STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL092-985	A. BUILDING: _____ B. WING _____	01/27/2025

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V 000	INITIAL COMMENTS An annual survey was completed on 1/27/25. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 3 and has a current census of 3. 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 (E) name or initials of person administering the drug.	V 118		

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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 observation, record review and interview the facility failed to administer medications on the written order of a physician and failed to keep MARs current for 2 of 3 clients (#1 and #3). The findings are: A. Review on 1/23/25 of client #1's record revealed: - Admission date: 10/1/21 - Diagnoses: Schizoaffective Disorder, Tardive Dyskinesia, Moderate Intellectual Disability, Pituitary Tumor, Osteoarthritis, Hyperlipidemia, Type 2 Diabetes, Dementia associated with other underlying disease without behavioral disturbance, Bilateral Lower Extremity Edema - Physician's order dated 5/15/24 for memantine hydrochloride (hcl) 10 milligrams (mg) take 1 tablet by mouth twice daily (dementia) Review on 1/24/25 of client #1's MARs from 11/1/24 - 1/24/25 revealed: - No staff initials that documented administration of memantine hcl at 8am from 11/1/24 - 11/30/24 and on 12/7/24, 12/8/24, 12/14/24, 12/15/24, 12/21/24, 12/22/24, 12/28/24, 12/29/24 - No staff initials that documented administration of memantine hcl at 8pm from	V 118		

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V 118	Continued From page 2 11/1/24 - 12/31/24 Interview on 1/23/25 client #1 reported: - She received her medication daily - She never missed medication Observation on 1/23/25 at 12:25pm revealed: - Client #1's medications were prepackaged in pouches by the pharmacy and sorted by date and time to be administered - Memantine hcl was included in the prepackaged roll of medication to be administered daily at 8 am and 8 pm Interview on 1/23/25 staff #1 reported: - She had worked at the facility since September of 2024 - The facility used an electronic MAR that was accessed by facility staff on a mobile application - She did not have full access to the electronic system and could not see any past MARs Interview on 1/27/25 the Lead Staff reported: - There had been a problem with their electronic MAR that prevented some facility staff from being able to see each medication for each client - Facility staff were not able to see client #1's memantine hcl in the electronic MAR system in November 2024 and December 2024 but it was administered as ordered during that time Interviews on 1/24/25 and 1/27/25 the House Manager #1 reported: - The facility kept paper forms of the clients' MARs "in case something doesn't record" in the electronic MAR system - She had tried to get memantine hcl added to client #1's electronic MAR system and staff were supposed to be recording it on the paper MARs	V 118		

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V 118	Continued From page 3 until it was added - Memantine hcl was in client #1's prepackaged medication pouches and it was administered daily as ordered during November and December of 2024 but staff did not consistently record it on the paper MAR forms - She was unable to find the November 2024 paper MAR - Although the November 2024 and December 2024 electronic MARs appeared blank for client #1's memantine hcl, the system also reported "data already recorded" Interview on 1/27/25 the Qualified Professional (QP) reported: - There had been a technical issue with their electronic MAR system that did not allow some facility staff full access to each clients electronic MARs - On 1/1/25, he reentered all medication into the electronic MAR system for client #1 which resolved the issue with staff access Interview on 1/27/25 the Director of Operations (DOO) reported: - The facility had been using the electronic MAR system for "a little over a year" - There had been some issues with "getting it fully off the ground and getting the facility fully implemented with using it" - The facility was still using paper MARs in some instances - He had been notified of some technical problems with the electronic MAR system - He had attempted to identify the cause of the error with client #1's memantine hcl within the system - Although the November 2024 and December 2024 electronic MARs appeared blank for client #1's memantine hcl, the system also reported	V 118		

