STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL097-003	A. BUILDING: _____ B. WING _____	R 10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SYNERGY RECOVERY AT THE BUNDY CENTE	118 PEACE STREET NORTH WILKESBORO, NC 28659

(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, follow up and complaint survey was completed on 10/17/18. The complaint was unsubstantiated (Intake # NC142840). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .4400 - Substance Abuse Intensive Outpatient Program; and 10A NCAC 27G .5000 Facility Based Crisis Service for Individuals of All Disability Groups	V 000		
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 3 of 4 sampled clients (Client #1, Former Client (FC) #3 and FC #4). The findings are: Record review on 10/16/18 for Client #1 revealed: -Admission date of 10/13/18 with diagnoses of Alcohol Use Disorder and Alcohol withdrawal symptoms.	V 123		

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V 123	Continued From page 1 -Physician ordered on 10/13/18 Trazadone (insomnia) 100mg at 9pm, if still awake at 11pm repeat Trazadone 100mg. Review on 10/16/18 of October 2018 MAR for Client #1 revealed: -Trazadone was refused on 10/15/18 at 9pm. -No documentation of notification to pharmacist or physician was made. Record review on 10/16/18 for FC #3 revealed: -Admission date of 9/26/18 with diagnoses of Alcohol Use Disorder, High Blood Pressure (HBP), Chronic Obstructive Pulmonary Disease (COPD) and Cataracts. -Discharge date of 9/30/18. -Physician ordered on 9/26/18 Neurontin (pain) 300mg 4 times daily; Clonidine (withdrawal symptoms) 0.2mg 3 times daily and Trazadone (insomnia) 100mg at 9pm and 11pm if still awake. Review on 10/16/18 of September 2018 MAR revealed: -Neurontin was refused 9/29/18 at 1pm, 6pm, 10:30pm and 9/30/18 at 6am and 1pm (5 doses). -Clonidine was refused on 9/27/18 at 6am and 9/28/18 at 10:30pm (2 doses). -Trazadone was refused 9/27/18 at 9pm. -No documentation of immediate notification to pharmacist or physician was made. Record review on 10/16/18 for FC #4 revealed: -Admission date of 8/27/18 with diagnoses of Alcohol Use Disorder, Major Depression and Alcohol Withdrawal Symptoms. -Discharge date of 8/30/18. -Physician ordered on 8/27/18 Tegretol (nerve pain) 100mg 4 times daily; Neurontin (pain) 300mg 4 times daily and Clonidine (withdrawal symptoms) 0.2mg 3 times daily. -Tegretol was refused on 8/29/18 at 10.30pm, 8/30/18 at 6am, 1pm and 6pm (4 doses).	V 123		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 123	Continued From page 2 -Neurontin was refused 8/29/18 at 10.30pm, 8/30/18 at 6am, 1pm and 6pm (4 dosses). -Clonidine was refused 8/29/18 at 3pm and 10.30pm, 8/30/18 at 6am and 3pm (4 doses). -No documentation of immediate notification to pharmacist or physician was made. Interview on 10/16/18 with Client #1 revealed: -He did not recall missing any ordered medication. Multiple attempts to contact FC #3 and FC #4 were not successful. Interview on 10/17/18 with Intake Med Tech revealed: -The Medical Director (MD) had established medication protocols depending upon what substance the incoming clients were withdrawing from. -Med Techs were required to take specialized training and testing. -The MD was on call 24/7 365days. He was on site Mondays and Thursdays and was always available by pager/phone. -The Med Techs documented all medication refusals that the MD could review. -They already had a process in place to identify and track medication errors including refused meds. Interview on 10/17/18 with the Chief Executive Officer revealed: -He was unaware of the requirement for immediate notification to physician or pharmacist for refused meds. -They would work with their MD to create a process that would meet this requirement of immediate notification.	V 123		