STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HAWTHORNE HOUSE	281 WHEELER HILLS ROAD BURNSVILLE, NC 28714

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on November 26, 2024. The complaint was substantiated (intake #NC00223500). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 6 and has a current census of 6. The survey sample consisted of audits of 3 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		

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V 118	Continued From page 1 (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 record review and interviews, the facility failed to ensure that medications were administered on the written order of a physician affecting 1 of 3 audited clients (#1). The findings are: Review on 11/22/24 of Client #1's record revealed: -Date of admission: 1/6/07. -Diagnoses: Edema, Unspecified; Unspecified Convulsions; Rash and Other Nonspecific Skin Eruption; Dysphagia, Unspecified; Undescended Testicle, Unspecified, Bilateral; Neuromuscular Dysfunction of Bladder, Unspecified; Other Muscle Spasm Contracture of Muscle, Multiple Sites; Pain in Unspecified Hip; Pressure Ulcer of Unspecified Part of Back, Unspecified; Erythema Intertrigo; Constipation, Unspecified; Bilateral Inguinal Hernia, Without Obstruction or Gangrene, Not Specified as Recurrent; Barrett's Esophagus Without Dysplasia; Gastro-Esophageal Reflux Disease Without Esophagitis; Allergic Rhinitis, Unspecified; Venous Insufficiency (chronic) (peripheral); Raynaud's Syndrome Without Gangrene; Primary Open-Angle Glaucoma, Bilateral, Mild Stage;	V 118		

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V 118	Continued From page 2	V 118		

Paraplegia, Unspecified; Spastic Hemiplegia Affecting Unspecified Side; Cerebral Palsy, Unspecified; Sleep Apnea, Unspecified; Moderate Intellectual Disabilities; and Anxiety Disorder, Unspecified.
-Physician order's:
-Linzess capsule (cap) 290 micrograms (mcg), take 1 cap every morning for spastic quadriplegic cerebral palsy dated 1/19/24.
-Baza Barrier Cream, apply topically to affected area above tailbone twice daily for wound care dated 1/19/24.
-Lumigan solution .01%, instill 1 drop into affected eye(s) every evening for Glaucoma dated 2/8/24.

Review on 11/22/24 of Client #1's MAR dated 9/1/24-10/31/24 revealed:
-Linzess cap 290 mcg was not initialed as administered 10/1/24.
-Baza Barrier Cream was not initialed as applied:
-8am on 9/6, 9/9, 9/16, 9/26, 10/1, and 10/3.
-8pm on 9/5, 9/8, and 9/25.
-8am and 8pm on 9/7, 9/10-9/15, and 10/2.
-Lumigan solution .01% was not initialed as instilled 9/14-9/16.

Interview on 11/21/24 with Client #1 revealed:
-Staff administered his medications (meds) and applied his scheduled creams.

Interview on 11/22/24 with the Direct Support Professional (DSP) #1 revealed:
-She was not sure why Client #1 was out of Baza Barrier Cream or why he missed the additional doses in September and October 2024.
-Staff would use the A&D ointment or Aquaphor lotion if the Bara Barrier Cream was not available, "Client #1 always got something to put on him."
-"Sometimes they (medications) run out before

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V 118	Continued From page 3 requesting to be refilled." Interview on 11/25/24 with the Vocational Technician (VT) revealed: -She only ordered meds when told to order from the Unit Clerk (UC). -Ordered Client #1's Baza Barrier Cream online. -She was not sure why there was a gap in Client #1 not receiving his Baza Barrier Cream in September and October 2024. -She ordered Client #1's Baza Barrier Cream on 9/9/24 and it was delivered 9/16/24, and ordered it again on 9/24/24 and it was delivered 9/26/24. Interviews on 11/22/24 and 11/25/24 with the UC revealed: -The VT would order Client #1's Baza Barrier Cream online. -She did not know why Client #1 would have been out of the Baza Barrier Cream. -Staff were expected to let her know when meds were running low prior to running out so they can be re-ordered. -"Sometimes the med is (already) out when I am told it needs to be re-ordered." -She was "not told anything" about Client #1's Baza Barrier Cream delay in September or that it needed to be ordered. Interviews on 11/19/24 and 11/22/24 with the Registered Nurse (RN) revealed: -Came on as a full time RN covering the facility in August 2024. -Was still in the transition phase for this facility, "trying to get it (medication process) straightened out for this facility." -Reviewed the med storage room monthly at the facility, "looking at meds, making sure they match to the MAR, and checking expiration dates." -She was not aware of Client #1's meds not being	V 118		

