Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	mhl013-142	A. BUILDING: _____ B. WING _____	R 10/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDEMERE GROUP HOME	2158 WINDEMERE DRIVE KANNAPOLIS, NC 28083

(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 complaint and follow up survey was completed on 10-18-18. The complaint was unsubstantiated (#NC 00143659). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G 5600A Supervised Living for Adults Whose Primary Diagnosis is a Mental Illness.	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	DHSR - Mental Health NOV 13 2018 Lic. & Cert. Section	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Cynthia VanCo TITLE Res. Team Leader (X6) DATE

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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 observation, record review and interviews, the facility failed to ensure that medications were being given according to physicians orders and ensure that the MAR was accurate, effecting 3 out of 3 audited clients (clients 1,2, and 3). The findings are: Finding #1: Review on 10-16-18 of client #1's physician orders revealed: -discontinue Omeprazole 20 mg twice a day and start pantaprozole 40 mg 2 times a day signed 10-2-18 -Nicotine patch apply one time daily dated 9-20-18 -gabapentin 300 mg two caps twice a day Review on 10-16-18 of Client #1's October 2018 MAR revealed: -Nicotine patch not signed for as being given. -Omeprazole 20 mg continued to be document as being given twice a day through the 15th, Pantaprozole 40 mg documented as being given twice a day except for Oct 6,7,8,9 and the 15th in the PM -AM medications for the 16th not documented -Gabapentin 300 mg not documented Oct. 15, PM medication Interview on 10-16-18 with the facility manager revealed:	V 118	V118 In order to rectify the issues with Client #1 – the discontinued medication omeprazole was returned to pharmacy – this is evidenced by the return documentation in this packet showing it was picked up by the pharmacy. Client #1 has also seen his primary care on 10/30/2018 at which time no complications from the double medications were found. To ensure there is not a reoccurrence, both RM and Staff on duty will review all new medication orders and discontinue orders on the day of the appointment or within 24 hours of the appointment, removing any old medications at the time of review and preparing the medication for return to the pharmacy. A discontinued order was given for the nicotine patches and a copy is included with this plan of correction. To address the issue of lack of documentation for 8am medications for clients #1, #2, and #3, an in-service review of the medication policy was completed 10/31- In-service materials included in this packet. Immediate documentation of medication dispensed was noted strongly in the in-service with disciplinary action as a follow-up measure for non-compliance. Residential Manager will review all MAR's weekly at sporadic times to ensure immediate documentation. Residential Team Leader is also making a request to upper management to increase nursing oversite to 1 x monthly as a second check for appropriate documentation and any issues or other errors noted.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 118	Continued From page 2 -Client #1 did not want to quit smoking so they sent the Nicotine patch back to the pharmacy. -He did not know why the Omeprazole was still being given. -They had talked to staff several times about keeping the MAR updated and signing it as soon as the medications were given. Finding 2: Review on 10-16-18 of physicians orders for client #2 revealed: -Physicians order for ensure or equivalent twice a day dated 10-8-18 Review on 10-16-18 of client #2's October 2018 MAR revealed: -No ensure documented as being given. -October 16th AM medications not documented Interview on 10-16-18 with the Qualified Professional revealed: -Client #2 did not like the ensure, so they didn't give it to her. -They would get a discontinue order for it. Finding #3 Review on 10-16-18 of client #3's physicians orders revealed: -Vitamin D 1.25 one cap on Thursday Review on 10-16-18 of client #3' s September 2018 MAR revealed: -Vitamin D 1.25 signed daily through the 21, except for the 8th -No am meds signed for October 16, AM	V 118	Upon review of the medication for Client #3 and the issue of documentation of Vitamin D being given daily instead of weekly, it was noted that this was not possible as there was only medications for the once weekly administration of the vitamin. This was also covered in the in-service and the residential manager marked off on the MAR's for this client the dates for the next month that the vitamin is given to ensure staff clearly understand it is weekly and only needs to be documented weekly. Staff was previously under the impression that if the client had taken the medication on the date prescribed, that it needed to be documented as given for the whole week. In-service revealed that staff were unclear about how to document weekly medication so this was reviewed also with the residential manger taking lead on marking the MAR to assist in prevention of this kind of error in the future.	

