Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL059-088	A. BUILDING: _____ B. WING _____	10/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TURNING POINT GROUP HOME	505 EAST PAYNE ROAD MARION, NC 28752

(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 October 23, 2025. 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 6 and has a current census of 5. 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 interview, the facility failed to ensure medication was administered to a client only on the written order of a physician affecting 1 of 3 audited clients (Client#2), and failed to keep MARs current affecting 2 of 3 audited clients (Client#2 and Client#3). The findings are: Review on 10/21/25 of Client#2's record revealed: -Date of Admission: 4/1/20. -Diagnoses: Down Syndrome; Gastroesophageal Reflux Disease (GERD); Depression; Barrett's Esophagus; Vitamin B12 Deficiency; Stage III Chronic Kidney Disease; Moderate Intellectual Developmental Disability. -Physician's orders included: -Debrox (ear wax buildup) 6.5% ear wax removal administer 5 drops to the right ear twice daily (BID) every other day dated 12/11/24 and 9/3/25. -Metronidazole 0.75% cream (antibiotic) apply topically BID dated 5/30/25. -Refresh Liquigel 1% ophthalmic solution (eye lubricant) instill 1 drop to both eyes BID dated 5/30/25. -Polyethylene Glycol (PEG) powder (laxative) 1 capful mixed with water/juice daily dated 9/4/25.	V 118	**Issues Noted V118:** *1- The facility failed to ensure medication was administered to a client only on the written order of a physician affecting 1 of 3 audited clients (Client#2)* -No physician's order for Trazodone. -"[Client#2] was given a 100 mg tablet of Trazodone, which she took..." *2- The facility failed to keep MARs current affecting 2 of 3 audited clients (Client#2 and Client#3).* -Client#2's MARs dated 8/1/25-10/21/25 revealed: •Debrox was initialed as administered 1-3 times every day (instead twice per day, every other day) 9/1/25 through 9/9/25 as follows: twice on 9/1/25; three times on 9/2/25, 9/3/25 and 9/4/25; twice on 9/5/25; three times on 9/7/25; twice on 9/8/25; and three times on 9/9/25. •Debrox was initialed as administered twice per day every day (instead of every other day) 10/1/25 through 10/17/25. •Both the Metronidazole and Refresh Liquigel were not initialed as administered at 8:00 pm on 10/20/25, or 8:00 am on 10/21/25. •PEG powder was initialed as administered 9/4/25-9/9/25. •Zeasorb Powder was not initialed as administered at 8:00 pm on 10/20/25, or 8:00 am on 9/19/25 and 10/21/25. -Client#3's MARs dated 8/1/25-10/21/25 revealed: •Fluconazole was initialed as administered every day (instead of once per week) 8/1/25-10/21/25. -Interview on 10/23/25 with the local pharmacist revealed: •4 tablets of Fluconazole were dispensed for Client#3 on 5/12/25 and again on 10/22/25. •There were no other refills and the Fluconazole would have been packaged separately from Client#3's other medications. **Root Cause:** *1-Staff handed Client #1 medication to Client #2 by accident.* *2-Staff failed to follow medication orders when administering medications. Staff failed to document medication given on correct days.*	

