STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL084-100	A. BUILDING: _____ B. WING _____	02/13/2025

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MOSS LANE II	42414 MOSS LANE NEW LONDON, NC 28127

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V 000	INITIAL COMMENTS An annual survey was completed on 2/13/25. Deficiencies were 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 106	27G .0201 (A) (8-18) (B) GOVERNING BODY POLICIES 10A NCAC 27G .0201 GOVERNING BODY POLICIES (a) The governing body responsible for each facility or service shall develop and implement written policies for the following: (8) use of medications by clients in accordance with the rules in this Section; (9) reporting of any incident, unusual occurrence or medication error; (10) voluntary non-compensated work performed by a client; (11) client fee assessment and collection practices; (12) medical preparedness plan to be utilized in a medical emergency; (13) authorization for and follow up of lab tests; (14) transportation, including the accessibility of emergency information for a client; (15) services of volunteers, including supervision and requirements for maintaining client confidentiality; (16) areas in which staff, including nonprofessional staff, receive training and continuing education; (17) safety precautions and requirements for	V 106		

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V 106	Continued From page 1 facility areas including special client activity areas; and (18) client grievance policy, including procedures for review and disposition of client grievances. (b) Minutes of the governing body shall be permanently maintained. This Rule is not met as evidenced by: Based on observation, record reviews and interviews the facility failed to implement a policy for incident reporting. The findings are: 1. Reviews on 2/5/25 and 2/7/25 of client 2's record revealed: -Admission date of 3/2/21. -Diagnoses of Moderate Intellectual Disability, Seizure Disorder, Unspecified Psychosis due to substance or known psychological condition, Sleep Disorder, Intermittent Explosive Disorder, Schizoaffective Disorder, Bipolar Disorder, History of Traumatic Brain Injury, Personality Disorder, Type II Diabetes, Hypothyroidism and Hyperlipidemia. Physician's orders dated 1/2/24 and 1/1/25 for the following medication: Glycopyrrolate 2 milligrams (mg) (Drooling), one tablet three times daily Divalproex 500 mg (Seizure Disorder), one tablet twice daily Phenobarbital 32.4 mg (Seizure Disorder), one tablet in the morning Phenobarbital 32.4 mg, three tablets at bedtime Zonisamide 100 mg (Seizure Disorder), three capsules twice daily Levetiracetam 500 mg (Seizure Disorder), three	V 106		

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tablets twice daily
Benztropine 1 mg (Involuntary movements), one tablet twice daily
Tamsulosin 0.4 mg (Enlarged Prostate), one capsule twice daily
Lactulose 10 grams (gm)/15 milliliters (ml) (Constipation) take 60 ml three times daily
Senna 8.6 mg (Constipation), one tablet twice daily
Metformin 500 mg (Diabetes), two tablet twice daily
Glipizide 10 mg (Diabetes), one tablet twice daily
Olanzapine 20 mg (Bipolar Disorder), one tablet twice daily
Trazodone 100 mg (Sleep), two tablets at bedtime
Zolpidem 5 mg (Sleep), one tablet at bedtime

Review on 2/7/25 of Medication Administration Records (MARs) for client #2 revealed:

Client #2 refused medication for the following dates and times:

January 2025-
-On 1/21 he refused all morning doses of medication
-On 1/26 he refused all evening doses of medication
-On 1/27 he refused all morning doses of medication
-On 1/27 he refused Glycopyrrolate, Lactulose and Metformin evening doses

December 2024-
-On 12/1, 12/6 and 12/31 he refused all morning doses of medication
-On 12/2 he refused all evening doses of medication
-On 12/6 he refused Metformin and Lactulose

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V 106	Continued From page 3	V 106		

evening doses
-On 12/8 he refused all morning doses of medication
-On 12/8 he refused Glycopyrrolate evening dose
-On 12/11 he refused all morning and evening doses of medication
-On 12/4 and 12/29 he refused all evening doses of medication
-On 12/23 and 12/30 he refused Glycopyrrolate evening dose

November 2024-
-On 11/4, 11/14, 11/15 and 11/27 he refused all morning doses of medication
-On 11/16 he refused all evening doses of medication
-On 11/17 he refused all evening doses of medication

October 2024-
-On 10/15 and 10/31 he refused all morning doses of medication
-On 10/28 he refused all morning doses
-On 10/30 he refused all morning and evening doses of medication

September 2024-
-On 9/2 he refused Glycopyrrolate 2 pm dose
-On 9/5 he refused all morning doses of medication
-On 9/5 he refused Glycopyrrolate evening dose
-On 9/17 he refused all morning doses of medication
-On 9/19 he refused Glycopyrrolate 2 pm dose
-On 9/24 he refused all morning doses of medication

