

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>mhl075-013</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/26/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>COOPERRIIS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 HEALING FARM LANE MILL SPRING, NC 28756</b>
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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) COMPLETE DATE
V 000	<p><b>INITIAL COMMENTS</b></p> <p>An annual survey was completed on 4/26/18. A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Individuals with Mental Illness.</p>	V 000		
V 123	<p><b>27G .0209 (H) Medication Requirements</b></p> <p>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.</p> <p>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 1 of 3 sampled clients (Client #1). The findings are:</p> <p>Record review on 4/26/18 for Client #1 revealed: -Admission date of 11/10/16 -Diagnoses of Schizophrenia and Cannabis Use Disorder. -Physician ordered medications included: -Daily Essential Nutrients 4 caps three times a day for nutritional support. -Fish Oil 1 cap twice daily for nutritional support. -L-Methyfolate Calcium 15mg once in the</p>	V 123		

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

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V 123	<p>Continued From page 1</p> <p>morning for nutritional support. -NAC 600mg once in the morning for liver support. Review of February-April MARs for Client #1 revealed: -Daily Essential Nutrients was initialed and circled on 2/2/18, 2/10/18, 3/7/18 and 4/16/18. -Fish Oil was initialed and circled on 2/2/18, 2/10/18, 3/7/18 and 4/16/18. -L-Methyfolate Calcium was initialed and circled on 2/2/18 and 2/10/18. -NAC 600mg was initialed and circled on 2/2/18 and 2/10/18. The exception note for all circled dates indicated Client #1 "did not come during 2 hour window."</p> <p>There was no documentation or incident reporting of missed or refused medications for Client #1 available.</p> <p>Interview on 4/26/18 with the Nurse Manager revealed: -Typically their nurses contacted the Medical Director (MD) via text when a client missed or refused a medication. -The reason for the exception notes was most often that the client did not come (to the nurses office) during the 2 hour window. -She did not enter the exception note in the EMAR until after she had spoken to the MD. -There was no other communication log or documentation from the nurses that the MD was notified. -She was unable to pull up the specific text messages from her phone that she sent to the physician for those missed medications for Client #1.</p> <p>Interview on 4/26/18 with the Managing Director revealed:</p>	V 123		

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V 123	Continued From page 2  -He thought the nurses used their level 1 incident report form for any missed/refused meds. -They had some difficulty with the EMAR and their electronic medical records being unable to link together. -This documentation would be easily corrected by adding the MD notification to the EMAR	V 123		