STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-403	A. BUILDING: _____ B. WING _____	02/27/2025

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ASHCRAFT HOME	1351 ASHCRAFT LANE CHARLOTTE, NC 28209

(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 27, 2025. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. The facility is licensed for 6 and has a current census of 6. 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 review and interviews the facility failed to ensure medications were administered on the written order of a physician and failed to ensure MARs were kept current. The findings are: Review of Client #1's record on 2/21/25 revealed: -Admission date 12/1984 -Diagnoses: Cerebral Palsy, Hypertension, Diabetes Mellitus, Obstructive Sleep Apnea and Vitamin D deficiency. -Physician Order dated 1/15/25 for Senna Plus (Constipation) 8.6 Milligrams (mg)-50 mg, 1 tablet twice daily -Physician Order dated 12/4/24 for Novolog Flexpen Syringe (Diabetes), inject 15 Units Subcutaneous (Sub-Q) before each meal -Physician Order dated 12/11/24 for Novolog Flexpen Syringe (Diabetes), Sliding Scale based on blood sugar: 0-139 give 0 units, 140-170 give 1 unit, 171-200 give 2 units, 201-230 give 3 units, 231-260 give 4 units, 261-290 give 5 units, 291-320 give 6 units, 320+ give 7 units -Physician Order dated 12/5/24 to check blood sugar before and after breakfast, lunch, and dinner Review of Client #1's MARs on 2/21/25 revealed:	V 118		

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V 118	Continued From page 2 -No documentation to reflect Senna Plus 8.6mg-50mg administered on the following dates: 1/15/25, 1/16/25, 1/17/25, 1/18/25, 1/19/25 and 1/20/25 at 8:00 AM - No documentation to reflect Novolog Flexpen syringe, 15 units had been administered on 12/15/24 at 5:30PM and 12/28/24 at 5:30 PM - No documentation to reflect Novolog Flexpen Syringe sliding scale had been administered on 12/15/24 at 5:30PM and 12/28/24 at 5:30 PM - No documentation to reflect blood sugar was checked on the following dates and times: 12/12/24 (12:30 PM to 2:00 PM), 12/13/24 (12:30 to 2:00 PM), 12-14-24 (8:30 AM to 10:00 AM and 12:30 PM to 2:00 PM), 12-15-24 (5:00 PM to 7:00 PM), 12/19/24 (12:30 PM to 2:00 PM and 5:00 PM to 7:00 PM), 12/20/24 (12:30 PM to 2:00 PM), 12/21/24 (12:30 PM to 2:00 PM), 12/23/24 (12:30 PM to 2:00 PM) 12/27/24 (12:30 PM to 2:00 PM), 1/2/25 (12:30 PM- 2:00 PM), 1/3/25 (12:30- 2:00 PM), 1/4/25 (12:30 PM- 2:00 PM) and 1/10/25 (12:30 PM- 2:00PM) Interview with Client #1 on 2/21/25 revealed: - Knew he had diabetes - Knew he took medication for diabetes - Staff took his blood sugar readings daily - Staff administered his medication everyday Interview with Staff #2 on 2/25/25 revealed: - Staff took blood sugar readings four times a day, before and after breakfast lunch and dinner - Had not called the nurse recently for high blood sugar readings - Before starting sliding scale called nurse more Interview with the Group Home Manager on 2/25/25 revealed: -The pharmacy was located approximately 2 hours a way, which made it difficult to obtain the	V 118		

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V 118	Continued From page 3 medication (Senna Plus) due to the distance. "We only use a local pharmacy for antibiotics or pain medications". -Was not aware the Novolog Flexpen syringe 15 Units or the Novolog Flexpen syringe sliding scale had not been administered on 12/15/24 or 12/28/24 - MARs are electronic and the internet may have been down - "We have issues with the internet, the system will jump offline and then we have a blank on the MAR" Due to the 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 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 review and interviews, the facility failed to immediately report medication	V 123		

