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	MHL014-087	A. BUILDING: _____ B. WING _____	R 03/13/2018

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THE LANDING	2419 MORGANTON BOULEVARD LENOIR, NC 28645

(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 A follow up survey for the Type B was completed on 3/13/18. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.	V 000	DHSR - Mental Health APR 16 2018 Lic. & Cert. Section	
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. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation	V 118	The position of residential coordinator was established to oversee facility operations. Residential Coordinator has selected specific staff each shift to administer medications and those staff have received additional training in medication administration and documentation from the Program Director. Staff have been assigned to check the med box each day and fill out a log which the Residential Coordinator will check once a week. A memo was distributed to all staff on 3/13/18 that outlines the following: Any time there is a medication error the QI Director, Program Director, and	3/14/18

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V 118	Continued From page 1 with a physician. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to keep the MAR current and failed to follow the written order of a physician affecting 3 of 3 sampled clients (Client #1, #2 and #3). The findings are: Cross Referenced: 10A NCAC 27G .0209 Medications Requirements (Tag V123). Based on record review and interviews, the facility failed to immediately notify a physician or pharmacist of medication errors for 2 of 3 sampled clients (Client #1 and #2). Record review on 3/6/18 for Client #1 revealed: -Admission date of 10/13/17 with diagnoses of Attention Deficit Hyperactivity Disorder (ADHD) and Disruptive Mood Dysregulation Disorder (DMDD). -Age-15 -Physician ordered medications included: -Mupirocin 2% ointment apply to affected areas twice daily for rash ordered 3/3/17. Review on 3/6/18 of February and March 2018 MARs revealed: -Mupirocin was initialed as administered at 8am on 2/29/18. -Mupirocin was blank from March 1-6 (survey entrance) with no discontinue order. Record review on 3/6/18 for Client #2 revealed: -Admission date of 2/2/18 with diagnoses of ADHD, Conduct Disorder, Post-Traumatic Stress	V 118	Residential Coordinator must be notified when the error is discovered; For each medication error a pharmacist must be notified at the time the error is discovered and staff must document the time, date, and the name of the pharmacist they spoke to; and If a medication is not in the facility to administer when talking to the pharmacist you must follow up with the pharmacist why the medication has not been delivered, and that information must be communicated to the QI Director, Program Director, and the Residential coordinator. Residential Coordinator has been designated as the contact person for southern pharmacy when there are issues with medications to ensure the issue is handled appropriately and in a timely manner.	

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V 118	Continued From page 2 Disorder (PTSD) and Tremors. -Age-16 -Physician ordered medications included: -Primodone 250mg 2 tabs twice daily for tremors ordered 12/21/17. -Strattera 25mg once daily for ADHD ordered 2/16/18. Review on 3/6/18 of February 2018 MAR revealed: -Primodone was not given at 8am on 2/4/18-2/9/18. Notes on back of MAR dated 2/4/18 and 2/7/18 indicated "medication was not in facility." -Primodone was not given at 8pm on 2/6/18-2/9/18. -Strattera was not initialed as administered until 2/22/18 (6 days after ordered). Record review on 3/6/18 for Client #3 revealed: -Admission date of 11/3/17 with diagnoses of Oppositional Defiant Disorder, ADHD and Persistent Depressive Disorder. -Age-15 -Physician ordered medications included: -Cetirizine 10mg 1 tab at bedtime for allergies -Trazodone 50mg 1 ½ tabs at bedtime for sleep -Aptensio XR 20mg once daily for ADHD -Intuniv 4mg once daily for ADHD Review on 3/6/18 of February and March 2018 MARs revealed: -Cetirizine was not initialed as administered on 2/6/18. -Trazodone was not initialed as administered on 2/6/18. -Aptensio was documented twice - initialed as administered on 2/7/18 on handwritten MAR and on 2/7/18 on typed pharmacy MAR. -Intuniv was initialed as administered on 2/7/18	V 118	Residential coordinator will ensure that all MARS are current and up to date. Residential Coordinator reviewed policies at the staff meeting and is responsible for monitoring floor staff's competency in medication administration and documentation. Residential coordinator will review the MARs at least once a week to ensure they are accurate and up to date and will keep a log of with the time and date of each review and alert the QI Director if there are any issues. QI director will meet with the residential coordinator monthly to review MARs, and logs.	

