STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL096-062	A. BUILDING: _____ B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCI-SIMMONS	801 SIMMONS STREET GOLDSBORO, NC 27530

(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	INITIAL COMMENTS An annual survey was completed on February 13, 2025. Deficiencies were cited This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 5 and currently has a census of 4. 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 record reviews and interviews the facility failed to administer medications on the written order of a physician and failed to keep the MARs current for 3 of 3 audited clients (#1, #2, and #3). The findings are: Finding #1: Review on 02/12/25 of client #1's record revealed: - Admission date of 02/26/08. - Diagnoses of Mild Intellectual Developmental Disabilities (IDD), Elevated Cholesterol, Hypercholesterolemia and Anxiety. Review on 02/13/25 of a client #1 physician order dated 01/27/25 revealed Naproxen (pain reliever) 500 milligrams (mg) - 1 tablet twice daily for 15 days. Review on 02/12/25 of client #1's February 2025 MAR revealed: - No staff initials to indicate the Naproxen was administered as ordered on 02/08/25 and 02/09/25 at 8pm. Interview on 02/13/25 client #1 stated: - He had resided at the facility for several years. - He did not recall the names of his medications.	V 118		

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V 118	Continued From page 2 - He received his medications daily. Finding #2: Review on 02/12/25 of client #2's record revealed: - Admission date of 12/19/22. - Diagnosis of Mild IDD. Review on 02/13/25 of a physician order for client #2 dated 10/23/24 revealed; - Topicort (inflammation and itching) 0.25% topical cream - apply 1 application twice daily. Review on 02/12/25 of client #2's February 2025 MAR revealed: - Topicort was transcribed to apply topically at 8am and 8pm. - The letter "D" was entered in the section for staff initials to indicate administration of Topicort 02/05/25 at 8pm, 02/06/25 thru 02/11/25 at 8am and 8pm and 02/12/25/25 at 8am. - The letter "D" was not on the key for omissions on the MAR. Observation on 02/12/25 at approximately 12:25pm of client #2's medications revealed: - An empty tube of Topicort 0.25% cream dispensed from the pharmacy on 01/02/25. - No additonal applications could be extracted from the tube for administration. Interview on 02/12/25 client #2 stated: - He had resided at the facility. - He had been to the doctor and received a medication for dry skin (Topicort). - He was supposed to used the dry skin medication twice daily. - He did not have any dry skin medication. Finding #3:	V 118		

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V 118	Continued From page 3 Review on 02/12/25 of client #3's record revealed: - Admission date of 05/24/06. - Diagnoses of Moderate IDD, Impulse Control Disorder, Seizure Disorder, Bipolar Disorder, Major Depressive Disorder, Epilepsy, Seasonal Allergies, Anemia, Athlete's Feet and Anemia. Review on 02//13/25 of client #3's physician orders dated 07/10/24 revealed: - Nystatin Powder (antifungal) - apply to affected area twice daily. - Carbamazepine (seizures) 200mg - take one tablet three times daily. Review on 02/12/25 of client #3's January 2025 and February 2025 MARs revealed: January 2025 - No staff initials to indicate Carbamazepine 1/15/25 and 01/26/25 at 8pm. - The letter "D" was entered in the section for staff initials to indicate administration of Nystatin Powder 01/06/25 thru 01/10/25 at 8am and 8pm, 01/11/25 at 8pm, 01/12/25 at 8pm, 01/13/25 thru 01/16/25 at 8am and 8pm, 01/29/25 thru 01/31/25 at 8am and 8pm.. February 2025 - The letter "D" was entered in the section for staff initials to indicate administration of Nystatin Powder 02/01/25 at 8pm, 02/02/25 at 8pm, 02/03/25 thru 02/10/25 at 8am and 8pm, 02/11/25 at 8am and 02/12/25 at 8pm. Observation on 02/12/25 at approximately 1:15pm of client #3's medications revealed no Nystatin Powder available for administration. Interview on 02/12/25 client #3 was not able to recall if he had missed his Nystatin powder.	V 118		