Review on 2/6/25 of the facility's incident reports revealed:
-No Level I incident reports related to client #2's

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V 106	Continued From page 4 medication refusals from September 2, 2024 thru January 27, 2025. 2. Review on 2/7/25 of client #1's record revealed: -Admission date of 1/9/24. -Diagnoses of Moderate Intellectual Disability, Down's Syndrome, Impulse Control Disorder, Type II Diabetes, Obesity, Heart Disease and Mixed Receptive and Expressive Language Disorder. Review on 2/7/25 of client #3's record revealed: -Admission date of 4/18/23. -Diagnoses of Moderate Intellectual Disability, Type II Diabetes Mellitus, Hyperlipidemia, Hypertension and Obsessive-Compulsive Disorder. Observation on 2/5/25 at approximately 1:33 PM revealed: -Living Room: Three wall patches ranged from approximately fifteen inches by eight inches to three inches by eight inches. -Hallway: Wall patch was approximately four inches by four inches with an additional quarter sized hole in the middle of the patch. -Client #1's bedroom: Four wall patches ranged from approximately one and half feet by two feet to four inches by four inches inches and headboard of bed laminate covering was peeled. Review on 2/6/25 of the facility's incident reports revealed: -No Level I incident reports related to clients #1's and #3's property damage at the facility. Review on 2/7/25 of the facility's incident reporting policy revealed: -"Each incident is assigned a risk level based on	V 106		

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V 106	Continued From page 5 the level of risk the incident poses to the person (s) supported and the organization. Risk levels are identified as:...All level 1 incidents should be leveled as low risk...Examples...medication errors that do not threaten the person's health or safety...aggressive or destructive behavior that does not involve law enforcement...Upon discovery of a qualifying people supported event details pertaining to the event should be entered into [name of online system] within 72 hours of discovery." Interview on 2/7/25 with staff #1 revealed: -"We don't do any paper incident reports." -They didn't do any incident reports for medication refusals and property damage. -They documented the medication refusals and property damage on a behavior data form. Interview on 2/7/25 with the Direct Support Supervisor revealed: -Staff should be doing incidents reports for property damage to the facility. -He didn't know if staff did incident reports for medication refusals for client #2. -The Qualified Professional (QP) was responsible for ensuring those incident reports were completed. Interview on 2/6/25 with the agency's Registered Nurse (RN) revealed: -She didn't realize medication refusals were considered a medication error for this state. -She had not seen any incident reports completed by staff for medication refusals. -She didn't require staff complete a form for medication refusals. -Staff documented the medication refusals on the Medication Administration Record (MAR).	V 106		

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V 106	Continued From page 6 Interviews on 2/5/25 and 2/6/25 with the QP revealed: -She was aware of client #2's medication refusals. -Staff did no incident reports whenever clients refused their medication. -The agency's RN had staff document those medication refusals on a separate form. -She didn't know they were required to do incident reports for medication refusals because they were filling out a separate form for the nurse. -Clients #1 and #3 were responsible for the facility's property damage. -Staff were not doing incident reports for the property damage. -"I never really thought about staff doing incident reports for property damage." -She confirmed the facility failed to follow their policy for incident reporting.	V 106		
V 112	27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally	V 112		

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V 112	Continued From page 7 responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to develop and implement a goal and strategies to meet the needs of one of three clients (#2). The findings are: Reviews on 2/5/25 and 2/7/25 of client 2's record revealed: -Admission date of 3/2/21. -Diagnoses of Moderate Intellectual Disability, Seizure Disorder, Unspecified Psychosis due to substance or known psychological condition, Sleep Disorder, Intermittent Explosive Disorder, Schizoaffective Disorder, Bipolar Disorder, History of Traumatic Brain Injury, Personality Disorder, Type II Diabetes, Hypothyroidism and Hyperlipidemia. -Physician's orders dated 1/2/24 and 1/1/25 for the following medication: Glycopyrrolate 2 milligrams (mg) (Drooling), one tablet three times daily Divalproex 500 mg (Seizure Disorder), one tablet twice daily	V 112		