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V 118	Continued From page 4 administered and applied as scheduled in September and October 2024 until she reviewed the MARs during this recent Division of Health Service Regulation survey. -Staff reported to her that they were not aware that they awere allowed to call her regarding meds. -Nursing relied on staff communicating when meds were running low and needed refills. -Staff were responsible for contacting the nurse with med issues or concerns. -The facility will have plans of correction in place to ensure adequate oversight, documentation and communication of meds moving forward. Interview on 11/21/24 with the Qualified Professional revealed: -She did not know Client #1 had missed applications of his Baza Barrier Cream in September and October 2024 and didn't report any meds being out. -"...Didn't see any (meds) running low or needing to be refilled, didn't see any (meds) out." -"I know that every time we (staff and herself) changed him (Client #1), made sure he got his creams and powders as needed." Interview on 11/25/24 with the Pharmacist reveled: -There were no adverse effects for Linzess Cap 290 mcg not being administered on 10/1/24, Lumigan Solution .01% not instilled 9/14-9/16, and Baza Barrier Cream not applied as scheduled. Interviews on 11/21/24 and 11/22/24 with the Director of Operations revealed: -She did not have any notes for a delay in ordering Client #1's meds or him being out of meds.	V 118		

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V 118	Continued From page 5 -Notification processes "were not being followed" by previous leadership for the facility. -Staff should be checking the amount of meds left after they adminster meds and then notify nursing for any concerns. -"Biggest issue is this unit (facility) was not utilizing [electronic system], (staff) didn't input stuff into [electronic system] (information related to medication errors)." -The facility has a process where we can request emergency med delivery from the pharmacy if necessary. -She would work "with the facility to ensure better communication between staff and leadership." Due to the failure to accurately document medication administration, it could not be determined if the client received their medications 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:	V 123		

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V 123	Continued From page 6 Based on record reviews and interviews, the facility failed to ensure all medication (med) administration errors were immediately reported to a pharmacist or physician affecting 1 of 3 audited clients (#1). The findings are: Review on 11/22/24 of Client #1's record revealed: -Date of admission: 1/6/07. -Diagnoses: Edema, Unspecified; Unspecified Convulsions; Rash and Other Nonspecific Skin Eruption; Dysphagia, Unspecified; Undescended Testicle, Unspecified, Bilateral; Neuromuscular Dysfunction of Bladder, Unspecified; Other Muscle Spasm Contracture of Muscle, Multiple Sites; Pain in Unspecified Hip; Pressure Ulcer of Unspecified Part of Back, Unspecified; Erythema Intertrigo; Constipation, Unspecified; Bilateral Inguinal Hernia, Without Obstruction or Gangrene, Not Specified as Recurrent; Barrett's Esophagus Without Dysplasia; Gastro-Esophageal Reflux Disease Without Esophagitis; Allergic Rhinitis, Unspecified; Venous Insufficiency (chronic) (peripheral); Raynaud's Syndrome Without Gangrene; Primary Open-Angle Glaucoma, Bilateral, Mild Stage; Paraplegia, Unspecified; Spastic Hemiplegia Affecting Unspecified Side; Cerebral Palsy, Unspecified; Sleep Apnea, Unspecified; Moderate Intellectual Disabilities; and Anxiety Disorder, Unspecified. -Physician order's: -Linzess capsule (cap) 290 micrograms (mcg), take 1 cap every morning for spastic quadriplegic cerebral palsy dated 1/19/24. -Baza Barrier Cream, apply topically to affected area above tailbone twice daily for wound care dated 1/19/24. -Lumigan solution .01%, instill 1 drop into affected eye(s) every evening for Glaucoma	V 123		

