 290 micrograms (mcg), 7/1/24.
-Metoprolol ER 25 mg, 7/1/24 9:00am, 7/7/24 8:00pm, 7/19/24, 8:00pm.
-Pantoprazole 40mg tab, 7/1/24.
-Psyllium Fiber Capsules, 7/1/24, 7/7/24 and 7/19/24.
-Risa quad Capsules, 7/1/24.
-Toviaz ER 8mg tab, 7/1/24.
-Trintellix 20mg tab, 7/1/24.
-Valacyclovir 1 gram, 7/26/24 4:00pm and 10:00pm, 7/27-7/29/24 10:00pm, and 7/30/24, 12:00AM and 10:00pm and 7/31/24 10:00pm.
-Vitamin B-12 500 mcg, tab, 7/1/24.
-Vitamin D3-5000U tab, 7/1/24.
-Westab Plus Tab (prenatal vitamin), 7/1/24.

Review on 9/10/24 of Client #3's record revealed:

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V 118	Continued From page 6 -Admission Date: 9/3/16. -Diagnoses: Schizophrenia, Bipolar Disorder, Type 2 Diabetes, Hypertension, GERD, Moderate Alcohol Use Disorder (D/O), and Moderate Cocaine Use D/O. -Physician Orders included the following: -Ventolin HFA 90 mcg (inhaler/asthma), inhale 2 puffs PO, 4 times a day (QID), dated 9/19/22. -B-12 1,000 mcg, intramuscular every month (injection) (low vitamin B), dated 6/12/24. -Trulicity 3mg/0.5ml (milliliter) pen, inject 3mg sub-q (subcutaneous) every 7 days, dated 8/25/23. Review on 9/11/24 of Client #3's MAR dated 7/1/24 to 9/11/24 revealed: -No staff initials to indicate medication was administered on the following dates: -July 2024: -B-12 1000 mcg injection, 7/1/24-7/31/24. -Ventolin HFA 90mcg inhaler (scheduled at 8:00am, 12:00pm, 4:00pm, and 8:00pm), 7/1/24 12:00pm, 7/4/24-7/5/24 12:00pm and 4:00pm, 7/10/24 4:00pm, 7/11/24 12:00, 4:00pm, 7/17/24 4:00pm, 7/18/24-7/19/24 12:00 and 4:00pm, and 7/23/24 12:00 and 4:00pm dose. -August 2024: -Ventolin HFA 90mcg inhaler, 8/1/24-8/2/24 4:00pm, 8/7/24 12:00pm and 4:00pm, 8/8/24-8/9/24 12:00pm, 8/11/24 12:00pm, 8/14/24 4:00pm, 8/15/24 12:00pm, 8/16/24 4:00pm, 8/21/24 4:00pm, 8/23/24 4:00pm, 8/29/24 4:00pm, and 8/30/24 12:00pm and 4:00pm. -September 2024: -Ventolin HFA 90mcg inhaler, 9/5/24 12:00pm and 4:00pm and 9/6/24 4:00pm. Interview on 9/10/24 with Staff #1 revealed:	V 118		

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-Had worked at the facility since 10/2023.
-The facility had medication issues prior to current Qualified Professional/House Manager (QP/HM) being hired in July 2024 and staff had worked on trying to get things where they should be.
-"When I got here (hired) a lot of meds were messed up..."
-Client #2 frequently went to the emergency room and may be related to the missing signatures.
-On 7/724, Client #2 slept late and missed her medication.
-Could not locate an incident report related to those missing signatures on the MAR for Client #2 in July 2024.

Interview on 9/12/24 with Staff #2 revealed:
-Administered medications to the clients while on shift.
-Did not know about missing signatures for the July 2024 MARs, "...[Staff #1] probably gave them and just didn't document it."
-On 7/19/24 staff took the clients bowling and "didn't give meds."

