STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl082-042	A. BUILDING: _____ B. WING _____	08/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMPSON GROUP HOME	300 JACOBS STREET CLINTON, NC 28328

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V 000	INITIAL COMMENTS An annual survey was completed on August 15, 2018. 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 file followed up by appointment or consultation with a physician.	V 118		

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This Rule is not met as evidenced by:
Based on record reviews, interviews and observation the facility failed to administer medications as ordered by the physician and keep the MAR current affecting 1 of 3 audited clients (#2). The findings are:

Review on 08/14/18 of client #2's record revealed:
-52 year old male.
-Admission date of 03/14/88.
-Diagnoses of Schizoaffective Disorder, Depressed Type, Moderate Mental Retardation, Diabetes Type II and Hypertension.

Review on 08/14/18 of client #2's Physician orders revealed:
07/16/18
-Discontinue Geodon (used to treat schizophrenia and the manic symptoms of bipolar disorder) 80mg bid (twice a day).
-Discontinue Cogentin (reduces the effects of certain chemicals in the body that may be unbalanced as a result of disease (such as Parkinson's) and drug therapy) 1mg bid (twice a day).
-Start Invega (used to treat schizophrenia) 9mg PO (by mouth) qhs (at bedtime).

Review on 08/14/18 of client #2's July and August 2018 MAR's revealed the following transcription:
-Benztropine (Cogentin) 1mg Take 1 tablet by mouth twice daily.
-Ziprasidone (Geodon) 80mg Take 1 capsule by mouth twice a day.

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V 118	Continued From page 2 -Handwritten transcription next to each medication starting on July 17, 2018 and on the August MAR revealed, "Dc'd (discontinued) 07/16/18. -No initials after 07/16/18 were listed to indicate the medication had been administered. -Handwritten transcription on the 07/2018 revealed, "Invega 9mg Take (1) tablet by mouth at bedtime start 07/17/18. -Initials were present from 07/17/18-08/13/18 to indicate Invega 9mg had been administered. Observation on 08/14/18 at approximately 11:30am of client #2's bubble packs filled on 08/08/18 revealed Benztropine 1mg and Geodon 80mg and the medication had been removed from the bubble pack starting on 08/08/18-08/14/18 with two dates written (unable to identify transcription) next to two of the bubbles to indicate staff had removed the medication. Continued review on 08/14/18 of client #2's August 2018 MAR revealed: -No initials were present from 08/08/18-08/14/18 for Geodon 80mg and Benztropine 1mg to indicate the staff had administered the medication even though the medication had been removed from the bubble pack. During interview on 08/14/18 client #2 was unaware of the medications that was prescribed by the Physician. During interview on 08/14/18 the week day manager revealed: -She started working at the facility in May 2018. -She worked Monday-Friday as the manager. -She administered medications to the clients. -She was out of work last week and was not aware the discontinued medication had been	V 118		

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administered to client #2.
-The discontinued medication did not get delivered to the home until 08/08/18 and only received it from the 08/08/18 until it was discovered on 08/14/18.
-Client #2 did not have any changes from taking the medication.
-Client #2 continued to talk to someone not present and respond to stimuli not present which he was doing prior to the medication change.
-Staff #1 worked the week she was out and she had a long week and did not recognize the generic names on the medication and did not pay attention to the medication when she administered it to Client #2.

During interview on 08/15/18 staff #1 revealed:
-The error was an "honest mistake."
-She was normally very good about checking medications for the clients.
-She did not know how she missed that the medications had been discontinued.

During interview on 08/14/18 the Residential Service Coordinator revealed:
-She had been on vacation the week the medication had been delivered from the pharmacy to the office.
-She was responsible for dispersing the medication to the facility from the office.
-She knew the medication for client #2 had been discontinued and she would have removed it from the medication batch before sending it to the facility.
-The staff at the facility were aware the medication had been discontinued and was unsure why the staff administered the medication to client #2.

During interview on 0/14/18 the Qualified

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Professional (QP)/Executive Director revealed:
-She felt the error occurred due to the Physician not sending the discontinue order to the pharmacy.
-The medication should have never been sent to the facility from the office and the administrative staff working during that time did not check the medication appropriately.
-The staff working that week had previously been a house manager and knew the process for checking the medication to prevent errors.

Review on 08/14/18 of the Plan of Protection dated 08/14/18 and completed by the QP/Executive Director revealed:
"-What immediate action will the facility take to ensure the safety of the consumers in your care?
1. Administration to follow-up with Dr (doctor) and pharmacy to make sure all orders for medications are in place.
2. Staff will read MAR 3x (times) and compare to medication pack to ensure correct medication is given.

-Describe your plans to make sure the above happens.
1. Staff will be retrained in MAR.
2. Administration will monitor MAR 2X weekly."

Client #2 had a dignoses of Schizoaffective Disorder, Moderate Mental Retardation and Diabetes Type II insulin dependent. Client #2 reported having some psychotic symptoms including responding to internal stimuli at which point the Physician made changes to his psychotropic medication discontinuing the Geodon 80mg and Cogentin 1mg and prescribing Invega 9mg. The facility continued to administer the Geodon 80mg and Cogentin 1mg for a period of 7 days along with the Invega 9mg placing him

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V 118	Continued From page 5 at risk for abnormal heart rhythm and increased blood sugars which could be detrimental to health, safety and welfare. This deficiency constitutes a Type B rule violation. If the violation is not corrected within 45 days, an administrative penalty of $200.00 per day is imposed for failure to correct within 45 days.	V 118		