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V 118	Continued From page 3 Interview on 10-16-18 with the facility manager revealed: -He doesn't know why the vitamin D had been signed for, it was a documentation error as the pharmacy only sent 4 pills for the month. -He had spoken with staff repeatedly about documenting on the MAR as soon as the medication was given. This deficiency constitutes a recited deficiency and must be corrected with 30 days.	V 118		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on interview and observation the facility was not maintained as clean, safe, orderly and odor free. The findings are: Observation on 10-16-18 at approximately 4:00 pm of client of client #1's room revealed: -Strong smell of urine permeating the room -Several dirty (with what appeared to be feces) depends piled on floor -Dirty/clean clothes piled on the floor -Wet (and smelled like urine) comforter on the floor. -Old cups sitting on the floor and dresser -Very little floor space visible because of debris and laundry on the floor.	V 736	V736 Residential Manager and Residential Team Leader met with Client #1 regarding the state of his living quarters. Client #3 was issued a 30 day discharge on 10/13 due to these type issues of non-compliance. Client #3 is currently awaiting placement in a higher level of care due to lack of response to continuous requests and assistance offered to comply with HUD rules for cleanliness. Peer support service was also requested to make outings contingent on Client #3 having cleaned his room. All staff are to focus on encouragement and assistance to allow for some assistance for Client #3 with his cleaning tasks. Staff and management will continue to follow up and assist with cleaning as needed until placement is secured for Client #3.	

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V 736	Continued From page 4 Interview on 10-17-18 with the facility manager revealed: -Client #1 would refuse to clean his room. -They have had to call exterminators several times because of roaches in the room. (No roaches were visible at this time.) Interview on 10-17-18 with client #1 revealed: -He would not address the condition of his room but wanted to know why I was looking at it. Interview on 10-16-18 with the Qualified Professional revealed: -They had recommended client #1 for a higher level of care. -The staff repeatedly encouraged him to clean his room.	V 736		

MONARCH
Inservice Registration Form

TOPICS: Trainers-list each topic that you discuss

Medication Administration policy review - focus on start and stop meds, ensuring all prescribed meds are available until medication is d/c'ed by doctor, appropriate & timely recording of medication distribution

MINUTES:

DATE: 10-22 & 10/31 LOCATION: Windermere

TIME: _____ AM / PM UNTIL: _____ AM / PM

PRESENTER/TITLE: Richard Weathers, RM \ Cindy VanCamp, RTL

#	PRINT NAME	TITLE	DEPARTMENT	SIGNATURE
1	Katrina Hines	BS	LTSS	Katrina Hines
2	Denise Oliver	BS		Denise Oliver
3	Gerri Lambert	BS		Gerri Lambert
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MONARCH

MEDICATION ADMINISTRATION OBSERVATION

Employee's Name: _____ Observer's Name: _____

Date: _____ Time: _____ # of People Meds Given To: _____

Medications Administered: _____

_____

OBSERVATION	YES	NO	N/A
Medication Passer washed their hands before administering medication, between people, and at the end of administration.			
Medication Passer checked prescriptions against the MAR and physician's order, **BEFORE** administering the medications.			
Medication Passer verified the medication log/count sheet appropriately.			
Medication Passer checked the medication's expiration date.			
Prior to administering the medication, the Medication Passer compared the label on the medication with the MAR 3 times: a. when taking it from the shelf; b. before pouring; c. before putting it back on the shelf.			
If medication was a liquid, the Medication Passer placed the measuring cup on a flat surface, at eye level, when pouring.			
If syringe was used, the Medication Passer measured the correct amount.			
The Medication Passer never touched the medication.			
The Medication Passer used a supportive voice tone when prompting people during medication administration			
The Medication Passer ensured people's privacy when administering medication.			
The Medication Passer provided support and prompting only at the level needed by the person			
The Medication Passer can state reasons why the person is taking each medication given (or knows where to locate this information).			
The Medication Passer could state side effects of the medication.			

OBSERVATION	YES	NO	N/A
The Medication Passer talked with each person about possible side effects of the medication they are taking.			
The Medication Passer initialed the MAR after the medication was administered.			
The Medication Passer used the 6 rights:			
a. Right Person?			
b. Right Drug?			
c. Right Dose?			
d. Right Time?			
e. Right Route?			
f. Right Recording?			
The Medication Passer can state the allowable grace time for administering medications.			

Comments: _____

_____

_____

_____

I have received feedback and comments for this medication observation. I understand any areas that need to be improved.

_____ _____

Signature of Medication Passer Date

_____ _____

Signature of Observer Date

MEDICAL ISSUE

NEW MEDICATION ALERT!!!

