STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0411267	A. BUILDING: _____ B. WING _____	01/29/2025

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BARKSDALE HOME	807 GRETCHEN LANE GREENSBORO, NC 27410

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on January 29, 2025. The complaint was substantiated (Intake #NC00226076). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living. This facility is licensed for 2 and has a current census of 2. The survey sample consisted of audits of 2 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, interviews, and observations, the facility failed to administer medication on the written order of a physician and failed to keep the MARs current, affecting 1 of 2 clients (2). The findings are: Review on 1/22/25 of client #2's record revealed: -Date of admission: 12/29/23; -Diagnoses: Autism Disorder; Mixed Receptive-Expressive Language Disorder; Expressive language Disorder, and other problems related to lifestyle; -Physician order dated 7/25/24 for Abilify 15 milligrams (mg)(behavior), take 1 tablet by mouth daily; -There was no physician order to reflect Abilify 5 mg, take 1 tablet by mouth daily. Interview on 1/27/25 with the facility's pharmacy staff revealed: -Physician order dated 7/16/24 for Abilify 10 mg, take 1 tablet by mouth once daily; -Physician order dated 7/25/24 for Abilify 15 mg, take 1 tablet by mouth once daily. Review on 1/22/25 and 1/27/25 of client #2's	V 118		

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V 118	Continued From page 2 MARs from July 2024 to January 2025 revealed: -No documentation of Abilify 10 mg or 15 mg, take 1 tablet by mouth daily; -Abilify 5 mg was not documented as being administered from 7/1/24 to 7/31/24; -Abilify 5 mg was not documented as being administered from 9/25/24 to 9/30/24; -Abilify was not documented as being administered from 10/18/24 to 10/31/24; -Abilify 5 mg was documented on 11/1/24 of client #2 being on a leave of absence; -Abilify 5 mg was not documented as being administered from 11/2/24 to 11/30/24; Observation on 1/22/25 at 2:01pm of client #2's medications on-site revealed: -Abilify 10 mg, take 1 tablet by mouth daily; -There was no prescription for Abilify 15 mg. Attempted interviews on 1/23/25 and 1/27/25 with client #2's primary physician revealed: -A message was left for the physician and requesting a return call. No return call either day. Attempted interview on 1/22/25 with client #2 revealed: -Client #2 did not respond to any questions. Interviews on 1/24/25 and 1/27/25 with client #2's legal guardian (LG) revealed: -"[Client #2's] behaviors of hitting himself in the head increased in mid-September, October, and November of 2024;" -She and the AFL Provider had communicated with the physician about client #2's behavior; -The doctor relied on AFL Provider's observations of the day-to-day reactions to the Abilify; -The last in office visit was 7/3/24 and the understanding was she, AFL Provider, and the doctor would communicate through the	V 118		

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V 118	Continued From page 3	V 118		

physician's electronic medical information system;
-She gave the AFL Provider access to client #2's physician's electronic medical information system. Whenever a message was sent to the doctor, she or AFL Provider would receive a notification and be able to respond to the conversation. "I was very involved in the conversations."

Interviews on 1/22/25 and 1/27/25 with the AFL Provider revealed:
-"I was cutting the medication in half (Abilify 10 mg) with a pill cutter per the doctor saying I could;"
-"I was going off of what [LG] would say (administration of the Abilify);"
-He and the LG discussed that client #2 was more aggressive on the Abilify and agreed to stop administering the Abilify in November 2024;
-"It was my understanding the doctor was in agreement with the medication (Abilify) not being administered;"
-"Stopping the administration of the Abilify 5 mg was an experiment;"
-"There was no change or discontinue order for Abilify for [client #2] from July 2024 to January 2025;"
-He started back administering client #2's, Abilify 5 mg in December 2024;
-"[Client #2's] last in-person appointment with the doctor was July 2024, the first time he met the doctor. Client #2 had 2 virtual appointments with the doctor either in July or August 2024."

Interviews on 1/23/25 and 1/24/25 with the Clinical Supervisor #1 (CS) revealed:
-"I checked to make sure the medication was present and locked up and left the MAR for [the nurse] to review;"

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V 118	Continued From page 4 -"Sometime in December 2024 the doctor had taken [client #2] off some of his medications. No physician orders were provided to support this statement;" -On 12/20/24 she completed a home visit and reviewed client #2's medications. This included counting each medication and "the count for the Abilify was off. There was more pills than there should have been;" -"From my understanding [AFL Provider] took [client #2] off his Abilify but the documentation appeared as if the medication was administered on the December MAR;" -She requested updated physician orders of all of client #2's medications (last week and again on 1/24/25). "I have not received the orders yet;" -She was unaware of the Abilify 15 mg not being administered in November 2024; -"I was unaware the label on the medication bottle was different from the MARs; -The Registered Nurse (RN) brought concerns to her attention about AFL Provider not documenting medication when administered in August of 2024; -"[AFL Provider] did not follow medication administration policy, chain of command, and the agency does not take verbal orders;" -Her home visits were completed monthly. "I am responsible for some of this (medication administration) for not cross referencing the pill bottle with the MAR." Interview on 1/27/25 with the RN revealed: -"I did not follow up on the missing documentation for November 2024 MAR because that is not my responsibility. I had no notation that I notified anyone;" -"I'm responsible for configuring, activating monthly MARs, and updating MARs when I receive updated physician orders;" -Physician orders were scanned to her from AFL	V 118		