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V 118	Continued From page 2 -Zeasorb powder (antifungal) apply BID dated 5/30/25. -No physician's order for Trazodone. Review on 10/23/25 of an "Abound Health - Level I Incident Report" dated 9/29/25 revealed: -Former Staff#1 "was in the process of administering evening medication when she accidentally handed [Client#2] another client's (Client #1's) medication." -"[Client#2] was given a 100 mg tablet of Trazodone, which she took..." -"The staff contacted the manager, who subsequently called the pharmacist...The pharmacist stated that [Client#2] would feel drowsy but have no ill effects..." Review on 10/21/25 of Client#2's MARs dated 8/1/25-10/21/25 revealed: -Debrox was initialed as administered 1-3 times every day (instead twice per day, every other day) 9/1/25 through 9/9/25 as follows: -twice on 9/1/25; three times on 9/2/25, 9/3/25 and 9/4/25; twice on 9/5/25; three times on 9/7/25; twice on 9/8/25; and three times on 9/9/25. -Debrox was initialed as administered twice per day every day (instead of every other day) 10/1/25 through 10/17/25. -Both the Metronidazole and Refresh Liquigel were not initialed as administered at 8:00 pm on 10/20/25, or 8:00 am on 10/21/25. -PEG powder was initialed as administered 9/4/25-9/9/25. -Zeasorb Powder was not initialed as administered at 8:00 pm on 10/20/25, or 8:00 am on 9/19/25 and 10/21/25. Review on 10/21/25 of Client#3's record revealed: -Date of Admission: 6/7/21.	V 118	**Corrective Measures:** *-To address the deficiencies in MAR documentation, Group Home DSPs and Group Home manager will undergo retraining in Medication Administration. Group Home QP will undergo retraining in MAR & Medication Training for Supervisors. This will be completed by 11/30/2025.* *-Group Home DSPs and Group Home Manager will receive coaching regarding the importance of working with one client at a time when administering medications to avoid mix-ups and ensure full attention is given to each individual. Coaching for some staff was completed on 11/6/2025. Remaining staff will be coached and documentation completed by 11/19/25.* *- Group Home DSPs and Group Home Manager will also be coached on double-checking client identity and medication labels before giving any meds, to make sure the right client is getting the right medication at the right time. Coaching for some staff was completed on 11/6/2025. Remaining staff will be coached and documentation completed by 11/19/25.* *-Group Home DSPs and Group Home Manager will receive coaching regarding improper record keeping. Coaching for some staff was completed on 11/6/2025. Remaining staff will be coached and documentation completed by 11/19/25.* *-QP will receive coaching regarding failure to complete medication reviews appropriately. Coaching for some staff was completed on 11/6/2025. Remaining staff will be coached and documentation completed by 11/19/25.* **Preventative Measures:** *-Group Home DSPs and Group Home Manager will be required to re-take Medication Administration training. This will be completed by 11/30/2025.* *-Group Home QP will be required to re-take MAR & Medication Training for Supervisors. This will be completed by 11/30/2025.* *-QP will review the MAR and orders monthly. QP will complete a monthly MAR review check tool to ensure that MARs and orders are current and that any medication changes are noted correctly.* *-Residential Manager and Regional Manager will complete quarterly medication reviews for each client at Turning Point Group Home for the next 6 months. Each client's review will be documented using the MAR review check tool.*	11/30/25 11/19/25 11/19/25 11/19/25 11/19/25 11/30/25 11/30/25 5/31/26

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V 118	Continued From page 3 -Diagnoses: Moderate Intellectual Developmental Disability; Hypertension; Hypercholesterolemia; Type II Diabetes; Chronic Kidney Disease. -Physician's orders included: Fluconazole (antifungal) 200 milligrams (mg) 1 tablet once per week for 6 months dated 5/12/25. Review on 10/21/25 of Client#3's MARs dated 8/1/25-10/21/25 revealed: -Fluconazole was initialed as administered every day (instead of once per week) 8/1/25-10/21/25. Interview on 10/23/25 with the local pharmacist revealed: -4 tablets of Fluconazole were dispensed for Client#3 on 5/12/25 and again on 10/22/25. -There were no other refills and the Fluconazole would have been packaged separately from Client#3's other medications. Interview on 10/21/25 with Staff#1 revealed: -Staff were supposed to administer medications for "one client at a time." -"[Client#2] got [Client#1's] meds (medications)...She (Former Staff#1) could have pre-popped meds..." -Debrox was administered to Client#2 as ordered by the physician, "I'm sure she got it every other day, even though I marked it (Client#2's MAR) every day..." -She had "missed page 2" of Client#2's October 2025 MAR and hadn't noticed there were errors. -Client#3's doctor ordered Fluconazole to be taken for 4 weeks. "I think the doctor said 'I'm gonna give it (Fluconazole) to him (Client#3) for a month.'" Interview on 10/21/25 with the Residential Coordinator revealed: -"Staff just aren't paying attention and marking	V 118	**Who will monitor and How often:** *-QP will review the MAR and orders monthly. QP will complete a monthly MAR review check tool to ensure that MARs and orders are current and that any medication changes are noted correctly.* *-Residential Manager and Regional Manager will complete quarterly medication reviews for each client at Turning Point Group Home for the next 6 months. Each client's review will be documented using the MAR review check tool.* **Timetable for Correction:** *-All re-training will be completed by 11/30/2025.* *-All coaching will be completed and documented by 11/19/2025.* *-Medication reviews completed by Residential Manager and Regional Manager for Turning Point Group Home will be completed by 5/31/2026.*	5/31/26 11/30/25 11/19/25 5/31/26