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V 123	Continued From page 7 dated 2/8/24. Review on 11/22/24 of Client #1's Medication Administration Record (MAR) dated 9/1/24-10/31/24 revealed: -Linzess cap 290 mcg was not initialed as administered 10/1/24. -Baza Barrier Cream was not initialed as applied: -8am on 9/6, 9/9, 9/16, 9/26, 10/1, and 10/3. -8pm on 9/5, 9/8, and 9/25. -8am and 8pm on 9/7, 9/10-9/15, and 10/2. -Lumigan solution .01% was not initialed as instilled 9/14-9/16. Interview on 11/21/24 with Client #1 revealed: -Staff administered his meds and applied his scheduled creams. Interview on 11/22/24 with the Direct Support Professional (DSP) #1 revealed: -She was not sure why Client #1 was out of the Baza Barrier Cream or why he missed the additional doses in September and October 2024. -Staff used the A&D or Aquaphor lotion if the Bara Barrier Cream was not available, "Client #1 always got something to put on him." -She would let the Unit Clerk (UC) know when meds need to be refilled and tried to catch them before they run out, "sometimes they run out before to get refilled." Interview on 11/25/24 with the Vocational Technician (VT) revealed: -She only ordered meds when told to order from the UC. -Ordered Client #1's Baza Barrier Cream online. -Staff told the UC when meds needed to be re-ordered that were not on a cycle order, then the UC told her, and she ordered them. -She was not sure why there was a gap in Client	V 123		

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V 123	Continued From page 8 #1 not receiving his Baza Barrier Cream in September and October 2024. -She ordered Client #1's Baza Barrier Cream on 9/9/24 and it was delivered 9/16/24, ordered 9/24/24 and was delivered 9/26/24. Interviews on 11/22/24 and 11/25/24 with the UC revealed: -The VT would order Client #1's Baza Barrier Cream online. -She did not know why Client #1 would have been out of the Baza Barrier Cream. -Staff were expected to let her know when meds were running low prior to running out so they can be re-ordered. -"Sometimes the med is out when I am told it needs to be re-ordered." -She was not told anything about Client #1's Baza Barrier Cream delay in September or that it needed to be ordered. -The pharmacist or physician was not contacted for clients not receiving their meds as scheduled. This would be a training issue and she "asked for additional training" surrounding meds. -She was responsible for reporting med errors. -She was not aware that when Client #1 did not have medicated cream applied as scheduled, it required documented consultation with a pharmacist or physician. Interviews on 11/19/24 and 11/22/24 with the Registered Nurse (RN) revealed: -Came on as a full time RN covering the facility in August 2024. -Was still in the transition phase for this facility, "trying to get it (medication process) straightened out for this facility." -Reviewed the med storage room monthly at the facility, "looking at meds, making sure they match to the MAR, and checking expiration dates."	V 123		

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V 123	Continued From page 9 -She was not aware of Client #1's meds not being administered and applied as scheduled in September and October 2024 until she reviewed the MARs during this recent Division of Health Service Regulation survey. -Staff reported to her that they were not aware that they were allowed to call her regarding meds. -Nursing relied on staff communicating when meds were running low and needed refills. -Staff were responsible for contacting the nurse with med issues or concerns. Interview on 11/21/24 with the Qualified Professional (QP) revealed: -She did not know Client #1 had missed applications of his Baza Barrier Cream in September and October 2024)and didn't report any meds being out. -"...Didn't see any (meds) running low or needing to be refilled, didn't see any (meds) out." -"I know that every time we (staff and herself) changed him (Client #1), made sure he got his creams and powders as needed." Interview on 11/25/24 with the Pharmacist reveled: -There were no adverse effects for Linzess Cap 290 mcg not being administered on 10/1/24, Lumigan Solution .01% not instilled 9/14-9/16, and Baza Barrier Cream not applied as scheduled. Interviews on 11/21/24 and 11/22/24 with the Director of Operations revealed: -She did not have any notes for a delay in ordering Client #1's meds or him being out of meds. -Notification processes "were not being followed" by previous leadership for the facility. -It was expected that anytime there was a missed	V 123		

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V 123	Continued From page 10 med, we do an investigation report. -Staff should check the amount of meds ;eft after they administer meds and notify nursing for any concerns. -"Biggest issue is this unit (facility) was not utilizing [electronic system], (staff) didn't input stuff into [electronic system] (information related to medication errors)." -The facility had a process where we could request emergency med delivery from the pharmacy if necessary. -She will work "with the facility to ensure better communication between staff and leadership."	V 123		
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.	V 291		