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V 118	Continued From page 5 Provider CS. "I have not received any updated physician orders for [client #2's] Abilify since 9/3/24;" -"On 12/7/24, I completed a routine check of MARs and identified one medication that was not documented for daily. Abilify 5 mg was documented for on 11/1/24, but none of the other days of the month were documented for." Interview on 1/24/25 with the Program Manager/Clinical Supervisor #2 (PM/CS) revealed: -"I was aware there had been some medication changes with [client #2's] medications. That [AFL Provider] and [LG] were discussing the medication changes and [client #2's] behaviors;" -"I was unaware that [client #2] was not being administered his Abilify; -"A report comes out every Tuesday about missing documentation on the MAR from the previous week. Each CS received the report to discuss with providers (AFL) to make corrections." Interview on 1/28/25 with the licensee's Area Director revealed: -The licensee had outlined corrective measures, "that are being put into action (medication administration);" -She was notified on 12/19/24, by the CS #1 that AFL Provider had not administered client #2 the medication (Abilify); -"At the end of the month (12/30/24) [AFL Provider] was not administering the Abilify according to doctor's orders;" -"In the summer (unsure of when) the RN notified me and [CS #1] that [AFL Provider's] documentation was not timely. He (AFL Provider) was playing catch-up;" -She was the direct supervisor for the CS's.	V 118		

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V 118	Continued From page 6 Review on 1/29/25 of the facility's Plan of Protection, dated 1/29/25 and completed by the Program Manager revealed: What immediate action will the facility take to ensure the safety of the consumers in your care? AFL Provider is completing a medication administration refresher class today (1/29/25) at 2pm the nurse who is a nurse with the agency and in charge of keeping the medication list current in electronic record. She will review the policies, procedures and expectations for administering medications and documenting them daily online. Clinical Supervisor will meet with both AFL Provider and the guardian to ensure they are aware to send any medication changes immediately after a medical appointment so it can be changed in electronic record in a timely manner. Describe you plans to Make sure the above happens. The agency has a search engine spreadsheet that was started recently that is shared via email every Tuesday morning. The spreadsheet informs Clinical supervisors of any medications that weren't documented (initialed) in electronic record for the prior week which runs Sunday through Saturday. Clinical supervisors have to complete a general event incident report for anyone who has a medication error for the prior week. In addition, during the monthly Alternative Family Living visits, the Clinical supervisor will compare the current list in electronic record. If there are any discrepancies, the Clinical supervisor double check with the prescribing physician or pharmacy and send any changes to the nurse so she can update the medications in electronic record. We	V 118		

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V 118	Continued From page 7 will also ensure AFL Provider also knows how to accurately comment if the individual was Leave of absence or if a medication was discontinued or added. The facility was licensed as Alternative Family Living and served two male clients with the diagnoses of Down Syndrome; Moderate Intellectual Disabilities, and Autism Disorder. Client #2 had a physician order dated July 25, 2024 for Abilify 15 mg. He was not administered his Abilify 15 mg from July 25, 2024 to January 2025. The label on the Abilify medication bottle reflected Abilify 10 mgs was prescribed from July 16, 2024 to July 25, 2024. The MARs had documented from July 2024 to January 2025 that client #2 was to receive Abilify 5 mgs. During the month of November 2024 client #2 was not administered the medication Abilify at all, after it was discussed with AFL Provider, LG and client #2's primary physician to discontinue the medication due to behaviors. There was not a physician order in place to discontinue the Abilify during the month of November 2024. Client #2 began receiving his Abilify again in December 2024 and the physician had given instructions to the AFL Provider and the LG to administer 5 mg at that time. Instructions were given to break the 10 mg pills of Abilify in half to be administered. There was not a physician's order for this change at that time. No physician orders were provided to reflect changes and or discontinue of the Abilify for client #2. The MARs from July 2024 to January 2025 were not kept current. The Clinical Supervisor #1, the nurse, and the Licensee's Area Director became aware of issues with the AFL provider's documentation in December 2024. Corrective measures to address the issues with medication administration were outlined on December 30, 2024. However, the corrective	V 118		

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V 118	Continued From page 8 measures had not been implemented as of January 22, 2025. Medication was not being administered as prescribed, documentation was not kept current, and the MARs were not updated to reflect current physician orders. This deficiency constitutes a Type B violation which was detrimental to the health, safety, and welfare of the client.	V 118		