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V 118	Continued From page 3 on handwritten MAR and on 2/7/18 on typed pharmacy MAR. -According the medication count written above initials on each MAR revealed the Intuniv supply ran out on 2/13/18, 2 days prior to the discontinue order dated 2/15/18. Review on 3/6/18 of Medication Error Level 1 Incident Reports from 2/2/18-3/6/18 revealed: -5 Medication Error/Level 1 incident reports. -2 Medication Error/Level 1 incident reports regarding Client #2 were for "medication undelivered by pharmacy." Incidents occurred 2/6/18-2/9/18 and 2/4/18-2/9/18. Review on 3/8/18 of Group Supervision Meetings revealed: -Meeting on 12/20/17, the former Healthcare Coordinator reviewed a new way to document on the MAR. "If the medication has been ordered and is not in the facility it does not have to be put on the MAR sheet until day three. At day three, the Lead QP must be called to inform them the medication is not there." -Meeting on 1/23/18, Staff #1 discussed new pharmacy forms and that Over the Counter (OTC) meds and external medication would be kept in a different cabinet. -Meeting on 2/22/18, the Program Director "spoke first about the current med errors and the plan of correction we are under. What she wants to happen is each person should send her a text if they discover a med error and the staff still have to do an incident report (which should have been done that day) it needs to be sent to the Lead at that time and we should not be negligent ..." Interview on 3/6/18 with Client #1 revealed: -He got his meds every time it was scheduled. -He didn't think he had missed any meds.	V 118		

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V 118	Continued From page 4 Interview on 3/6/18 with Client #2 revealed: -He knew all the meds he took and received them on time. -He did not receive his Primodone for 3-4 days because the pharmacy hadn't delivered it. -His Intuniv had been discontinued. Interview on 3/6/18 with Client #3 revealed: -He received his meds when he was supposed to and never missed any. -He did not believe he ever received a double dose of any meds. Interview on 3/8/18 with Pharmacy Tech revealed: -She had spoken to the neurologist office on 2/8/18 to find they had sent the script to the wrong pharmacy. -Script for Primodone was sent to pharmacy on 2/9/18, was filled and delivered 2/10/18. Interview on 3/8/18 with the Pharmacist revealed: -The Strattera (for Client #2) was an uncommon strength and had to be ordered. -It was filled on 2/19/18 and left the pharmacy with delivery at 8pm. It was delivered to facility lock box on 2/20/18 at 2am. -The pharmacy had a back-up system when emergency meds were needed. -The pharmacy had provided a training for staff on 1/24/18 which included this on-call system for any emergency medication need. Interview on 3/13/18 with outside Contracted RN revealed: -She completed her review on 2/28/18 and gave her audit check-sheets to the Program Director. -She would typically inform the staff of review results but the staff person was outside on the	V 118		

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V 118	Continued From page 5 phone. -She must have overlooked the absence of notes on the back of the MAR for Client #2's Primodone. (No note for 2/5/18 am dose, 2/6/18 am and pm doses, 2/7/18 pm dose, 2/8/18 am and pm doses or 2/9/18 am and pm doses.) -She missed blank spaces on the MAR for Client #3 Trazadone and Zyrtec for 2/6/18. -She missed possible double administration of Intuniv and Aptensio for Client #1 on 2/7/18 which was marked as given on two February MARs. Interview on 3/8/18 with Staff #1 revealed: -She left 2 messages at doctor's office regarding script for Primodone. "When the nurse called back she reported to the Health Care Coordinator (HCC) the script was sent again to the pharmacy." -The HCC sent an email on 2/7/18 to the doctor regarding the Primodone script. -Thought Client #1 was finished with Mupirocin since the rash had cleared despite not having a discontinue order. Interview on 3/8/18 with the Lead QP revealed: -Licensee changed pharmacies to prevent this delay in receiving medications. -Contracted RN completed audit on all meds and MAR on 2/26/18. -"We know we screwed up but we thought the medication (Primodone) was coming." -Staff didn't think to check the lock box on the patio (for the Strattera). Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. Plan of Protection reviewed on 3/13/18 and	V 118		