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V 112	Continued From page 8 Phenobarbital 32.4 mg (Seizure Disorder), one tablet in the morning Phenobarbital 32.4 mg, three tablets at bedtime Zonisamide 100 mg (Seizure Disorder), three capsules twice daily Levetiracetam 500 mg (Seizure Disorder), three tablets twice daily Benztropine 1 mg (Involuntary movements), one tablet twice daily Tamsulosin 0.4 mg (Enlarged Prostate), one capsule twice daily Lactulose 10 grams (gm)/15 milliliters (ml) (Constipation) take 60 ml three times daily Senna 8.6 mg (Constipation), one tablet twice daily Amlodipine 10 mg (High Blood Pressure), one tablet daily Pioglitazone 15 mg (Diabetes), one tablet daily Metformin 500 mg (Diabetes), two tablet twice daily Glipizide 10 mg (Diabetes), one tablet twice daily Olanzapine 20 mg (Bipolar Disorder), one tablet twice daily Trazodone 100 mg (Sleep), two tablets at bedtime Zolpidem 5 mg (Sleep), one tablet at bedtime Humalog Kwik Insulin, inject 10 units subcutaneously as needed if blood sugar is greater than 300 and recheck in 1 hour, inject 5 more units if blood sugar is greater than 150 Blood glucose check four times daily (before meals and at bedtime) -Individualized Support Plan (ISP) dated 2/1/25 had no goal and strategies to address medication refusals and allowing staff to check his blood glucose levels. Review on 2/7/25 of Medication Administration Records (MARs) for client #2 revealed he refused medication and/or blood glucose checks for the	V 112		

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V 112	Continued From page 9 following dates and times: January 2025- -On 1/21 he refused all morning doses of medication and blood glucose check at bedtime -On 1/26 he refused all evening doses of medication and blood glucose checks before breakfast, dinner and bedtime -On 1/27 he refused all morning doses of medication and blood glucose check before dinner -On 1/27 he refused Glycopyrrolate, Lactulose, Metformin evening doses and blood glucose check before lunch -Client #2 refused 45 doses of medication within the month -Client #2 refused to have his blood glucose checked by staff 6 times December 2024- -On 12/1, 12/6 and 12/31 he refused all morning doses of medication and blood glucose checks before breakfast -On 12/2 he refused all evening doses of medication and blood glucose check at bedtime -On 12/6 he refused Metformin, Lactulose 2 pm doses and the blood glucose check before bedtime -On 12/8 he refused all morning doses of medication and blood glucose checks before breakfast and lunch -On 12/8 he refused Glycopyrrolate evening dose -On 12/11 he refused all morning and evening doses of medication; blood glucose checks before dinner and at bedtime -On 12/4 and 12/29 he refused all evening doses of medication and blood glucose checks at bedtime -On 12/23 and 12/30 he refused Glycopyrrolate evening dose	V 112		

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V 112	Continued From page 10 -On 12/26 he refused blood glucose check before breakfast -Client #2 refused 131 doses of medication within the month -Client #2 refused to have his blood glucose checked by staff 11 times November 2024- -On 11/4, 11/14, 11/15 and 11/27 he refused all morning doses of medication -On 11/16 he refused all evening doses of medication and blood glucose checks before dinner and at bedtime -On 11/17 he refused all evening doses of medication and blood glucose check at bedtime -Client #2 refused 70 doses of medication within the month -Client #2 refused to have his blood glucose checked by staff 3 times October 2024- -On 10/15 and 10/31 he refused all morning doses of medication -On 10/28 he refused all morning doses and blood sugar check before breakfast -On 10/30 he refused all morning and evening doses of medication -Client #2 refused 70 doses of medication within the month -Client #2 refused to have his blood glucose checked by staff 1 time September 2024- -On 9/2 he refused Glycopyrrolate 2pm dose and blood glucose check before lunch -On 9/5 he refused all morning doses of medication -On 9/5-Glycopyrrolate evening dose -On 9/17 he refused all morning doses of medication	V 112		

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-On 9/19 he refused Glycopyrrolate 2 pm dose
-On 9/24 he refused all morning doses of medication
-Client #2 refused 45 doses of medication within the month
-Client #2 refused to have his blood glucose checked by staff 1 time

Review on 2/7/25 of the seizure record log for client #2 revealed:

January 2025-
-Seizure activity was noted on 1/28, 1/27, 1/22 and 1/12
-The seizures lasted from 1 minute and 10 seconds to 3 minutes
-Description of seizures: Drooling, fidgeting with objects, picking at clothes/taking off clothes, staring, sudden dropping of objects, eyes upward, eyes downward, dancing/twirling, unresponsive, head drop and limp body. Symptoms varied for each seizure
-Behavior after seizure: Confused each time

Client #2 refused a total of 16 doses of seizure medication during that month (1/21, 1/26 and 1/27)
Seizure medication included: Divalproex, Phenobarbital, Zonisamide and Levetiracetam

December 2024-
-Seizure activity was noted on 12/18, 12/17 X 2, 12/16 and 12/15
-The seizures lasted from 1 minute and 8 seconds to 15 minutes
-Description of seizures: Drooling, falling to the floor, biting tongue/lips, fidgeting with objects, staring, sudden dropping of objects, eyes downward, dancing/twirling, unresponsive, head drop, limp body, jerking while conscious and rapid