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V 118	Continued From page 4 Interview on 02/13/25 staff #1 stated: - She had worked at the facility for 6 years. - Client #3's Nystatin Powder was supposed to be administered twice daily. - When medications run out they let the pharmacy know. Interview on 02/12/25 staff #4 stated: - He did not recall running out of medications. - Staff complete incidents reports for missed medications. Interview on 02/13/25 the Vice President stated: - Staff may have forgotten to initial the MARs in areas. - The topical and powder medications were "timed" by the pharmacy and sent at specific intervals. - She had spoken with staff about why the letter "D" was on the MARs. - Staff reported the letter "D" was on the key for the previous MARs for medication not available. - She would follow up with the pharmacy to ensure medications did not run out. Due to failure to accurately document medication administration, it could not be determined if clients 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	V 123		

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V 123	Continued From page 5 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: Based on record reviews and interviews the facility failed to ensure all medication administration errors were immediately reported to a pharmacist or physician affecting 2 of 3 audited clients (#2 and #3). The findings are: Finding #1: Review on 02/12/25 of client #2's record revealed: - Admission date of 12/19/22. - Diagnosis of Mild IDD. - No documentation the physician or pharmacist had been notified immediately of any medication administration errors in February 2025. Review on 02/13/25 of a physician order for client #2 dated 10/23/24 revealed; - Topicort (inflammation and itching) 0.25% topical cream - apply 1 application twice daily. Review on 02/12/25 of client #2's February 2025 MAR revealed: - Topicort was transcribed to apply topically at 8am and 8pm. - The letter "D" was entered in the section for staff initials to indicate administration of Topicort 02/05/25 at 8pm, 02/06/25 thru 02/11/25 at 8am and 8pm and 02/12/25/25 at 8am. - The letter "D" was not on the key for omissions	V 123		

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V 123	Continued From page 6 on the MAR. Observation on 02/12/25 at approximately 12:25pm of client #2's medications revealed: - An empty tube of Topicort 0.25% cream dispensed from the pharmacy on 01/02/25. - No additonal applications could be extracted from the tube for administration. Interview on 02/12/25 client #2 stated: - He had resided at the facility. - He had been to the doctor and received a medication for dry skin (Topicort). - He was supposed to used the dry skin medication twice daily. - He did not have any dry skin medication. Finding #2: Review on 02/12/25 of client #3's record revealed: - Admission date of 05/24/06. - Diagnoses of Moderate IDD, Impulse Control Disorder, Seizure Disorder, Bipolar Disorder, Major Depressive Disorder, Epilepsy, Seasonal Allergies, Anemia, Athlete's Feet and Anemia. - No documentation the physician or pharmacist had been notified immediately of any medication administration errors in January 2025 or February 2025. Review on 02//13/25 of client #3's physician orders dated 07/10/24 revealed: - Nystatin Powder (antifungal) - apply to affected area twice daily. - Carbamazepine (seizures) 200mg - take one tablet three times daily. Review on 02/12/25 of client #3's January 2025 and February 2025 MARs revealed: January 2025	V 123		

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V 123	Continued From page 7 - No staff initials to indicate Carbamazepine 1/15/25 and 01/26/25 at 8pm. - The letter "D" was entered in the section for staff initials to indicate administration of Nystatin Powder 01/06/25 thru 01/10/25 at 8am and 8pm, 01/11/25 at 8pm, 01/12/25 at 8pm, 01/13/25 thru 01/16/25 at 8am and 8pm, 01/29/25 thru 01/31/25 at 8am and 8pm.. February 2025 - The letter "D" was entered in the section for staff initials to indicate administration of Nystatin Powder 02/01/25 at 8pm, 02/02/25 at 8pm, 02/03/25 thru 02/10/25 at 8am and 8pm, 02/11/25 at 8am and 02/12/25 at 8pm. Observation on 02/12/25 at approximately 1:15pm of client #3's medications revealed no Nystatin Powder available for administration. Interview on 02/12/25 client #3 was not able to recall if he had missed his Nystatin powder. Interview on 02/13/25 the Vice President stated: - The topical and powder medications were "timed" by the pharmacy and sent at specific intervals. - She had spoken with staff about why the letter "D" was on the MARs. - Staff reported the letter "D" was on the key for the previous MARs for medication not available. - Staff should notify the physian or pharmacist when medication errors occurred. - She would follow up with the facility staff regarding the lack of notification of missed medications to the physician or pharmacist.	V 123		
V 366	27G .0603 Incident Response Requirements	V 366		