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V 118	Continued From page 4 the MAR." -It had been "a while" since she had been to the facility.	V 118	**Issues Noted V119:** *1- The facility failed to dispose of medication in a manner that guarded against diversion or accidental ingestion affecting 1 of 3 audited clients (Client#2).* -Observation on 10/21/25 at approximately 1:00 pm of Client#2's medications revealed: •Zeasorb powder expired in January 2025. -Review on 10/21/25 of Client#2's MARs dated 8/1/25-10/21/25 revealed: •Zeasorb Powder was initialed as administered BID 8/1/25-8/31/25, 9/1/25-9/10/25, 9/20/25-9/30/25, and 10/1/25-10/19/25. **Root Cause:** *-Staff failed to properly dispose of medications once the medication expired.* **Corrective Measures:** *-To address the deficiencies in proper medication disposal, Group Home DSPs and Group Home manager will undergo retraining in Medication Administration. Group Home QP will undergo retraining in MAR & Medication Training for Supervisors. This will be completed by 11/30/2025.*	11/30/25
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge.	V 119	*-Group Home DSPs and Group Home Manager will receive coaching regarding the importance of following correct procedures for disposing of medications and the understanding of why proper disposal matters. Coaching for some staff was completed on 11/6/2025. Remaining staff will be coached and documentation completed by 11/19/25.* **Preventative Measures:** *-Group Home DSPs and Group Home Manager will be required to re-take Medication Administration training. This will be completed by 11/30/2025.* *-Group Home QP will be required to re-take MAR & Medication Training for Supervisors. This will be completed by 11/30/2025.* *-QP will review the MAR and orders monthly. QP will complete a monthly MAR review check tool to ensure that MARs and orders are current and that any medication changes are noted correctly.* *-Residential Manager and Regional Manager will complete quarterly medication reviews for each client at Turning Point Group Home for the next 6 months. Each client's review will be documented using the MAR review check tool.*	11/19/25 11/30/25 11/30/25 5/31/26

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V 119	Continued From page 5 This Rule is not met as evidenced by: Based on record review, observation, and interview the facility failed to dispose of medication in a manner that guarded against diversion or accidental ingestion affecting 1 of 3 audited clients (Client#2). The findings are: Review on 10/21/25 of Client#2's record revealed: -Date of Admission: 4/1/20. -Diagnoses: Down Syndrome; Gastroesophageal Reflux Disease (GERD); Depression; Barrett's Esophagus; Vitamin B12 Deficiency; Stage III Chronic Kidney Disease; Moderate Intellectual Developmental Disability. -Physician's orders included: Zeasorb powder (antifungal) apply twice daily (BID) dated 5/30/25. Observation on 10/21/25 at approximately 1:00 pm of Client#2's medications revealed: -Zeasorb powder expired in January 2025. Review on 10/21/25 of Client#2's MARs dated 8/1/25-10/21/25 revealed: -Zeasorb Powder was initialed as administered BID 8/1/25-8/31/25, 9/1/25-9/10/25, 9/20/25-9/30/25, and 10/1/25-10/19/25. Interview on 10/21/25 with the Residential Coordinator revealed: -"Staff just aren't paying attention..." -It had been "a while" since she had been to the facility.	V 119	**Who will monitor and How often:** *-QP will review the MAR and orders monthly. QP will complete a monthly MAR review check tool to ensure that MARs and orders are current and that any medication changes are noted correctly.* *-Residential Manager and Regional Manager will complete quarterly medication reviews for each client at Turning Point Group Home for the next 6 months. Each client's review will be documented using the MAR review check tool.* 5/31/26 **Timetable for Correction:** 11/30/25 *-All re-training will be completed by 11/30/2025.* *-All coaching will be completed and documented by 11/19/2025.* 11/19/25 *-Medication reviews completed by Residential Manager and Regional Manager for Turning Point Group Home will be completed by 5/31/2026.* 5/31/26
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (h) Medication errors. Drug administration errors	V 123		