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V 112	Continued From page 12 blinking of eyes. Symptoms varied for each seizure -Behavior after seizure: Confused or deep sleep Client #2 refused a total of 40 doses of seizure medication during that month (12/1, 12/2, 12/4, 12/6, 12/8, 12/11, 12/23, 12/26 and 12/29) Seizure medication included: Divalproex, Phenobarbital, Zonisamide and Levetiracetam November 2024- -Seizure activity was noted on 11/17 and 11/16 X 2 -The seizures lasted from 2 minute and 1 second to 2 minutes and 3 seconds -Description of seizures: Drooling, staring, unresponsive, head drop, dancing/twirling, falling to floor, rapid blinking of eyes and head and eyes turned to the left. Symptoms varied for each seizure -Behavior after seizure: Confused Client #2 refused a total of 24 doses of seizure medication during that month (11/4, 11/14, 11/15, 11/16, 11/17 and 11/27) Seizure medication included: Divalproex, Phenobarbital, Zonisamide and Levetiracetam October 2024- -Seizure activity was noted on 10/31 X 2 -The seizures lasted from 3 minutes and 13 seconds to 3 minutes and 22 seconds -Description of seizures: Drooling, fidgeting with objects, picking at clothes/taking off clothes, staring, unresponsive, jerking while conscious, sudden dropping of objects, rapid blinking of eyes, jerking arms movements left and right side and loss of bowel control. Symptoms varied for each seizure. -Behavior after seizure: Confused	V 112		

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V 112	Continued From page 13 Client #2 refused a total of 20 doses of seizure medication during that month (10/15, 10/28, 10/30 and 10/31) Seizure medication included: Divalproex, Phenobarbital, Zonisamide and Levetiracetam September 2024- -Seizure activity was noted on 9/19 -The seizure lasted for 1 minute and 5 seconds -Description of seizures: Drooling, loss of bladder control and staring. Symptoms varied for each seizure. -Behavior after seizure: Confused and drowsy Client #2 refused a total of 12 doses of seizure medication during that month (9/2, 9/5, 9/17, 9/19 and 9/24) Seizure medication included: Divalproex, Phenobarbital, Zonisamide and Levetiracetam Interview on 2/7/25 with client #2 revealed: -"I will not take my medication because staff do me wrong." -"I'm taking too much medication, and it makes me have seizures." -"The doctor just wants my money." -He had a seizure about 2 weeks ago. -"The medication make me have seizures." Interview on 2/7/25 with staff #1 revealed: -"In the last 6 months client #2 refused his medication for 4-5 days or more each month." -Client #2 refused the morning and/or evening doses of medication. -Client #2 also refused his blood glucose checks. -Client #2 would sometimes not take his medication unless they gave him some type of snack. -Client #2 said "the medication cause seizures,	V 112		

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but if he don't take the medication that is when he starts having seizure."
-Client #2 had a seizure last week in the van, he thought last Tuesday (1/28/25).
-"In the last 6 months [client #2] seems to have a seizure just about every three weeks."
-"Whenever [client #2] had seizures he had the seizures back to back."
-"It could be 2 seizures in one day."
-"Whenever [client #2] has a seizure he twitches, stares and shakes a little."
-"Some weeks he may have a seizure several days during that week."
-Client #2 had nothing in his plan to address the medication refusals and staff checking his blood glucose levels.
-"We just try to encourage [client #2] to take his medication and have his blood sugar checked."

Interview on 2/7/25 with the Direct Support Supervisor revealed:
-Client #2 refused his medications on a weekly basis.
-Staff asked client #2 several times and he would not take his medications.
-"[Client #2] may take the morning doses and refuse his night doses of the medication."
-"[Client #2] will also refuse the morning doses and then take the night doses of his medication."
-"Sometimes [client #2] refuse to take his medication for the entire day."
-"[Client #2] will sometimes have behaviors because he is not taking his medication."
-"[Client #2] will be verbally and physically aggressive."
-"[Client #2] also had seizures "behind" not taking his medication."
-'[Client #2] had several seizures related to his medication refusals."
-Client #2 had a seizure last week. He could not

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remember which day.
-"[Client #2] took a few seizure medications."
-"In the last 3 months [client #2] had several seizures as a result of not taking his seizure medication."
-"Sometimes [client #2] would have 2-3 seizures a day."
-He wasn't sure if there was anything in client #2's plan to address the medication refusals.
-"They will try to give [client #2] [a flavored drink mix] and [flavored tortilla chips] to take the medication and he will still sometimes refuse."