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V 291	Continued From page 11 (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 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 review and interview, the facility failed to ensure service coordination was maintained with other professionals responsible for treatment for 1 of 3 audited clients (#1). The findings are: Review on 11/22/24 of Client #1's record revealed: -Date of admission: 1/6/07. -Diagnoses: Edema, Unspecified; Unspecified Convulsions; Rash and Other Nonspecific Skin Eruption; Dysphagia, Unspecified; Undescended Testicle, Unspecified, Bilateral; Neuromuscular Dysfunction of Bladder, Unspecified; Other Muscle Spasm Contracture of Muscle, Multiple Sites; Pain in Unspecified Hip; Pressure Ulcer of Unspecified Part of Back, Unspecified; Erythema Intertrigo; Constipation, Unspecified; Bilateral Inguinal Hernia, Without Obstruction or Gangrene, Not Specified as Recurrent; Barrett's Esophagus Without Dysplasia; Gastro-Esophageal Reflux Disease Without Esophagitis; Allergic Rhinitis, Unspecified; Venous Insufficiency (chronic) (peripheral); Raynaud's Syndrome Without Gangrene; Primary Open-Angle Glaucoma, Bilateral, Mild Stage; Paraplegia, Unspecified; Spastic Hemiplegia Affecting Unspecified Side; Cerebral Palsy,	V 291		

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V 291	Continued From page 12 Unspecified; Sleep Apnea, Unspecified; Moderate Intellectual Disabilities; and Anxiety Disorder, Unspecified. -No discharge paperwork or documentation for 10/4/24-10/12/24 hospitalization. -No discharge paperwork or documentation for 10/12/24-10/13/24 hospitalization. Interview on 11/21/24 with Client #1 revealed: -Went to the hospital on 10/4/24-10/12/24 and again on 10/12/24-10/13/24. Interview on 11/21/24 with the Vocational Technician (VT) revealed: -Client #1 was hospitalized on 10/4/24 due to running a fever over 100 degrees Fahrenheit. -When Client #1 was discharged back to the facility on 10/12/24, the House Manager (HM) noticed "open sores" on the inside of his legs. -The HM called 911 and Client #1 was taken back to the hospital on 10/12/24. -Client #1 was discharged back to the facility on 10/13/24. -The hospital said, "there was nothing they can do and that the creams the group home has would take care of it (blisters on his thighs)." Interviews on 11/21/24 and 11/22/24 with the Qualified Professional (QP) revealed: -Worked with Client #1 on 10/3/24 and noticed his demeanor had changed and he had red spots on his thighs during his changing. -The former nurse was notified on 10/4/24 of Client #1 running a low grade fever and they did an on-site evaluation of Client #1 that morning. -On 10/4/24 the former nurse recommended that staff call 911 if Client #1's fever went above 100 degrees Fahrenheit. -Client #1 was picked up by ambulance at the facility and brought to the hospital on 10/4/24.	V 291		

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	MHL100-024	A. BUILDING: _____ B. WING _____	R 11/26/2024

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V 291	Continued From page 13 -On 10/12/24, Client #1 was discharged back to the facility from the hospital. -Upon being discharged back to the facility, the HM noticed Client #1 had blisters and did not feel comfortable to treat him at the facility. -Client #1 was transported by ambulance back to the hospital on 10/12/24, was treated for his blisters and discharged back to the facility on 10/13/24. -She did not receive hospital discharge paperwork for Client #1's hospitalization on 10/4/24 and on 10/12/24. Interview on 11/22/24 with the Registered Nurse (RN) revealed: -Client #1 had been in the hospital on 10/4/24-10/12/24 and was sent back on 10/12-10/13/24. -The hospital didn't send paperwork for Client #1 upon being discharged back to the facility on 10/12/24. -Client #1 was not admitted to the hospital on 10/12/24, he was in the emergency room and was discharged back to the facility the next day on 10/13/24. Interview on 11/21/24 with the Director of Operations (DO) revealed: -She did not have discharge paperwork or documentation for Client #1's hospitalization on 10/4/24-10/12/24 and 10/12/24-10/13/24. -She "didn't get any direct reports for anything other than (Client #1's) hospitalization (10/4/24-10/12/24) and that he had to return (10/12/24-10/13/24)." -There was a former qualified professional covering the facility during the time Client #1 was hospitalized. -"Some of our notification processes weren't being follow, had to make changes in leadership	V 291		