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V 123	Continued From page 6 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 interview, the facility failed to ensure medication errors were reported immediately to a physician or pharmacist affecting 1 of 3 audited clients (#2). The findings are: Review on 10/21/25 of Client#2's record revealed: -Date of Admission: 4/1/20. -Diagnoses: Down Syndrome; Gastroesophageal Reflux Disease (GERD); Depression; Barrett's Esophagus; Vitamin B12 Deficiency; Stage III Chronic Kidney Disease; Moderate Intellectual Developmental Disability. -Physician's orders included: Zeasorb powder (antifungal) apply twice daily (BID) dated 5/30/25. Review on 10/21/25 of Client#2's MARs dated 8/1/25-10/21/25 revealed: -In the section title Nurse's Medication Notes on the September 2025 MAR, documentation indicated Client#2 "Refused powder (Zeasorb) says her rash is gone..." on 9/2/25 and Zeasorb powder was noted as "waiting on refill," "waiting on script," or "waiting on Dr. refill" on 9/11/25, 9/12/25, 9/15/25, 9/16/25, 9/17/25 and 9/18/25.	V 123	**Issues Noted V123:** *1- The facility failed to ensure medication errors were reported immediately to a physician or pharmacist affecting 1 of 3 audited clients (#2).* - Review on 10/21/25 of Client#2's MARs dated 8/1/25-10/21/25 revealed: •In the section title Nurse's Medication Notes on the September 2025 MAR, documentation indicated Client#2 "Refused powder (Zeasorb) says her rash is gone..." on 9/2/25 and Zeasorb powder was noted as "waiting on refill," "waiting on script," or "waiting on Dr. refill" on 9/11/25, 9/12/25, 9/15/25, 9/16/25, 9/17/25 and 9/18/25. -Review on 10/23/25 of the facility's incident reports dated 8/1/25-10/23/25 revealed: •No documentation of Client#2's missed doses of Zeasorb having been reported immediately to a physician or pharmacist. -Interview on 10/21/25 with Staff#1 revealed: •Client#2 could "refuse her powder (Zeasorb) is she doesn't have a rash...I will...put it in the notes if she refuses..." •Unaware she was supposed to contact the physician or pharmacist. •She would usually inform the doctor of missed doses of medications during the client's next scheduled medical appointment. **Root Cause:** *-Staff did report medication errors to their direct supervisor, did not contact the pharmacist or physician and incident reports were not completed timely.* **Corrective Measures:** -Incident reports have been completed for the days client #2 missed Zeasorb medication. *-To address the deficiencies in proper reporting of medication errors, Group Home DSPs and Group Home manager will undergo retraining in Medication Administration. Group Home QP will undergo retraining in MAR & Medication Training for Supervisors.* *-Group Home DSPs and Group Home Manager will receive coaching regarding the importance of notifying chain of support and medical professional immediately when there are medication erorrs. Coaching for some staff was completed on 11/6/2025. Remaining staff will be coached and documentation completed by 11/19/25.*	10/22/25 11/30/25 11/19/25

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V 123	Continued From page 7 Review on 10/23/25 of the facility's incident reports dated 8/1/25-10/23/25 revealed: -No documentation of Client#2's missed doses of Zeasorb having been reported immediately to a physician or pharmacist. Interview on 10/21/25 with Staff#1 revealed: -Client#2 could "refuse her powder (Zeasorb) is she doesn't have a rash...I will...put it in the notes if she refuses..." -Unaware she was supposed to contact the physician or pharmacist. -She would usually inform the doctor of missed doses of medications during the client's next scheduled medical appointment. Interview on 10/23/25 with the Residential Coordinator revealed: -If a client refused a medication, staff were to call the local pharmacy and inquire about side effects. -Medication refusals were medication errors which required staff to notify the guardian, the Qualified Professional (QP) and the Residential Coordinator. -Staff were to notify the physician and get a refill whenever a medication was unavailable. -Client#2's medication errors "should have been reported to me (Residential Coordinator) or [QP]..." -Staff should have completed an incident report.	V 123	**Preventative Measures:** *-Group Home DSPs and Group Home Manager will be required to re-take Medication Administration training. This will be completed by 11/30/2025.* 11/30/25 *-Group Home QP will be required to re-take MAR & Medication Training for Supervisors. This will be completed by 11/30/2025.* 11/30/25 *-QP will review the MAR and orders monthly. QP will complete a monthly MAR review check tool to ensure that MARs and orders are current and that any medication changes, refusals or missed medications are noted correctly.* *-Residential Manager and Regional Manager will complete quarterly medication reviews for each client at Turning Point Group Home for the next 6 months. Each client's review will be documented using the MAR review check tool.* 5/31/26 **Who will monitor and How often:** *- QP will review the MAR and orders monthly. QP will complete a monthly MAR review check tool to ensure that MARs and orders are current and that any medication changes, refusals or missed medications are noted correctly.* *-Residential Manager and Regional Manager will complete quarterly medication reviews for each client at Turning Point Group Home for the next 6 months. Each client's review will be documented using the MAR review check tool.* 5/31/26 **Timetable for Correction:** *-All re-training will be completed by 11/30/2025.* 11/30/25 *-All coaching will be completed and documented by 11/19/2025.* 11/19/25 *-Medication reviews completed by Residential Manager and Regional Manager for Turning Point Group Home will be completed by 5/31/2026.* 5/31/26	