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	34G196	A. BUILDING _____ B. WING _____	C 05/29/2025

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(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) COMPLETION DATE
W 000	INITIAL COMMENTS A complaint survey was completed on 5/29/25 for intake #NC00230835. The allegation was substantiated and deficiencies were cited.	W 000		
W 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation and interview the governing body failed to exercise general policy, budget, and operating direction over the facility relative to food supply. The finding is: Observations in the home on 5/29/25 revealed a kitchen pantry which included an additional freezer. Continued observation revealed there was not a sufficient amount of food (can goods (15) and box items (3) or snack items (0) for clients' choice during mealtimes. Further observation revealed eight loaves of expired (2/2024) frozen bread and twelve packages of frozen fish without an expiration date inside the freezer. Subsequent observations in the home revealed the emergency food supply was stored in a kitchen cabinet above the stove. Continued observation revealed there was not a sufficient amount of emergency water (3 packs of 24) and food supplies (about 12 can goods and some drink mix). Further observation revealed the emergency water supply was opened and used daily instead of emergency need only. Interview with the qualified intellectual disabilities professional (QIDP) on 5/29/25 confirmed there	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 104	Continued From page 1 was not enough water and food for the emergency supply and that it should have been stored in a readily accessible storage bin. Continued interview with the QIDP revealed that expired goods should have been discarded and the fish should have been labeled.	W 104		
W 136	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(11) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. This STANDARD is not met as evidenced by: Based on observation, document review, and interviews, the facility failed to have an effective system to assure 5 of 5 clients (#1, #2, #3, #4 and #5) were provided the opportunity to participate in a variety of community integration opportunities. The finding is: Observation in the group home on 5/29/25 from11:45am-1:20pm revealed clients (#1, #2, #3, #4 and #5) to have completed their lunch meal and to transition to various activities of leisure and outdoor activities. Review on 5/29/25 of an activity calendar on the wall in the group home revealed April 2025 calendar was posted and the home manager (HM) had to locate the May 2025 calendar in her desk drawer. Continued review of the April 2025 calendar revealed radio/tv church every Sunday, walk at the park (4/7), dinner out (4/22), and van ride (4/26). Further review revealed there were no tracking logs (van or staff communication logs) or any additional documentation to verify clients participated in any community outings.	W 136		

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W 136	Continued From page 2 Subsequent review of the activity calendars dated December 2024-May 2025 revealed the following: December 2024: radio/tv church every Sunday, lunch out (12/14), van ride (12/21), dinner out (12/30). January 2025: radio/tv church every Sunday, lunch out (1/25), van ride (1/11), dinner out (1/13). February 2025: radio/tv church every Sunday, lunch out (2/8), van ride (2/15), dinner out (2/18). March 2025: radio/tv church every Sunday, lunch out (3/29), van ride (3/8), dinner out (3/12). May 2025: radio/tv church every Sunday, lunch out (5/29), van ride (5/8), dinner out (5/12). Continued review revealed there were no tracking logs (van or staff communication logs) or any additional documentation to verify clients participated in any community outings or attending church outside of watching on tv and listening on the radio. Interview with staff D on 5/29/25 revealed clients participate in various activities in the yard and in the living area. Continued interview with staff D revealed that she was unaware of what activity was scheduled for today and she did not know where the activity calendar was located at the home. Interview with the HM on 5/29/25 revealed clients are taken to the local restaurants and the parks in the community per the calendar and that is the responsibility of the staff to follow the activity calendar to ensure participation. Continued interview with the HM revealed that there is no tracking logs or documentation of the community outings and that the outings usually take place on second shift.	W 136		

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W 136	Continued From page 3 Interview with the qualified intellectual disabilities professional (QIDP) on 5/29/25 revealed that the activity calendar should be current and on the wall in the group home for staff to follow. Continued interview with the QIDP revealed there is no tracking logs or any other documentation to verify the clients are participating in the community outings.	W 136		
W 318	HEALTH CARE SERVICES CFR(s): 483.460 The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to: provide nursing services in accordance to client's needs (W331); ensure medications were administered in accordance with physician's orders (W368); and labeling for drugs and biologicals must be based on currently accepted professional principles and practices (W388). The cumulative effects of these systemic practices resulted in the facility's failure to provide statutory mandated services in the area of health care.	W 318		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record reviews and interviews, Nursing services failed to meet the needs of 1 of 5 clients	W 331		

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(#3) by failing to ensure prescribed seizure medications were available in the home for medication administration. The finding is:

Review of records on 5/29/25 for client #3 revealed a physician's order (P.O.) dated 5/9/25. Continued review of the P.O. revealed client #3 to be prescribed a seizure medication Clobazam 10 mg tablet to be administered via G-tube twice daily at 7:00 AM and 8:00 PM. Further review of records revealed a physician contact form with a physician's order dated 4/28/25 to increase Clobazam 10 mg in the AM and 15 mg in the PM continue Lamotrigine; keep seizure log and bring to appointment.