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V 366	Continued From page 8 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; (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	V 366		

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V 366	Continued From page 9	V 366		

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 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

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V 366	Continued From page 10 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 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 record review and interview, the facility failed to ensure Level I incident reports were completed for any medication errors for two of three audited clients (#2 and #3). The findings are: Review on 02/12/25 of facility records from December 2024 thru February 2025 revealed no level I or II incident reports for medication errors for client #2 or client #3 Finding #1: Review on 02/12/25 of client #2's record revealed: - Admission date of 12/19/22. - Diagnosis of Mild IDD.	V 366		

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V 366	Continued From page 11 Review on 02/13/25 of a physician order for client #2 dated 10/23/24 revealed; - Topicort (inflammation and itching) 0.25% topical cream - apply 1 application twice daily. Review on 02/12/25 of client #2's February 2025 Medication Administration Records (MAR) revealed: - Topicort was transcribed to apply topically at 8am and 8pm. - The letter "D" was entered in the section for staff initials to indicate administration of Topicort 02/05/25 at 8pm, 02/06/25 thru 02/11/25 at 8am and 8pm and 02/12/25/25 at 8am. - The letter "D" was not on the key for omissions on the MAR. Observation on 02/12/25 at approximately 12:25pm of client #2's medications revealed: - An empty tube of Topicort 0.25% cream dispensed from the pharmacy on 01/02/25. - No additonal applications could be extracted from the tube for administration. Interview on 02/12/25 client #2 stated: - He had resided at the facility. - He had been to the doctor and received a medication for dry skin (Topicort). - He was supposed to used the dry skin medication twice daily. - He did not have any dry skin medication. Finding #2: Review on 02/12/25 of client #3's record revealed: - Admission date of 05/24/06. - Diagnoses of Moderate IDD, Impulse Control Disorder, Seizure Disorder, Bipolar Disorder, Major Depressive Disorder, Epilepsy, Seasonal Allergies, Anemia, Athlete's Feet and Anemia.	V 366		

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V 366	Continued From page 12 Review on 02//13/25 of client #3's physician orders dated 07/10/24 revealed: - Nystatin Powder (antifungal) - apply to affected area twice daily. - Carbamazepine (seizures) 200mg - take one tablet three times daily. Review on 02/12/25 of client #3's January 2025 and February 2025 MARs revealed: January 2025 - No staff initials to indicate Carbamazepine 1/15/25 and 01/26/25 at 8pm. - The letter "D" was entered in the section for staff initials to indicate administration of Nystatin Powder 01/06/25 thru 01/10/25 at 8am and 8pm, 01/11/25 at 8pm, 01/12/25 at 8pm, 01/13/25 thru 01/16/25 at 8am and 8pm, 01/29/25 thru 01/31/25 at 8am and 8pm.. February 2025 - The letter "D" was entered in the section for staff initials to indicate administration of Nystatin Powder 02/01/25 at 8pm, 02/02/25 at 8pm, 02/03/25 thru 02/10/25 at 8am and 8pm, 02/11/25 at 8am and 02/12/25 at 8pm. Observation on 02/12/25 at approximately 1:15pm of client #3's medications revealed no Nystatin Powder available for administration. Interview on 02/12/25 client #3 was not able to recall if he had missed his Nystatin powder. Interview on 02/13/25 staff #1 stated: - She had worked at the facility for 6 years. - Client #3's Nystatin Powder was supposed to be administered twice daily. - When medications run out they let the pharmacy know.	V 366		

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V 366	Continued From page 13 Interview on 02/12/25 staff #4 stated: - He did not recall running out of medications. - Staff complete incidents reports for missed medications. Interview on 02/13/25 the Vice President stated: - Staff may have forgotten to initial the MARs in areas. - The topical and powder medications were "timed" by the pharmacy and sent at specific intervals. - She had spoken with staff about why the letter "D" was on the MARs. - Staff reported the letter "D" was on the key for the previous MARs for medication not available. - Staff should complete level I incident reports when medications were missed. - She would follow up with staff on incident reporting.	V 366		