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V 291	Continued From page 14 to ensure our process were being followed."	V 291		
V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit. This Rule is not met as evidenced by: Based on observation and interviews, the facility's water temperatures were not maintained between 100-116 degrees Fahrenheit (F) in areas where clients were exposed to hot water. The findings are: Observation on 11/22/24 at 9:45am of Client #1's personal bathroom revealed: -The hot water temperature was 130 degrees F at the sink. -The hot water temperature was 124 degrees F at the shower. Observation on 11/22/24 at 10:06am of Client #5's personal bathroom revealed: -The hot water temperature was 122 degrees F at the sink. -The hot water temperature was 122 degrees F at the shower. Observation on 11/22/24 at 10:10am of Client #6's personal bathroom revealed:	V 752		

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V 752	Continued From page 15 -The hot water temperature was 122 degrees F at the sink. -The hot water temperature was 118 degrees F at the shower. Interview on 11/22/24 with Client #1 revealed: -Staff washed his hands and bathed him every morning. -He had not received any burns from his water being too hot at his bathroom sink or shower. Interview on 11/22/24 with the Direct Support Professional (DSP) #1 revealed: -Worked 3rd shift and bathed Client #1 each morning she was on shift. -She tested the hot water on her arm each time before bathing or washing Client #1's hands. -She turned the hot water knob in the shower halfway for bathing Client #1, "never all the way hot." -There were "never any burns" and she was "very careful" and made sure the water was "not too hot" for Client #1. Interview on 11/22/24 with the DSP #2 revealed: -Worked 1st shift. -Client #1 mainly brushed his teeth at his bathroom sink. -She tested the hot water on herself each time before she washed Client #1's hands or brushed his teeth. Interview on 11/22/24 with the House Manager (HM) revealed: -During the Division of Health Service Regulation survey in 2023, the hot water temperature needed to be turned down. -Hot water temperatures were checked each month during fire drills. -Only checked the water temperatures at the	V 752		

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V 752	Continued From page 16	V 752		

kitchen sink and the staff office sink where medications were administered.
-She did not check the client's bathrooms for hot water temperatures, "...I haven't checked [Client #1's] room for water temperature, should be checking in there and every water faucet (in the facility)."
-"No one (staff or clients) has said anything to me (about water being too hot)."
-Staff "know to check the water temperature to make sure it is not too hot."
-She will "have maintenance adjust the hot water temperature" and "will get it taken care of immediately."

Interview on 11/22/24 with the Qualified Professional revealed:
-The maintenance man needed to adjust the facility's hot water temperature.
-Staff were expected to test the hot water on themselves before the clients were bathed or hands washed.

Interview on 11/22/24 with the Director of Operations (DO) revealed:
-The facility maintenance staff worked on the water heater.
-"We'll get it fixed immediately (hot water temperature adjusted between 100-116 degrees F)."

Review on 11/22/24 of the Plan of Protection (POP) dated 11/22/24 completed by the DO revealed:
-"What immediate action will the facility take to ensure the safety of the consumers in your care? [Local county] Housing Authority owns the Hawthorne House property. Contacted property manager, [property manager], on 11/22/24. Property manager dispatched maintenance to the

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V 752	Continued From page 17 facility and corrected temperature on 11/22/24 1:30pm. Describe your plans to make sure the above happens. Monthly inspections will continue to be completed by the house manager, including the addition of ensuring accurate water temperatures throughout the home including the kitchen and bathrooms." This deficiency constitutes a recited deficiency. The facility served clients with diagnoses which included Mild to Moderate Intellectual Disabilities, Cerebral Palsy, Anxiety Disorder, Epilepsy and Attention Deficit Hyperactivity Disorder. The hot water temperatures in the clients' bathrooms at the sink and shower had temperatures up to 130 degrees F. This deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and must be corrected within 23 days.	V 752		