Interview on 9/12/24 with the Qualified Professional (QP) revealed:
-Had worked at the facility since the middle of July 2024.
-Was responsible for medication oversight at the facility.
-"Haven't looked at MARs yet for when they (medications) are late."
-The nurse "hadn't been on site" since she was hired.
-"I didn't realize how bad they (MARs) looked until I printed them out."

Due to the failure to accurately document medication administration, it could not be determined if the client received their medications

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V 118	Continued From page 8 as ordered by the physician.	V 118		
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted. . This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure all medication errors were immediately reported to a pharmacist or physician affecting 3 of 3 audited clients (#1, #2, and #3). The findings are: Review on 9/10/24 of Client #1's record revealed: -Admission Date: 6/6/24. -Diagnoses: Schizoaffective Disorder, Bipolar Type; Post Traumatic Stress Disorder (PTSD); Social Anxiety; Unspecified Intellectual Disabilities; Asthma; and Obesity. -Physician Orders dated 5/3/24 revealed: -Hydroxyzine 25 milligram (mg) tablet (tab) (anxiety), 2 tabs by mouth (PO) three times daily (TID). -Imipramine 10mg tab (overactive bladder), 2 tabs PO twice daily (BID), scheduled at 8:00am	V 123	V123 QM complete training with all staff at the home regarding contacting the physician/pharmacist for all medication errors as well as step by step instruction on incident report submission.	11/4/24

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V 123	Continued From page 9	V 123		

and 2:00pm.
-Lansoprazole 30mg capsule (cap) (antacid), 1 cap PO every day at 4:00PM.
-Buspirone 10mg tab (anxiety), 1 tab PO BID.

Review on 9/10/24 of Client #2's record revealed:
-Admission Date: 6/2/17.
-Diagnoses: Schizoaffective Disorder; Type 2 Diabetes; Gastroesophageal Reflux Disease (GERD); Hypertension; Vitamin D Deficiency; Recurrent Genital Herpes; Obesity; and Pseudo-seizures.
-Physician Orders included the following:
-Aripiprazole 15mg tab (antipsychotic), 1 tab PO daily (QD), dated 12/22/23.
-Atorvastatin 80mg tab (Hyperlipidemia), 1 tab PO in the evening (QHS), dated 4/4/24.
-Bupropion HCL SR 150mg tab, (Depression), 1 tab QD, dated 2/27/24.
-Docusate Sodium 100mg cap (constipation), 1 cap PO BID, dated 5/17/24.
-Ezetimibe 100mg tab (cholesterol), 1 tab QD, dated 5/17/24.
-Famotidine 20mg tab (GERD), 1 tab PO BID, dated 3/21/24.
-Linzess 290 micrograms (mcg) (constipation), 1 cap PO, QD, dated 8/7/23.
-Metoprolol ER 25 mg (anxiety), 1 tab PO BID, dated 8/30/23.
-Pantoprazole 40mg tab (GERD), 1 tab PO QD, dated 4/10/24.
-Psyllium Fiber Capsules (constipation), 2 caps PO QHS, dated 1/24/22
-Risa quad Capsules (probiotic), 1 cap PO QD, dated 7/26/23.
-Toviaz ER 8mg tab (incontinence), 1 tab PO, QD, dated 2/28/24.
-Trintellix 20mg tab (antidepressant), 1 tab PO QD, dated 2/28/24.
-Valacyclovir 1 gram (Herpes)1 tab PO, every

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8 hours for 7 days, dated 7/25/24.
-Vitamin B-12 500 mcg, tab (low vitamin B), 1 tab PO QD, dated 1/26/24.
-Vitamin D3-5000U tab, (vitamin D deficiency), 1 tab PO QD, dated 4/26/24.
-Westab Plus Tab (prenatal vitamin), 1 tab QD, dated 1/22/24.

