Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	MHL082-079		05/24/2018

NAME OF PROVIDER OR SUPPLIER
MERCY CARE II

STREET ADDRESS, CITY, STATE, ZIP CODE
3950 ROSEBORO HIGHWAY
CLINTON, NC 28328

(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 118	Continued From page 3 -A bubble pack labeled Levothyroxin Tab (tablet) 200mcg Take 1 tablet by mouth everyday Sub (substitute for Synthroid) Filled: 5/15/18 -5 pills were missing out of 30 pills Interview was attempted on 05/23/18 with client #1 but was unsuccessful due to client #1 not responding. Interview on 05/24/18 staff #6 revealed: -She administered the wrong dose of medication to client #1. -She went by the MAR and did not look at the bubble pack of the medication. -She did not know she had given the wrong dose of the medication. -Another staff had called her and informed her she had given the wrong dose of the medication. -The doctor was called. -Client #1 was not acting any different when she left her shift. Interview on 05/23/18 staff #1 revealed: -Staff #6 gave client #1 the wrong dose of Synthroid on 05/16/18. -She discovered the mistake when she came on shift between 7:30-8:00am on 05/16/18. -Client #1's doctor was notified and wanted the Synthroid held for 7 days. -Poison Control was contacted. -The pharmacy was contacted. -Client #1 was taken to the Emergency Room on 05/17/18 and was released the same day. -Client #1 was only given the wrong dose on 05/16/18 in the morning.	V 118	DHSR - Mental Health JUN 21 2018 Lic. & Cert. Section	

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V 118	Continued From page 2 6am. The staff gave four 200mcg Levothyroxine which equal 800mcg which the staff should of read the label before distributing the medication. Contacted [Pharmacy] and ask why did they send 200mcg instead of 50mcg like they stated. They thought that it would of been easier to give one 200mcg pill. They stated that we need to continue to monitor her and check her blood pressure throughout the day and that she should be ok. Contacted her primary dr. (doctor) about the medication error and her nurse stated that she will notify us about what [Doctor] decide to do. Called back on this day 5/16/18 and the dr. had not made a decision yet. Received a call on 05/17/18 approx.(approximately) 10am stating that [Doctor] would like to hold her levothyroxine for 7 days and on the 7th day bring her in the office as a walk-in or same day appointment. As time progressed throughout the day staff became concern about the consumer and decided to take her to the ER (emergency room) to get check out. Consumer was released from the ER and they stated that they could not find nothing medically wrong with her." Review on 05/23/18 of the hospital emergency room Patient Health Summary for client #1 dated 05/17/18 revealed: "-Patient brought to ED (emergency department) by group home owner for evaluation of weakness, specifically pt (patient) not verbally responding appropriately. Pt recently hospitalized for UTI (urinary tract infection) and released 2 days ago. Also, of note-pt was d/c (discharged) with a RX (prescription) of 200mcg of synthroid once daily, per group home owner pt was given too much synthroid yesterday-800mcg instead of 200mcg." Observation on 05/23/18 of client #1's medication revealed:	V 118		

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V 118	Continued From page 1 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 administer medication as ordered by a physician for one of two clients (#1). The findings are: Review on 05/23/18 of client #1's record revealed: -55 year old female. -Admission date of 11/11/10. -Diagnoses of Paranoid Schizophrenia, Mild Mental Retardation, Hypertension, Seizure Disorder, Hypothyroidism and High Cholesterol. -Physician Order dated 05/15/18 Levothyroxine 50 MCG 200 MCG by mouth daily at 6am. Review on 05/23/18 of the North Carolina Incident Response Improvement System report dated 05/16/18 revealed: "-Consumer [Client #1] was released from the hospital on 05/15/18. When she was released from the hospital several of her medication was discontinued and also she receive several new medication orders. One of the medications that she received was Levothyroxine 200mg by mouth daily at 6am. The pharmacy [Name of Pharmacy] stated that they was sending 50mcg which mean consumer will need to take four 50mcg which mean consumer will need to take four 50mcg to equal 200mcg per her order. When the staff gave the medication they gave the medication according to the way it was written on the MAR. Give four 50 mcg to equal 200mcg by mouth at	V 118		

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V 000	INITIAL COMMENTS A complaint survey was completed on May 24, 2018. The complaints were substantiated (intake #NC00139014 and NC00139145). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	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. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR	V 118	V118 27G.0209 (c) Medication Requirements. This rule was not met as evidenced by record review, Observation review that ~~the~~ Mercy Care II did not administer medication as ordered by a physician for #1 Client. Mercy Care will correct this by meeting with staff that made medication error and having her go back through medication training and reminding her how important it is to go by all the rules in administering medications. Mercy Care Exec Direct will also check medication according to orders and labels before writing on MAR Directions of how to administer meds so that all will correspond each time a medication is ordered.	6/29/18

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Executive Direct

TITLE: Executive Director

(X6) DATE: 6/6/18

- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Wendy Boone at 252-568-2744.

Sincerely,

Emily Stanley, BSW

Emily Stanley, BSW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: Sarah Stroud, Director, Eastpointe LME/MCO
Jeanette Jordan-Huffam, Quality Management Director, Eastpointe LME/MCO
File

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

May 30, 2018

Sonja Whitted
Mercy Care, Inc.
218 Moore Street
Clinton, NC 28328

Re: Complaint Survey completed 05/24/18
Mercy Care II, 3950 Roseboro Highway, Clinton, NC 28328
MHL # 082-079
E-mail Address: mercycareinc@yahoo.com
Intake #NC00139145 and NC00139014

Dear Ms. Whitted:

Thank you for the cooperation and courtesy extended during the complaint survey completed 05/24/18. The complaint was substantiated.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Tag cited is a standard level deficiency.

Time Frames for Compliance

- Standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is 07/23/18.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.