Subsequent review of records for client #3 for 3 months revealed medication administration records (MAR) to note that the client did not receive her seizure medications ordered for 7:00 AM and 8:00 PM in March with 34 errors, April with 9 errors, and in May the medication record control logs noted 26 errors. Nursing did not have evidence of following up on staff not documenting nor administering client #3's seizure medication until 5/29/25. Nursing did not have evidence of any in-service training with staff to ensure communication regarding increase in seizures, missed dosages, and medications not being available for administration to the client.

Review of seizure record and P.O.'s on 5/29/25 revealed client #3 to have 5 seizures on 5/22/25 and the client received prescribed Diazepam 10 mg rectal gel insert. The client is to receive 5 mg into rectum as needed for seizures more than 5 minutes long or seizure cluster. Continued review of seizure record revealed 3 seizures on 5/23/25 and 6 seizures on 5/27/25 and staff did not follow

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protocol and administer prescribed Diazepam. Nursing was aware of increased seizure activity on 5/27/25 and did not follow-up to verify that the client received her prescribed Diazepam 10 mg.

Review of the medication record control logs on 5/29/25 revealed the 7:00 AM Clobazam 10 mg to not be given 5/1-5/8/25 and 5/21-5/27/25. Continued review of the 8:00 PM Clobazam 15 mg revealed the medication to not be given 5/9-5/12/25 and 5/21-5/27/25. Nursing did not follow up with the pharmacy nor did the staff in the group home to ensure that client #3's new physician's order increasing the client's seizure medications on 4/28/25 was available and that resulted in increased seizures for the client. Staff did not notify nursing when the seizure medication was unavailable.

Interview with the home manager (HM) on 5/29/25 revealed that the facility was investigating client #3 not receiving her seizure medication. Continued interview with the HM revealed that client #3's Clobazam was ordered on 5/27/25 and the client received her 7:00 AM dosage on 5/28/25 and 5/29/25 and 8:00 PM on 5/28/25. Further interview with the HM revealed that the staff was documenting that they gave the medication; however, the seizure medication was not in the facility nor available for administration. Staff did not make nursing aware of the seizure medication Clobazam not being available for administration.

Interview with the facility nurse on 5/29/25 verified that client #3 is prescribed Clobazam 10 mg at 7:00 AM and Clobazam 15 mg at 8:00 PM and had missed dosages of the medication. Continued interview with the facility nurse

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W 331	Continued From page 6 revealed that she noticed that client #3 was having an increase in seizures and noticed discrepancies with staff administering client #3's seizure medication Clobazam. The medication was ordered from the pharmacy on 5/27/25 to ensure the client received her prescribed medication per P.O.'s on 4/28/25; however, no training to staff regarding increase in medication and seizure documentation. Nursing did not communicate with the pharmacy to ensure the delivery of the client's Clobazam was sent to the facility nor did nursing ensure that old medications were returned and disposed of properly.	W 331		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the system for drug administration failed to assure all drugs were administered in compliance with physician orders for 1 of 5 clients in the group home (#3). The finding is: Review of records on 5/29/25 for client #3 revealed a physician's order dated 5/9/25. Continued review of the physician orders revealed client #3 to be prescribed a seizure medication Clobazam 10 mg tablet to be administered via G-tube twice daily at 7:00 AM and 8:00 PM. Further review of records revealed a physician contact form with a physician's orders dated 4/28/25 to increase Clobazam 10 mg in the AM and 15 mg in the PM continue Lamotrigine. Keep seizure log and bring to appointment.	W 368		

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W 368	Continued From page 7 Subsequent review of records for client #3 revealed medication administration records (MAR) for 3/1-3/31/2025 to note missing dosages of Clobazam10 mg at 7:00 AM to be 3/2-3/14/25; 3/18/25, 3/19/25, 3/20/25,3/25/25 and 3/26/25. The missing dosages at 8:00 PM to be 3/1-3/13/25; 3/20, 3/21/25, and 3/27/25. There were a total of 34 missed dosages for client #3 in March and it is unknown if it was due to medication not available. The MAR for 4/1-4/30/25 revealed missing dosages at 7:00 AM to be 4/21/25 and 4/23/25. The missing dosages at 8:00 PM to be 4/1/25, 4/3/25, 4/10/25, 4/14/25, 4/22/25, 4/23/25, and 4/24/25. There were a total of 9 missed dosages for April due to staff error. The MAR for 5/1-5/30/25 revealed staff signatures to indicate administering Clobazam 10 mg medication at 7:00 AM and 8:00 PM except on 5/23/25. There were a total of 26 missed dosages in May due to medication not being available in facility. The medication was ordered on 5/27/25. Review of the medication record control logs on 5/29/25 revealed the 7:00 AM Clobazam 10 mg to not be given 5/1-5/8/25 and 5/21-5/27/25. Continued review of the 8:00 PM Clobazam 15 mg revealed the medication to not be given 5/9-5/12/25 and 5/21-5/27/25. Interview with the home manager (HM) on 5/29/25 revealed that the facility was investigating client #3 not receiving her seizure medication. Continued interview with the HM revealed that client #3's Clobazam was ordered on 5/27/25 and the client received her 7:00 AM dosage on 5/28/25 and 5/29/25 and 8:00 PM on 5/28/25.	W 368		