Interviews on 2/6/25, 2/7/25 and 2/11/25 with the Registered Nurse for the agency revealed:
-She notified the physician about client #2's medication refusals.
-She also made the physician aware that client #2 had several seizures.
-The physician said "[client #2] cycles, he has been doing this for years."
-"The physician really gave no type of feedback related to the medication refusals and seizures."
-"The physician would just tell me, [client #2] has a history of medication noncompliance and to continue reporting any medication refusals."
-"I'm not sure if [client #2's] seizures are always related to his medication refusals."
-"Client #2 had seizures some of the days when he took his medication."

Attempted interviews on 2/11/25, 2/12/25 and 2/13/25 with client #2's Psychiatrist revealed:
-On 2/11/25-Attempted to call the medical office and the phone kept disconnecting and not sending the call through to the operator.
-On 2/12/25 and 2/13/25 the receptionist stated the Psychiatrist was not available. She stated she would transfer the calls to his Nurse. The Nurse did not answer and a voicemail messages were

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left requesting the calls be returned.
-The call was never returned prior to the exit of survey on 2/13/25.

Attempted interviews on 2/12/25 and 2/13/25 with client #2's Neurologist revealed:
-On 2/12/25-The Neurologist was called and did not answer. A voicemail message was left requesting the call be returned.
-On 2/13/25-The receptionist answered the phone and stated the Neurologist was not available and would be out of the office until 2/28/25.

Interviews on 2/5/25, 2/6/25 and 2/7/25 with the Qualified Professional revealed:
-Client #2 refused his medication 3-5 times a month.
-"Whenever [client #2] refuses his medication it could be morning and/or evening doses."
-Client #2 did not refuse his medications every month.
-She was aware of client #2 had seizures.
-"[Client#2] has in his head the medications are causing the seizures."
-Client #2 would say "the doctor trying to make money off of me and the medication causes me to have seizures."
-Client #2 had no strategies in his plan to address the medication refusals and blood glucose checks.
-"Staff try to encourage [client #2] to take his medication, they can't make him take his medication. "
-There is a statement on his MAR for staff to give client #2 a flavored drink mix and flavored tortilla chips if he takes his medication.
-She "didn't realize" client #2 needed a specific goal and strategies in his plan to address the medication refusals and blood sugar checks.

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V 112	Continued From page 17 Review on 2/13/25 of a Plan of Protection written by the Regional Administrator dated 2/13/25 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? 1. [Regional Administrator] and [Qualified Professional] will schedule a team meeting with the Local Management Entity/Managed Care Organization, Behavioral Specialist and guardian to update the Individualized Support Plan and Behavior Support Plan to include: a. What plan should be in place when [client #2] refuses his medication and blood sugar checks. b. Add nursing and [the Physician] in the plan for backup. 2. Staff will notify [Agency Registered Nurse] when [client #2] refuses any medication. [Agency Registered Nurse] will notify [the Physician] for any additional recommendations or orders. [Agency Registered Nurse] will ensure all recommendations are completed. If [client #2] does develop adverse effects related to the medication refusal we will ensure to report to [the Physician]. Describe your plans to make sure the above happens. [Regional Administrator] has scheduled a team meeting with [Qualified Professional, Care Coordinator, Behavioral Specialist, Guardian] and [Agency Registered Nurse] to ensure [client #2] refusals of his medication and blood sugar checks are documented on the medication refusal form which serves as RHA Level 1 incident reporting. [Client #2's] Individualized Support Plan and Behavior Support Plan will be updated to reflect the steps we should implement as refusals of medication and blood sugar checks occur." Client #2's diagnoses included: Moderate Intellectual Disability, Seizure Disorder, Unspecified Psychosis due to substance or known psychological condition, Sleep Disorder,	V 112		

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V 112	Continued From page 18 Intermittent Explosive Disorder, Schizoaffective Disorder, Bipolar Disorder, History of Traumatic Brain Injury, Personality Disorder, Type II Diabetes, Hypothyroidism and Hyperlipidemia. Client #2 refused 361 doses of prescribed medication between 9/2/24 and 1/27/25. Client #2 also refused to allow staff to check his blood glucose levels 22 times between 9/2/24 and 1/27/25. The medications client #2 refused included: Glycopyrrolate, Divalproex, Phenobarbital, Zonisamide, Levetiracetam, Benztropine, Tamsulosin, Lactulose, Senna, Amlodipine, Pioglitazone, Metformin Glipizide, Olanzapine, Trazodone and Zolpidem. Four of those prescribed medications were for client #2's seizure disorder. Client #2 had 15 seizures between 9/19/24 and 1/28/25. Client #2 had seizures on some of the days when he refused the medication. Client #2 had no goal and strategies to address the medication refusals and blood glucose level checks. This deficiency constitutes a Type A1 rule violation for serious neglect and must be corrected within 23 days.	V 112		
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	V 114		

