STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL091-117	A. BUILDING: _____ B. WING _____	R 03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROANOKE AVENUE GROUP HOME	264 S BECKFORD DRIVE HENDERSON, NC 27536

(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 and follow up survey was completed on 3/26/25. 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 5 and has a current census of 4. The survey sample consisted of audits of 2 current clients and 1 former client.	V 000		
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address the client's presenting problem shall be documented.	V 111		

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This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to ensure an admission assessment was completed for 1 of 2 audited current clients (#4) and 1 of 1 former client (FC #5). The findings are:

Review on 3/19/25 client #4's record revealed:
- Admitted: 11/22/21
- Diagnoses: Moderate Intellectual Developmental Disabilities (IDD), Cerebral Palsy, and Intermittent Explosive Disorder
- No documentation of an admission assessment

Review on 3/19/25 FC # 5's record revealed:
- Admitted: 10/01/21
- Diagnoses: GERD (Gastro-Esophageal Reflux DIS with Esophagitis, without bleed, Unspecified Psychosis, Functional Urinary Continence, Essential Hypertension, Generalized Edema, Vitamin B12 deficiency, Cerebral Palsy, Unspecified, Major Depressive Disorder, Single Episode, Unspecified, Anxiety Disorder, Unspecified, and Mild IDD
- Discharged: 9/25/24
- No documentation of an admission assessment

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V 111	Continued From page 2 Interview on 3/24/25 the Qualified Professional (QP) reported: - Been the QP since 2014 - Was responsible for Independent Living Assessments (IDLA) at admission - Hadn't done any admission assessments since he had been employed at the facility - He had seen some admission assessments and they were more detailed than the IDLA but he hadn't done one - The Executive Director (ED) never told him that he had to do admission assessments Interview on 3/25/25 the ED reported: - The QP was responsible for admission assessments - The application for admission as well as the IDLA checklist had all the information on it for admission - The IDLA checklist was their admission assessment - When the "Local Management Entity (LME)" switched, they didn't require them to do a "full" admission assessment - When the new LME took over, she believed "I'm going to guess that it fell through the cracks with all the changes" Further interview on 3/26/25 the ED reported: - "it just fell through the cracks" but she would make sure they started doing the admission assessments again	V 111		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall	V 118		

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V 118	Continued From page 3 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. (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, observation and interview, the facility failed to ensure that the MAR was kept current affecting 1 of 2 audited current clients (#4). The findings are: Review on 3/19/25 of Client # 4's record revealed:	V 118		

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V 118	Continued From page 4 - Admitted: 11/21/21 - Diagnoses: Moderate Intellectual Disabilities, Cerebral Palsy, Intermittent Explosive Disorder - Physician order dated 12/13/24 revealed: - Divalproex Sodium (Sod) Delayed Release (DR) 500 milligrams (mg) tablet (tab), 1 tab every morning and 3 tabs every evening (anti-psychotic) Observation on 3/19/25 at approximately 2:45pm of Client #4's medication label revealed: - Divalproex Sod was filled 2/21/25 - Take 1 tab every morning and 3 tabs every evening Review on 3/19/25 of Client #4's January 2025 MAR revealed: - 8am and 8pm entries were listed for Divalproex Sod for staff to document medication as being administered Review on 3/19/25 of Client # 4's February 2025 - March 2025 MARs revealed: - No 8am entry was listed for staff to document medication as being administered Interview on 3/19/25 Staff #2 reported: - She was responsible for checking medications and the MARs - She checked the MARs with the actual medications when they were delivered to the facility - "it was an oversight as to why it was missed" Interview on 3/20/25 the Qualified Professional (QP) reported: - The facility nurse "mainly" did the MARs and medication checks - He did "spot checks" when he visited the facility to make sure the MARs had been signed	V 118		

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V 118	Continued From page 5 off on Interview on 3/20/25 the Executive Director (ED) reported: - The QP visited the group home monthly to do a documentation check - Medications were one thing the QP needed to check in case the staff and Residential Manager missed something - There was a checklist that included medication checks that the QP used when he visited the facility - Consultant nurses that visited the facility also checked the medications and MARs 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 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following	V 367		

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information:
(1) reporting provider contact and identification information;
(2) client identification information;
(3) type of incident;
(4) description of incident;
(5) status of the effort to determine the cause of the incident; and
(6) other individuals or authorities notified or responding.
(b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:
(1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or
(2) the provider obtains information required on the incident form that was previously unavailable.
(c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:
(1) hospital records including confidential information;
(2) reports by other authorities; and
(3) the provider's response to the incident.
(d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death

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V 367	Continued From page 7 immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to report all Level II incidents to the Local Management Company/Managed Care Organization (LME/MCO) within 72 hours of becoming aware of the incident. The findings are: Review on 3/19/25 of Client # 4's record revealed: - Admitted: 11/21/21	V 367		

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V 367	Continued From page 8 - Diagnoses: Moderate Intellectual Disabilities, Cerebral Palsy, Intermittent Explosive Disorder Review on 3/17/25 of the Incident Response Improvement System (IRIS) revealed: - No entries since 9/20/24 Review on 3/19/25 of the facility's incident report log book revealed: - "On December 10, 2024 when arriving 4pm home B.C complaint of a headache Give BC an Tylenol and told him to relax. At 7pm B.C. was still complaining of an headache so I give BC his PRN (as needed) Baclofen. At 9:30pm B.C was still complaining of an headache. I called nurse [facility nurse] for advice and was told that B.C. needed to be evaluated. I called EMS (emergency medical services) and [client #4] was transported to [local hospital]. Notifications made to Nurse, RM (residential manager), ED (executive director), and QP (qualified professional). Also his mom." Interview on 3/20/25 Client #4 reported: - He went to the hospital in December 2024 - "I just had headaches" Interview on 3/20/25 the QP reported: - He was made aware of incidents in the facility - He did not do IRIS - The ED did the IRIS reports Interview on 3/25/25 the ED reported: - She was responsible for completing IRIS - She was notified by phone call or text depending on the severity of the incident - She did not do an IRIS report for client #4 - She did not know that she needed to do one - She got confused on when to do IRIS	V 367		