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W 368	Continued From page 8 Further interview with the HM revealed that the staff was documenting that they gave the medication; however, the seizure medication was not in the facility. Interview with the facility nurse on 5/29/25 verified that client #3 is prescribed Clobazam 10 mg at 7:00 AM and Clobazam 15 mg at 8:00 PM. Continued interview with the facility nurse revealed that she noticed that client #3 was having an increase in seizures and noticed discrepancies with staff administering client #3's seizure medication Clobazam. The medication was ordered from the pharmacy on 5/27/25 to ensure the client received her prescribed medication as ordered. Further interview with the facility nurse revealed that the facility is looking into the medication errors and will implement all recommendations.	W 368		
W 388	DRUG LABELING CFR(s): 483.460(m)(1)(i) Labeling for drugs and biologicals must be based on currently accepted professional principles and practices. This STANDARD is not met as evidenced by: Based on observation and interviews, the facility failed to ensure all medications were labeled appropriately for 1 of 5 audited clients (#2). The finding is: Observations in the group home on 5/29/25 at 1:00 PM revealed a toiletry caddy belonging to client #2 to sit next to the medication cabinet. Continued observations revealed the Home Manager (HM) to take a bottle that was labeled	W 388		

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W 388	Continued From page 9 external use only (House Stock) out of the caddy. Further observation revealed the bottle to be labeled Remedy Phyto plex antifungal. Subsequent observation revealed the bottle had no instructions for administering medication to clients. Interview on 5/29/25 with the HM revealed that client #2 uses the antifungal medication to apply to her breast for rashes. Continued interview with the HM revealed that client #2 has received this medication for a long time. Further interview revealed that staff are not documenting client #2's rashes on the body check form. Interview on 5/29/25 with staff C revealed that client #2 is prescribed an ointment called Calmoseptine ointment that is applied to her breast for rashes. Continued interview revealed that the rash comes and goes and staff will apply ointment if they see the rash appear. Interview on 5/29/25 with the facility nurse verified that client #2 will use antifungal medication for rashes under the breast from the House Stock. Continued interview with the facility nurse verified that staff should contact the nurse if a rash is observed under the client's breast. Further interview with the nurse verified that the staff have not been in-service trained on House Stock.	W 388		
W 485	DINING AREAS AND SERVICE CFR(s): 483.480(d)(4) The facility must supervise and staff dining rooms adequately. This STANDARD is not met as evidenced by: Based on observation, record review and	W 485		

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W 485	Continued From page 10	W 485		

interview, the facility failed to ensure sufficient supervision in the dining room for 2 of 5 clients (#1 and #2). The findings are:

A. Staff failed to provide supervision during the lunch meal for client #1.

Observations in the home on 5/29/25 revealed client #1 to participate in the lunch meal which included two bologna sandwiches, wheat crackers, sliced oranges, and water. Continued observation revealed client #1 sat at the dining table and stuffed her mouth with her food until she completed her meal. Further observation revealed there were no staff in the dining area providing supervision and were unaware that client #1 stuffed all her food in her mouth.

Review on 5/29/25 of client #1's Nutritional Assessment dated 3/25/25, indicated that client #1 is on a regular, bite-sized, gluten-free, casein-free, double portion diet.

Interview on 5/29/25 with the qualified intellectual disabilities professional (QIDP) revealed staff should provide supervision during all mealtimes.

B. Staff failed to provide supervision during the lunch meal for client #2.

Observations in the home on 5/29/25 revealed client #2 to participate in the lunch meal which included a bologna sandwich, wheat crackers, sliced oranges, and water. Continued observation revealed client #2 sat at the dining table and ate her oranges then threw away the rest of her lunch into the trashcan. Further observation revealed there were no staff in the dining area providing supervision and were unaware that client #2

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W 485	Continued From page 11 threw her food away. Additional observation revealed client #2 left the table and sat in the living room area; staff did not offer her any other food options. Review on 5/29/25 of client #2's Nutritional Assessment dated 6/6/24, indicated that client #2 is on a 1500 calorie ADA, bite-sized pieces with no seconds. Food is cut into bite-sized pieces to prevent over stuffing of mouth with possible choking. Interview on 5/29/25 with the QIDP revealed staff should provide supervision during all mealtimes.	W 485		