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V 123	Continued From page 4 errors to a physician or pharmacist affecting 1 of 3 audited clients (#1). The findings are: Review on 2/21/25 of Client #1's record revealed: - Admission date 12/1984 - Diagnoses: Cerebral Palsy, Hypertension, Diabetes Mellitus, Obstructive Sleep Apnea and Vitamin D deficiency. - Physician Order dated 1/15/25 for Senna Plus (Constipation) 8.6 Milligrams (mg)-50mg, 1 tablet twice daily - No documentation in the facility's records from 1/1/25 to 1/31/25 to reflect Senna Plus 8.6 Milligrams (mg)-50mg administered on the following dates: 1/15/25, 1/16/25, 1/17/25, 1/18/25, 1/19/25 and 1/20/25 at 8:00 AM - No documentation to reflect a physician or pharmacist was notified on 1/15/25, 1/16/25, 1/17/25, 1/18/25, 1/19/25, and 1/20/25 at 8:00 AM for the Senna Plus 8.6mg-50mg twice daily had not been administered - Physician Order dated 11/4/24 for Novolog Flexpen Syringe, inject 15 Units Subcutaneous (Sub-Q) before each meal - Physician Order dated 12/11/24 for Novolog Flexpen Syringe, Sliding Scale based on blood sugar reading: 0-139 give 0 units, 140-170 give 1 unit, 171-200 give 2 units, 201-230 give 3 units, 231-260 give 4 units, 261-290 give 5 units, 291-320 give 6 units, 320+ give 7 units - No documentation to reflect a physician or pharmacist had been notified on 12/15/24 or 12/28/24 for the Novolog Flexpen syringe 15 Units (before meals) at 5:30 PM had not been administered - No documentation to reflect a physician or pharmacist had been notified on 12/15/24 and 12/28/24 for the Novolog Flexpen sliding scale at 5:30 PM had not been administered - Physician Order dated 7/17/24 for Bisacodyl	V 123		

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V 123	Continued From page 5 10MG Suppository (Constipation) 1 suppository Tuesday and Friday - MAR from 12/1/24 through 12/31/24 reflected Client #1 refused Bisacodyl 12/3/24, 12/5/24 and 12/13/24 - No documentation to reflect a physician or pharmacist had been notified on 12/3/24, 12/5/24 and 12/13/24 -MAR from 1/1/25 through 1/31/25 reflected Client #1 refused Bisacodyl on 1/3/25, 1/7/25, 1/10/25, 1/21/25, 1/24/25 and 1/31/25 - No documentation to reflect a physician or pharmacist had been notified of Client #1's refusal of Bisacodyl on 1/3/25, 1/7/25, 1/10/25, 1/21/25, 1/24/25 and 1/31/25 Interview with Client #1 on 2/26/25 revealed: - He refused the suppository - "I have a right to refuse my medications" Interview with the Group Home Manager on 2/25/25 revealed: - "We have issues with the internet, the system will jump offline and then we have a blank on the MAR" - Staff should have used a paper MAR when the system was down - Staff should have contacted a pharmacist or physician with medication errors - Staff should have documented an incident report	V 123		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more	V 291		

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V 291	Continued From page 6 than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure service coordination was maintained with other professionals responsible for treatment for 1 of 3 audited clients (#1). The findings are: Review on 2/21/25 of Client #1's record revealed : - Admission date 12/1984 - Diagnoses: Cerebral Palsy, Hypertension,	V 291		

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V 291	Continued From page 7 Diabetes Mellitus, Obstructive Sleep Apnea and Vitamin D deficiency - MAR for 1/1/25 through 1/31/25 with instructions for blood pressure checks daily at 8:00 am inform the Registered Nurse (RN) if systolic (top value) is >200 or diastolic (bottom value) is >100 - Blood pressure readings for the following dates: 1/1/25 (193/123); 1/3/25 (231/160); 1/4/25 (202/104); 1/5/25 (215/113); 1/6/25 (208/104); 1/7/25 (220/155); 1/10/25 (198/114); 1/17/25 (229/142); 1/18/25 (118/136) - No documentation to reflect the RN was notified on those dates of the blood pressure reading - No physician order for the blood pressure checks was provided by time of exit Interview with Client #1 on 2/26/25 revealed: -The cuff was not too tight on his wrist when staff took his blood pressure Interview with the Group Home Manager on 2/25/25 revealed: - The RN reviewed the MARs periodically - Uncertain who ordered the blood pressure readings daily but thought it was the RN Interview with the facility's RN on 2/27/25 revealed: - She was contacted by staff one time about Client #1's high blood pressure readings - Was not made aware of other incidences of high blood pressure readings - Client #1's physician ordered the blood pressure readings - Wanted to be contacted to determine additional symptoms that may warrant further evaluation Interview with the medical assistant for Client #1's physician on 2/26/25 revealed:	V 291		