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V 114	Continued From page 19 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. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure fire and disaster drills were done quarterly on each shift. The findings are: Review on 2/7/25 of the facility's fire and disaster drill log from (March 2024- January 2025) revealed: -There was no fire drill conducted for 1st shift during the 3rd quarter (July, August, September) of 2024. -There were no fire drills conducted for 2nd and 3rd shifts during the 2nd quarter (April, May, June) of 2024. -There was no disaster drill conducted for 2nd shift during the 4th quarter (October, November, December) of 2024. -There was no disaster drill conducted for 3rd shift during the 3rd quarter (July, August, September) of 2024. -There was no disaster drill conducted for 3rd shift during the 2nd quarter (April, May, June) of 2024. Interview on 2/7/25 with client #1 revealed: -They go outside for fire drills. -He didn't know what they did for disaster drills.	V 114		

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V 114	Continued From page 20 Interview on 2/7/25 with client #2 revealed: -They go outside to the fence for fire drills. -They also go outside for disaster drills. Interview on 2/7/25 with the Direct Support Supervisor revealed: -The facility had three separate staff shifts. -"The fire and disaster drills are to be done monthly by staff." -He wasn't aware of staff not doing the drills as required. Interview on 2/13/25 with the Qualified Professional revealed: -The Direct Support Supervisor was responsible for ensuring direct care staff completed the fire and disaster drills. -She was not aware the drills were not being done as required by staff. -She confirmed the facility failed to ensure fire and disaster drills were done quarterly on each shift.	V 114		
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,	V 118		

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V 118	Continued From page 21 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: Based on record reviews and interviews, the facility failed to keep the MAR current affecting two of three clients (#2 and #3). The findings are: Reviews on 2/5/25 and 2/7/25 of client 2's record revealed: -Admission date of 3/2/21. -Diagnoses of Moderate Intellectual Disability, Seizure Disorder, Unspecified Psychosis due to substance or known psychological condition, Sleep Disorder, Intermittent Explosive Disorder, Schizoaffective Disorder, Bipolar Disorder, History of Traumatic Brain Injury, Personality Disorder, Type II Diabetes, Hypothyroidism and Hyperlipidemia.	V 118		

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V 118	Continued From page 22 -Physician's orders dated 1/2/24 and 1/1/25 for the following medication: Glycopyrrolate 2 milligrams (mg) (Drooling), one tablet three times daily Divalproex 500 mg (Seizure Disorder), one tablet twice daily Phenobarbital 32.4 mg (Seizure Disorder), one tablet in the morning Phenobarbital 32.4 mg, three tablets at bedtime Zonisamide 100 mg (Seizure Disorder), three capsules twice daily Levetiracetam 500 mg (Seizure Disorder), three tablets twice daily Benztropine 1 mg (Involuntary movements), one tablet twice daily Tamsulosin 0.4 mg (Enlarged Prostate), one capsule twice daily Lactulose 10 grams (gm)/15 milliliters (ml) (Constipation) take 60 ml three times daily Senna 8.6 mg (Constipation), one tablet twice daily Metformin 500 mg (Diabetes), two tablet twice daily Glipizide 10 mg (Diabetes), one tablet twice daily Olanzapine 20 mg (Bipolar Disorder), one tablet twice daily Trazodone 100 mg (Sleep), two tablets at bedtime Zolpidem 5 mg (Sleep), one tablet at bedtime Humalog Kwik Insulin, inject 10 units subcutaneously as needed if blood sugar is greater than 300 and recheck in 1 hour, inject 5 more units if blood sugar is greater than 150 Blood glucose check four times daily (before meals and at bedtime) Review on 2/7/25 of client #2's MARs revealed: January 2025:	V 118		

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V 118	Continued From page 23 No staff initials to indicate the medication was administered for the following: -Glycopyrrolate 2 mg on 1/22 and 1/30 2 pm doses. December 2024: No staff initials to indicate the medication Glycopyrrolate 2 mg 2 pm dose was administered on 2/27 No staff initials to indicate blood glucose check on 12/27 before lunch November 2024: No staff initials to indicate the medication was administered for the following: -Glycopyrrolate 2 mg on 11/5 and 11/19 2 pm doses. October 2024: No staff initials to indicate the medication was administered for the following: -Benztropine 1 mg on 10/26 8 pm dose. -Glipizide 10 mg on 10/26 8 pm dose. -Glycopyrrolate 2 mg on 10/31 8 am dose. -Senna 8.6 mg on 10/26 8 pm dose. -Tamsulosin 0.4 mg on 10/26 8 pm dose. -Trazodone 100 mg on 10/26. -Zolpidem 5 mg on 10/26. No staff initials to indicate blood glucose check was completed on 10/26 before bedtime. September 2024: No staff initials to indicate the medication was administered for the following:	V 118		