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V 118	Continued From page 6 signed by QI Director on 3/13/18 revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? -Residential Coordinator will select specific staff each shift to administer medications. -Specific Staff will receive additional training in medication administration and documentation from the Program Director. -Staff will be assigned to check the med box each day and fill out a log. RC will check the log once a week. -A memo will be distributed to all staff on 3/13/18 that outlines the following: -Any time there is a medication error the QI Director, Program Director and Residential Coordinator must be notified when the error is discovered. -For each medication error a pharmacist must be notified at the time of the error is discovered and staff must documents the time, date and name of the pharmacist they spoke to. -If a medication is not in the facility to administer when talking to the pharmacist you must follow up with the pharmacist why the medication has not been delivered and that information must be communicated to the QI Director, Program Director and Residential Coordinator. -Residential Coordinator has been designated as the contact person for Southern Pharmacy when there are issues with medications. -QI Director will complete POC for all documented medications errors and follow up with the Residential Coordinator to follow through with recommendations. -Residential Coordinator will ensure that all MARs are current and up to date. -Residential Coordinator position requires QP status and enhanced knowledge/understanding of medication requirements and facility operations. Describe your plans to make sure the above	V 118		

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V 118	Continued From page 7 happens. Residential Coordinator will review all relevant policies at the upcoming staff meeting and will be responsible for monitoring floor staff's competency in medication administration and documentation. Residential Coordinator will review the MARs at least once a week to ensure they are accurate and up to date and will keep a log with the time and date of each review and alert the QI Director if there are any issues. QI Director will meet with the Residential Coordinator monthly to review MARs and logs." Due to multiple staff not following procedures to prevent delays in obtaining refills or newly prescribed medications, Client #1 was not administered 12 doses of Mupirocin; Client #2 was not administered 10 doses of Primodone or 6 doses of Strattera. Staff falsely documented administering Client # 1's topical ointment on 2/29/18. Because staff failed to correctly document the MAR for Client #3 it cannot be determined if he received Intuniv, Aptensio, Trazodone or Zyrtec as ordered for 2 days. In addition, Client #3 ran out of Intuniv supply 2 days prior to the discontinue order. The outside RN who was contracted to audit medication issues missed multiple concerns in her review. Staff also failed to immediately notify a pharmacist/physician when an ordered medication was not administered. As a result, clients with medical and psychiatric conditions may not have received their medications as prescribed which was detrimental to their health safety and welfare. This deficiency constitutes an Imposed Type B rule violation. An administrative penalty of $200.00 per day is imposed for failure to correct within 45 days.	V 118		

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V 123	Continued From page 8	V 123	The position of residential coordinator was established to oversee facility operations. Residential Coordinator has selected specific staff each shift to administer medications and those staff have received additional training in medication administration and documentation from the Program Director. Staff have been assigned to check the med box each day and fill out a log which the Residential Coordinator will check once a week. A memo was distributed to all staff on 3/13/18 that outlines the following: Any time there is a medication error the QI Director, Program Director, and Residential Coordinator must be notified when the error is discovered; For each medication error a pharmacist must be notified at the time the error is discovered and staff must document the time,	3/14/18
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 notify a physician or pharmacist of medication errors for 2 of 3 sampled clients (Client #1 and #2). The findings are: Record review on 3/6/18 for Client #1 revealed: -Admission date of 10/13/17 with diagnoses of Attention Deficit Hyperactivity Disorder (ADHD) and Disruptive Mood Dysregulation Disorder (DMDD). -Age-15 -Physician ordered medications included: -Mupirocin 2% ointment apply to affected areas twice daily for rash ordered 3/3/17. Record review on 3/6/18 for Client #2 revealed: -Admission date of 2/2/18 with diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), Conduct Disorder, Post-Traumatic Stress Disorder (PTSD) and Tremors. -Age-16	V 123		