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V 291	Continued From page 8 - Client #1's physician did not order the blood pressure readings - Blood pressure was normal when he came to his appointments - Client #1 reported to the physician the blood pressure cuff at the group home was too tight so that may have been the reason the readings at the group home were high Interview with the Pharmacist on 2/26/2025 revealed: - The pharmacy transcribed the medication administration information on the MAR, but did not add the blood pressure readings to the MAR -The pharmacy was not responsible for putting directives on the MAR -The pharmacist was able to see the electronic MAR and reported the RN added the instructions to check Client #1's blood pressure to the MAR - Did not know who ordered the blood pressure readings Interview with the facility's State Director on 2/27/25 revealed: - The RN can't make her own directives - All medical directives have to be ordered by the physician	V 291		
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 9	V 366		

(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

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V 366	Continued From page 10 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	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 366	Continued From page 11 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 interviews the facility failed to maintain documentation of level I incidents. The findings are: Review of Client #1's record on 2/21/25 revealed: - Admission date 12/1984 - Diagnoses: Cerebral Palsy, Hypertension, Diabetes Mellitus, Obstructive Sleep Apnea and Vitamin D deficiency. -- Physician Order dated 1/15/25 for Senna Plus Tablet 8.6mg-50mg (Milligrams), 1 tablet (tab) twice daily (BID) - MAR from 1/1/25 to 1/31/25 with no documentation to reflect Senna Plus Tab 8.6mg-50mg (BID) administered on the following dates: 1/15/25, 1/16/25, 1/17/25, 1/18/25, 1/19/25 and 1/20/25 at 8:00 AM - Physician Order dated 12/11/24 for Novolog Flexpen Syringe, Sliding Scale based on BG (blood sugar): 0-139 give 0 units, 140-170 give 1 unit, 171-200 give 2 units, 201-230 give 3 units, 231-260 give 4 units, 261-290 give 5 units, 291-320 give 6 units, 320+ give 7 units - MAR from 12/1/24 to 12/31/24 with no documentation to reflect Novolog Flexpen syringe, 15 units administered on 12/15/24 at	V 366		

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V 366	Continued From page 12	V 366		

5:30PM and 12/28/24 at 5:30 PM and no documentation to reflect Novolog Flexpen Syringe sliding scale administered on 12/15/24 at 5:30PM and 12/28/24 at 5:30 PM.

Review of the facility's level I incident reports on 2/21/25 revealed:
no documentation to reflect the following level I medication errors:
- Senna Plus Tab 8.6mg-50mg (BID) no documentation of administration on 1/15/25, 1/16/25, 1/17/25, 1/18/25, 1/19/25 and 1/20/25 (8:00 AM)
- Novolog Flexpen Sypringe 15 Units no documentation of administration on 12/15/24 (5:30) and 12/28/24 (5:30 PM)
- Novolog Flexpen Sliding Scale according to Blood Sugar Reading no documentation of administration on 12/15/24 (5:30 PM) and 12/28/24 (5:30 PM)
- Bisacodyl 10 MG suppository on no documentation of administration on 12/3/24, 12/6/24 and 12/13/24
- Bisacodyl 10 MG suppository on 1/3/25, 1/7/25, 1/10/25, 1/21/25, 1/24/25 and 1/31/25

Interview with the Group Home Manager on 2/25/25 revealed:
- Staff should have completed an incident report for medication errors
- She would look for all level I incident reports for Client #1

Interview with the Registered Nurse on 2/27/25 revealed:
- Staff should have completed an incident report for medication administration errors
- Staff should notified her with all medication errors
- Staff should have notified the group home

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-403	A. BUILDING: _____ B. WING _____	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHCRAFT HOME	1351 ASHCRAFT LANE CHARLOTTE, NC 28209

(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 366	Continued From page 13 manager with medication errors	V 366		