Review on 9/10/24 of Client #3's record revealed:
-Admission Date: 9/3/16.
-Diagnoses: Schizophrenia, Bipolar Disorder, Type 2 Diabetes, Hypertension, GERD, Moderate Alcohol Use Disorder (D/O), and Moderate Cocaine Use D/O.
-Physician Orders included the following:
-Ventolin HFA 90 mcg (inhaler/asthma), inhale 2 puffs PO, 4 times a day (QID), dated 9/19/22.
-B-12 1,000 mcg, intramuscular every month (injection) (low vitamin B), dated 6/12/24.
-Trulicity 3mg/0.5ml (milliliter) pen, inject 3mg sub-q (subcutaneous) every 7 days, dated 8/25/23.

Review on 9/11/24 of the facility's incident reports dated 6/1/24 to 9/11/24 revealed:
-A minimum of 9 medication (med) errors dated 8/30/24, 8/29/24, 8/23/24, 8/17/24, 8/16/24, 8/11/24, 7/10/24, 7/7/24, and 7/5/24 with no evidence that a pharmacist or physician was contacted.

Interview on 9/10/24 with Staff #1 revealed:
-The facility had med issues prior to current Qualified Professional/House Manager (QP/HM) hired in July 2024 and staff had worked on trying to get things where they should be.
-Staff would contact the pharmacy if there was med errors.
-Could not locate an incident report related to

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PARK VISTA GROUP HOME	38 THOMAS PARK DRIVE WAYNESVILLE, NC 28786

(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 123	Continued From page 11 those missing signatures on the MAR for Client #2 in July 2024. Interview on 9/12/24 with Staff #2 revealed: -Had to do an incident report if meds were given late in the evening and why. -Did not contact the pharmacist or physician for the above noted medication errors. -She has been instructed to contact the pharmacy for med errors and the correct window for dosing by the current QP/HM. Interview on 9/12/24 with the QP/HM revealed: -Was responsible for med oversight. -A staff meeting was held on 9/11/24 regarding medication administration. -Had been over the facility since July 2024 and was still catching up on notes and reviewing medication. -Saw how the MARs looked and advised it would be addressed and corrected, including re-training some staff.	V 123		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to be maintained in a safe, clean, and orderly manner. The findings are: Observation on 9/10/24 at 1:31PM of the facility revealed:	V 736		

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 736	Continued From page 12 -Client #2's bedroom was cluttered with food items, trash, and had an odor of urine. -Trash was on the top of the dresser. -A trash can beside the dresser was overflowing and had an incontinence pad folded over sticking out. -Blankets and clothing covered the floor. -Empty snack bags were on the bed. -The closet had clothes overflowing out into the bedroom and there was desk beside the window, a point of egress that was partially blocked by a chair and all of the clothing items. -A facility bathroom had a double sink that was covered in hygiene products, clothing on the floor and no toilet paper in the holder. -Hair care appliances were plugged in by the sink. Interview on 9/11/24 with Client #2 revealed: -Had been at the facility for 7 years. -She was working towards being "more independent." Interview on 9/10/24 with the Residential Administrator revealed: -He came to the facility today to work on some things that needed to be addressed. -Believed the facility's physical state was "unacceptable." Interview on 9/10/24 with Staff #1 revealed: -Client #2 struggled keeping her room clean. -He was the sole male staff with the all-female clients and tried not to go in their bedrooms alone to maintain professional boundaries. -Would tell Client #2 that she needed to clean up her room. Interview on 9/12/24 with Staff #2 revealed: -Staff and clients were responsible for the cleanliness of the facility.	V 736	V 736 GH Manager will revise individual's goals to incorporate a goal specifically for cleaning her room. GH Manager will develop a checklist for the individual to document completion of tasks with room cleaning. GH Manager will review the checklist with staff. QM follow up with program regarding completion and success with utilizing the checklist	11/4/24 11/4/24 11/4/24 12/4/24

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V 736	Continued From page 13 -"Some staff are better with following up than others." -Client #2 was independent and will say that she's cleaned her room. -Would check on Client #2's room more often. Interview on 9/12/24 with the Qualified Professional revealed: -Staff #1 contacted Client #2's sister and Client #2's sister told Client #2 to clean her room, and she did on 9/11/24. -Worked with Clients #1 and #2 to keep their rooms clean.	V 736		