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V 118	Continued From page 4 "data recorded" - He had been unable to identify the issue, but when client #1's medications were reentered on 1/1/25, all medications for client #1 were fully accessible to facility staff within the electronic MAR system B. Review on 1/23/25 of client #3's record revealed: - Admission date: 6/1/24 - Diagnoses: Autism Disorder, Severe Intellectual Disability - Physician's order dated 8/2/24 and discontinued on 12/3/24 for aripiprazole 5 mg take 1 tablet by mouth daily (mood) - Physician's orders dated 12/3/24: - Aripiprazole 10mg take 1 tablet by mouth every morning - Aripiprazole 5 mg take 1/2 tablet (2.5 mg) by mouth at 1 pm Review on 1/24/25 of client #3's MARs from 11/1/24-1/24/25 revealed: - Staff initials that documented administration of aripiprazole 5 mg from 12/3/24-12/31/24 - No staff initials that documented administration of aripiprazole 10 mg from 12/3/24 -12/31/24 - No staff initials that documented administration of aripiprazole 2.5 mg from 12/3/24 -12/31/24 Observation on 1/23/5 at 12:45pm revealed: - Client #3's medication were prepackaged in pouches by the pharmacy and sorted by date and time to be administered - Aripiprazole 10 mg was included in the prepackaged medication to be administered daily at 8 am - Aripiprazole 2.5 mg was included in the	V 118		

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V 118	Continued From page 5 prepackaged medication to be administered daily at 1 pm Interview on 1/27/25 the Lead Staff reported: - She had worked at the facility since July of 2024 - She took clients to doctor's appointments and ensured clients' medications were administered correctly and according to physician's orders - If there was a change with a client's medication, she communicated that change to the facility staff and to the House Manager #2 - The House Manager #2 ensured the electronic MAR system was updated with medication changes - She did not communicate the 12/3/24 change in the physician's order for client #2's aripiprazole until January 2025 when the new aripiprazole was dispensed by the pharmacy Interview on 1/27/25 the House Manager #1 reported: - The Lead Staff took client #3 to the doctor's appointment on the day of the change to the aripiprazole - The Lead Staff reported that "her (Lead Staff) and [House Manager #2's] communication was not sufficient regarding the medication change for [client #3]" Interview on 1/27/25 the House Manager #2 reported: - She reviewed the MARs monthly to ensure medications were accurate according to physician's orders, medications in the cabinet matched the MAR, and administration of medication was documented daily - The Lead Staff communicated with her about medication changes - The Lead Staff took client #3 to the doctors	V 118		

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V 118	Continued From page 6	V 118		

appointment on 12/3/24 and the aripiprazole order was changed
- She did not know the medication had changed until 1/24/25
- Medication was delivered to the facility once the pharmacy received the new order
- She "can't say when she (client #3) started taking the new order"

Interview on 1/27/25 the QP reported:
- The Lead Staff was supposed to bring all documents for medication changes to the House Manager #2 and the House Manager #2 was supposed to check with the pharmacy to ensure they received the updated order and coordinate pick up or delivery of the medication
- The House Manager #2 was to notify him of the medication changes and he was to update the electronic MAR system
- The former House Manager was responsible for doing each step herself, but she was no longer employed by the facility
- The former House Manager left the facility in August or September of 2024 and they had been trying to implement new systems
- On 1/1/25, he reentered all medication into the electronic MAR system for client #3, including the updated 12/3/24 orders for aripiprazole
- He was concerned about the medication errors and would address it with staff

Interview on 1/27/25 the DOO reported:
- The House Manager #2 put medication in the electronic MAR system, attended appointments with clients, obtained updated orders, communicated with the pharmacy about refills, coordinated pharmacy pick ups by her (House Manager #2) or the House Manager #1 or scheduled medication deliveries
- Once the pharmacy received the updated

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V 118	Continued From page 7 order for client #3's aripiprazole, the pharmacy would have sent the new medication to the facility and the facility staff "would have stopped giving the old medicine" - "I can with 99% certainty say that she (client #3) received the correct medicine and that it was just documented on the wrong MAR" Due to the failure to accurately document medication administration, it could not be determined if the client received medication as ordered by the physician.	V 118		