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V 118	Continued From page 24 -Benztropine 1 mg on 9/17 8 pm dose. -Divalproex 500 mg on 9/17 8 pm dose. -Glipizide 10 mg on 9/17 8 pm dose. -Glycopyrrolate 2 mg on 9/17 8 am dose and 9/24 2 pm dose. -Lactulose 10 gm on 9/27 4 pm dose. -Levetiracetam 500 mg on 9/17 8 pm dose. -Metformin 500 mg on 9/27 5 pm dose. -Olanzapine 20 mg on 9/17 8 pm dose. -Phenobarbital 32.4 mg on 9/17 8 pm dose. -Senna 8.6 mg on 9/17 8 pm dose. -Trazodone 100 mg on 9/17. -Zonisamide 100 mg on 9/17 8 pm. No staff initials to indicate blood glucose checks for the following: -On 9/4 before lunch. -On 9/6 before breakfast. -On 9/16 before bedtime. On 9/27 before dinner. Review on 2/5/25 of client #3's record revealed: -Admission date of 4/18/23. -Diagnoses of Moderate Intellectual Disability, Type II Diabetes Mellitus, Hyperlipidemia, Hypertension (HTN) and Obsessive-Compulsive Disorder. -Physician's order dated 2/7/24 for Lisinopril 10 mg (HTN), one tablet daily; Metformin 500 mg, one tablet twice daily with morning meals and Simvastatin 20 mg (HTN), one tablet daily. Review on 2/5/25 of client #3's December 2024 MAR revealed: No staff initials to indicate the medication was administered for the following: -Lisinopril 10 mg on 1/27. -Metformin 500 mg on 1/27 8 am dose. -Simvastatin 20 mg on 1/27.	V 118		

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V 118	Continued From page 25 Interview on 2/7/25 with the Direct Support Supervisor revealed: -Clients #2 and #3 received their medication as prescribed. -He thought it wasn't documented because the clients were away from the facility. -Clients #2 and #3 could have been in the community and/or on home visits and staff forgot to put their initials on the MARs. -He thought staff also forgot to put their initials for the blood glucose checks for client #2. Interview on 2/5/25 with the Qualified Professional revealed: -She had no idea why staff were not documenting the medication was administered and/or blood sugar checks were done for client #2. -"[Client #2] refuse his medications at times and staff possibly forgot to indicate it on the MARS." -Client #3 was on therapeutic leave towards the end of December 2025. -She gave no explanation as to why staff failed to document on 12/27/24 for some of the medications for client #3. -She confirmed the MARs were not kept current for clients #2 and #3.	V 118		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident;	V 366		

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V 366	Continued From page 26 (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals	V 366		

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V 366	Continued From page 27	V 366		

who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:
(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents;
(B) gather other information needed;
(C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and
(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and
(3) immediately notifying the following:
(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;
(B) the LME where the client resides, if different;
(C) the provider agency with responsibility for maintaining and updating the client's

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V 366	Continued From page 28 treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to implement a policy governing their response to Level I incidents as required. The findings are: 1. Review on 2/7/25 of Medication Administration Records (MARs) for client #2 revealed: Client #2 refused medication for the following dates and times: January 2025- -On 1/21 he refused all morning doses of medication -On 1/26 he refused all evening doses of medication -On 1/27 he refused all morning doses of medication -On 1/27 he refused Glycopyrrolate, Lactulose and Metformin evening doses December 2024- -On 12/1, 12/6 and 12/31 he refused all morning doses of medication -On 12/2 he refused all evening doses of medication	V 366		

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V 366	Continued From page 29 -On 12/6 he refused Metformin and Lactulose evening doses -On 12/8 he refused all morning doses of medication -On 12/8 he refused Glycopyrrolate evening dose -On 12/11 he refused all morning and evening doses of medication -On 12/4 and 12/29 he refused all evening doses of medication -On 12/23 and 12/30 he refused Glycopyrrolate evening dose November 2024- -On 11/4, 11/14, 11/15 and 11/27 he refused all morning doses of medication -On 11/16 he refused all evening doses of medication -On 11/17 he refused all evening doses of medication October 2024- -On 10/15 and 10/31 he refused all morning doses of medication -On 10/28 he refused all morning doses -On 10/30 he refused all morning and evening doses of medication September 2024- -On 9/2 he refused Glycopyrrolate 2 pm dose -On 9/5 he refused all morning doses of medication -On 9/5 he refused Glycopyrrolate evening dose -On 9/17 he refused all morning doses of medication -On 9/19 he refused Glycopyrrolate 2 pm dose -On 9/24 he refused all morning doses of medication 2. Observation on 2/5/25 at approximately 1:33 PM revealed:	V 366		

