

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL032-133	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/13/2025
NAME OF PROVIDER OR SUPPLIER THE SHERMAN HOUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 1712 SHERMAN AVENUE DURHAM, NC 27707		
(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	<p>INITIAL COMMENTS</p> <p>An annual survey was completed on January 13, 2025. Deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability and 10A NCAC 27G .5100 Community Respite for Individuals of all Disability Groups.</p> <p>This facility is licensed for 4 and has a current census of 3. The 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability has a current census of 3 and the 10A NCAC 27G .5100 Community Respite for Individuals of all Disability Groups has a current census of 0. The survey sample consisted of audits of 3 current clients in the 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability and 0 clients in the 10A NCAC 27G .5100 Community Respite for Individuals of all Disability Groups.</p>	V 000			
V 118	<p>27G .0209 (C) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(c) Medication administration:</p> <p>(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.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(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.</p>	V 118			

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

TITLE

(X6) DATE

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MHL & C 1/30/25

Division of Health Service Regulation

STATE FORM

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If continuation sheet 1 of 5

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V 118	<p>Continued From page 1</p> <p>(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:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p> <p>(D) date and time the drug is administered; and</p> <p>(E) name or initials of person administering the drug.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to keep the MAR current affecting one of three current clients (#2). The findings are:</p> <p>Observation on 1/13/25 at approximately 10:55 am of the medication bin for client #2 revealed: -There was a box of Mupirocin 2% topical cream (skin infection).</p> <p>Review on 1/13/25 of client #2's record revealed:</p> <p>-Admission date of 3/24/05.</p> <p>-Diagnoses of Autism Spectrum Disorder and Severe Intellectual Disability.</p> <p>-Physician order dated 7/17/24 for Mupirocin 2% topical cream, apply to left leg 3x daily.</p>	V 118		
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V 118	Continued From page 2 Review on 1/13/25 of client #2's January 2025 MAR revealed: -No staff initials to indicate the medication was administered on 1/1/25 thru 1/12/25 for the 3:00 pm dose of Mupirocin 2% topical cream. Interview on 1/13/25 with the Residential Manager revealed: -He reported he was "sure" client #2 received his 3:00 pm dose of the Mupirocin 2% topical cream for his left leg. -Client #2 was given the Mupirocin 2% topical cream when he returned from the Day Program. -He acknowledged the MAR was not kept current for client #2.	V 118	To ensure all MARs are current and include all medications, MARs will be generated from the pharmacy. Going forward MAR's will be reviewed daily. The Residential Manager will receive medication administration training again. The Residential Manager will also receive a review of his job description and job duties. The Residential Manager will also receive disciplinary action and if this occurs again the Residential Manager will be suspended and/or terminated.	
V 513	27E .0101 Client Rights - Least Restrictive Alternative 10A NCAC 27E .0101 LEAST RESTRICTIVE ALTERNATIVE (a) Each facility shall provide services/supports that promote a safe and respectful environment. These include: (1) using the least restrictive and most appropriate settings and methods; (2) promoting coping and engagement skills that are alternatives to injurious behavior to self or others; (3) providing choices of activities meaningful to the clients served/supported; and (4) sharing of control over decisions with the client/legally responsible person and staff. (b) The use of a restrictive intervention procedure designed to reduce a behavior shall always be accompanied by actions designed to insure dignity and respect during and after the intervention. These include: (1) using the intervention as a last resort;	V 513		

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V 513	<p>Continued From page 3 and</p> <p>(2) employing the intervention by people trained in its use.</p> <p>This Rule is not met as evidenced by: Based on record review, observation, and interviews, the facility failed to use the least restrictive and most appropriate settings and methods. The findings are:</p> <p>Review on 1/13/25 of client #2's record revealed: -Admission date of 3/24/05. -Diagnoses of Autism Spectrum Disorder and Severe Intellectual Disability. -No documentation of restriction in treatment plan.</p> <p>Observation on 1/13/25 at approximately 10:10 am revealed: -Client #2's clothing was in a locked closet in the hallway.</p> <p>Attempted interview on 1/13/25 with client #2 revealed: -He could not be interviewed because he was nonverbal.</p> <p>Interview on 1/13/25 with staff #1 revealed: -Client #2's clothing was locked in the closet in the hallway because he tore up his clothing. -Client #2 also threw pieces of his clothing into the toilet. -They had been locking his clothing away in the closet for about a year.</p> <p>Interview on 1/13/25 with the Residential</p>	V 513	<p>Client #2's clothing was returned to his closet in his room. The Residential Manager will receive client rights training as well as a review of his job description and job duties. The Residential Manager will also receive disciplinary actions and if this occurs again the Residential Manager will be suspended and/or terminated.</p>	
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V 513	<p>Continued From page 4</p> <p>Manager revealed:</p> <ul style="list-style-type: none">-Client #2's clothes were kept in closet because he will tear his clothing.-They had been locking his clothing in the closet since July 2024.-Client #2 tore up his clothes and the other client's clothes. <p>Interview on 1/13/25 with the Executive Director revealed:</p> <ul style="list-style-type: none">-She was aware of client #2 tearing up his clothes.-She was not aware of staff locking client #2's clothes in the hallway closet.-The team did not meet to put anything in place to address staff locking client #2's clothes away in the hallway closet.	V 513		
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