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V 123	Continued From page 9 Review on 3/6/18 of Medication Error Level 1 Incident Reports from 2/2/18-3/6/18 revealed: -5 Medication Error/Level 1 incident reports. -2 reports for Client #2 for "medication undelivered by pharmacy (Primodone for tremors)." -Report dated 2/10/18 signed by Staff #1 and Lead Qualified Professional (QP) for "dosage omitted 2/4/18-2/9/18 8am. [Client #2] missed his am dose of Primodone 250mg. Pharmacy did not have script on file. Lead followed up with the prescriber at [local medical center] and determined they had sent the script to the wrong pharmacy. On 2/9/18 [local medical center] sent the script to [local] pharmacy and the medication was delivered on 2/10/18". Time and date of notification and name of pharmacist indicated "see contact log" but no contact log was in use at that time. -Report dated 2/10/18 signed by Staff #1 and Lead QP for "dosage omitted 2/6/18-2/9/18 8pm. [Client #2] missed his pm dose of Primodone 500mg. Pharmacy did not have script on file. Lead followed up with the prescriber at [local medical center] and determined they had sent the script to the wrong pharmacy. On 2/9/18 Wake Forest sent the script to [local] pharmacy and the medication was delivered on 2/10/18". Time and date of notification and name of pharmacist indicated "see contact log" but no contact log was in use at that time. -No reports were available for Client #1 missing Mupirocin for 6 days (3/1/18-3/6/18). Review on 3/8/18 of Disciplinary Notice dated 2/24/18, signed by Lead QP to the current 6 staff (including herself) regarding dates of violation 2/4/18-2/9/18 revealed: "When a client's medicine is not in the facility it is adamant that you inform the lead by means of an	V 123	date, and the name of the pharmacist they spoke to; and If a medication is not in the facility to administer when talking to the pharmacist you must follow up with the pharmacist why the medication has not been delivered, and that information must be communicated to the QI Director, Program Director, and the Residential coordinator. Residential Coordinator has been designated as the contact person for southern pharmacy when there are issues with medications to ensure the issue is handled appropriately and in a timely manner. Residential coordinator will ensure that all MARS are current and up to date. Residential Coordinator reviewed policies at the staff meeting and is responsible for monitoring floor staff's competency	

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V 123	Continued From page 10 incident report which must be done on the shift it was discovered, whether or not you did the med error or not. AND THIS MUST BE DONE EACH DAY THE MEDICINE IS NOT IN THE FACILITY! If it is an am and pm med then both shifts should fill out an incident report. Then the incident report must be scanned directly to [Program Director] and [Quality Improvement (QI) Director]. Due to our facility not following protocol we could cost the company some serious monies in pay backs. PLEASE be aware of this as we work together to keep all of our clients safe." Interview on 3/8/18 with Staff #1 revealed: -"We only ask the pharmacist the 3 questions on the [level 1 incident report] form; 1) This error does not threaten the health or safety of the consumer, 2) This error does threaten the health and safety of the consumer ... or 3) This error will result in permanent physical or psychological impairment ..." -"The PRN (as needed) staff didn't know external medications were moved to the cabinet with the OTCs (over the counter)." -She was responsible for keeping the med cart straight and making sure incident reports were done with med errors. -Created a notebook to communicate changes/updates and re-orders but no staff used it. -Created pharmacy contact log specifically for med errors. -Client #2 had just moved in from sister facility and she thought the other facility had re-ordered all his meds. -She had called the pharmacy on 2/5/18 after Client #2 who moved on 2/2/18 still had no Primodone. -"No one communicated with me and no one took up the slack" on her days off regarding Client #2's	V 123	in medication administration and documentation. Residential coordinator will review the MARs at least once a week to ensure they are accurate and up to date and will keep a log of with the time and date of each review and alert the QI Director if there are any issues. QI director will meet with the residential coordinator monthly to review MARs, and logs.	

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V 123	Continued From page 11 Primodone. -She wrote the incident reports and was told by the Lead QP to combine the dates- to do 1 report for the AM and 1 report for the PM Primodone missed. Interview on 3/8/18 with the Lead QP revealed: -"Yes I wrote up all staff including myself because we all screwed up." -"We just got trained on the incident reports but we didn't follow our procedure." This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (tag V118) for an imposed Type B rule violation.	V 123		