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V 366	Continued From page 30 -Living Room: Three wall patches ranged from approximately fifteen inches by eight inches to three inches by eight inches. -Hallway: Wall patch was approximately four inches by four inches with an additional quarter sized hole in the middle of the patch. -Client #1's bedroom: Four wall patches ranged from approximately one and half feet by two feet to four inches by four inches inches and headboard of bed laminate covering was peeled. Review on 2/6/25 of the facility's incident reports revealed: -No Level I incident reports related to client #2's medication refusals from September 2, 2024 thru January 27, 2025. -No Level I incident reports related to clients #1's and #3's property damage at the facility. -There was no documentation to determine: The cause of the incident; If the facility developed and implemented corrective measures according to the provider specified timeframes not to exceed 45 days; no measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days and assigning person(s) to be responsible for implementation of the corrections and preventive measures. Interview on 2/7/25 with the Direct Support Supervisor revealed: -Staff should be doing incidents reports for property damage to the facility. -He didn't know if staff did incident reports for medication refusals for client #2. -The Qualified Professional (QP) was responsible for ensuring those incident reports were completed. Interview on 2/6/25 with the agency's Registered Nurse (RN) revealed:	V 366		

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V 366	Continued From page 31 -She didn't realize medication refusals were considered a medication error for this state. -She had not seen any incident reports completed by staff for medication refusals. -She didn't require staff complete a form for medication refusals. -Staff documented the medication refusals on the Medication Administration Record (MAR). Interviews on 2/5/25 and 2/6/25 with the QP revealed: -She was aware of client #2's medication refusals. -Staff did no incident reports whenever clients refused their medication. -The agency's RN had staff document those medication refusals on a separate form. -She didn't know they were required to do incident reports for medication refusals because they were filling out a separate form for the nurse. -Clients #1 and #3 were responsible for the facility's property damage. -Staff were not doing incident reports for property damage. -"I never really thought about staff doing incident reports for property damage." -She confirmed the facility failed to implement a policy governing their response to Level I incidents as required.	V 366		
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.	V 736		

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V 736	Continued From page 32 This Rule is not met as evidenced by: Based on observation and interviews, the facility and its grounds were not maintained in a clean, attractive, orderly manner and kept free from offensive odor. The findings are: Observation on 2/5/25 at approximately 1:33 PM revealed: -Kitchen: The front portion of two of the counter top drawers were missing. -Dining area: Chair had dark circular wet spot approximately ten inches by nine inches on the seat and the wall had a scrape approximately six inches to eight inches long with peeling paint around it. -Living Room: Three unfinished and unpainted wall patches ranged from approximately fifteen inches by eight inches to three inches by eight inches, right side of light switch plate was separating from the wall and floor boards had multiple scrapes and gouges running together next to the staff desk near the front door. -Bathroom #1: Baseboard was separating from the wall to the next to the tub and shower. -Hallway: Unfinished and unpainted wall patch was approximately four inches by four inches with an additional tennis ball sized hole in the middle of the patch and a spongy area on the floor gave way when stepped on. -Bathroom #2: Missing baseboard near shower and sink, half of a baseboard was missing near front of shower, multiple small dark grayish dots; approximately 2 inch by four inch area of peeling paint on wall above the acrylic wall panels in the shower; rusty paper towel holder; five slats missing from blinds, brownish stains and scrapes on the baseboards and a small piece of broken glass approximately 1/4 inch by 1/8 inch on the floor. -Client #1's bedroom: Strong urine smell, four	V 736		

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V 736	Continued From page 33 unfinished and unpainted wall patches ranged from approximately one and half feet by two feet to four inches by four inches inches, floorboards near the door were crumbled near the edges and headboard of bed laminate covering was peeled. -Client #3's bedroom: Approximately four brown stains on wall above desk ranged from approximately ten inches to two inches long. -Outside: Four 4 inch by 4 inch square by 8 feet long pieces of lumbar lining walkway disconnected from others with exposed screws and nails, approximately 30 pieces of trash in the yard including wrappers, napkins, paper towels, tissues, plastic drink lid and straw, toilet paper roll and approximately 20 cigarette butts on the ground. Interview on 2/5/25 and 2/6/25 with the Qualified Professional revealed: -Clients #1 and #3 punched the walls whenever they got upset and aggressive. -They had only one maintenance person for this region, and he was not able to address all of the maintenance issues with the facility. -She confirmed the facility and its grounds were not maintained in a clean, attractive, orderly manner and kept free from offensive odor.	V 736		