FOR: [redacted]

MED: Nicotine Patches

DETAILS: D/C - 10/18/19

- Do not give Medication

622645

Atrium Health

Physician's Order

Cabarrus Family Medicine
270 Copperfield Boulevard, Suite 102
Concord, NC 28025
Phone: 704-786-6521 Fax: 704-782-9703

Patient Name & DOB: [redacted]

Order for: D/C Nicotine patches

ICD-10 code (if needed): 5-4-94

MD Signature / Date [signature] 10/18/18

Rebekah Aurie, DO
NPI #1174901276
Dawn Caviness, MD
NPI #1639499098
Ryan Corbello, MD
NPI #1902333552
Paul Delaney, MD, MS
NPI #1659388189
Stacey Gipe, PA
NPI #1003887860

Paul Henson, MD
NPI #1396270740
Carla Jones, MD
NPI #1669460499
Rachel Koontz, NP-C
NPI #1558756155
Christopher Lake, MD
NPI #1104203496
Brian McCollough, MD
NPI #1417174616
Andrew Nance, MD
NPI #1831544949

Jerome Nymberg III, MD
NPI #1447248208
Ronald Pollack, MD
NPI #1598753360
Mark Robinson, MD
NPI #1912995788
Lori Seymour, PA
NPI #1255329025
Jacqueline Watson, MD
NPI #1922538503

Fax to:

Arc Services, Inc.

DISPOSAL OF MEDICATION FORM

Name of Person: [redacted] Record #: _____

Name of Medication: Omeprazole 20 mg

Strength of Medication: 20 mg Quantity Disposed Of: 8am - 17 8pm - 16 33

Method of Disposal: Sent to Pharmacy

Date of Disposal: 10/17/18

Name of Pharmacy: Mainstreet Pharmacy

Address of Pharmacy: 5006 Hwy 49 South
Mooresboro NC 28075

Comments:

D/C Order
10/2/18

Date: 10/17/18 Signature of Staff: Richard Weathers

Date: _____ Signature of Witness: _____

Date: _____ Signature of Pharmacist: _____

Drugs Returned to Pharmacy or Released to the Patient

Facility Endeavor

FACILITY USE							DISPOSITION					FOR PHARMACY USE ONLY						
Date Returned	Nurse's Initial	Patient's Name	Name, Strength & Form of Drug	Rx Number	Date of Issue	Quantity Returned	DISCONTINUED	PT DISCHARGED	PT. EXPIRED	DRUG DERRED	RELEASED TO PT.	Date	Count Verified	Billing Status	Destroyed (initial)	Credit Date	Credit Amt. $	Initial
10/7/18	RW	[redacted]	Propranolol 20mg			33												

INSTRUCTIONS:

(1) list controlled substances separately on the form supplied by the State Drug Authority.
(2) complete all applicable information in unshaded areas.
(3) keep pink copy and
(4) return both medication and forms to pharmacy
or
(5) have patient or responsible party sign form for medications release upon discharge, than forward forms to the pharmacy.

FOR MEDICATIONS RELEASED WITH PATIENT

I certify that the medications listed above are released to me and I understand and request that the medications are not dispensed in child-resistant containers.

Richard Weathers
Signature

10/7/18
Date

Witness

704-463-6518

MONARCH
Policy and Procedure Manual

PROGRAM: ALL	**DATE ISSUED/UPDATED: 08-07-96; 06-30-99; 10-31-01; 03-04-02; 06-15-05; 04-18-06; 06-20-06; 03-12-07, 4/6/09, 4/9/10, 1/7/11; 3-9-11, 3-17-11, 6/28/11, 8/17/11, 4/19/12, 2/5/13, 2/10/13, 7/22/14, 8/6/14, 11/17/14, 7/30/15; 9/19/16, 2/23/18; 5/10/18**
SECTION: Medical Services	**REGULATORY REFERENCE: APSM 30-1; NCAC Chapter 90 Article 9A Nurse Practice Act;10A NCAC 276.0209**
TOPIC: Medication Administration	☐ **OPERATIONAL POLICY** ☒ **BOARD POLICY**
POLICY OWNER:	**BOARD APPROVED DATE: 07-09-96; 06-15-05; 05-17-07, 10/24/14, 1/27/17** **(If applicable)**
SOP: ☐ **Yes** ☒ **No**	**FORM:** ☐ **Yes** ☒ **No**

POLICY:
It is the policy of Monarch to ensure that medications are safely administered as prescribed according to regulatory requirements and standards of practice.

Note: At no time will Monarch staff attempt to force medications on any person we serve

DEFINITIONS:

PRN Medication: medication given "when necessary" or "as circumstances require" as specified within the provider's order (i.e., give ibuprofen 200 mg every 8 hours as needed for headache pain).

Medication Administration Record (MAR): the form that serves as a legal record of the medications administered to an individual at an organization by a staff member. The MAR is a part of an individual's permanent medical record.

Medication Transcription: the process of transferring a provider's medication order(s) to the Medication Administration Record (MAR).

Standing Order: signed as orders to be administered as directed. Standing orders may be prn medications such as Tylenol (to be given for pain/fever).

PROCEDURE: MEDICATION TRANSCRIPTION

*Medication transcription will include the negating of any keys or code lists found on MARs provided by outside vendors.

Long Term Services and Supports (LTSS):
The transcription of medication may only be completed by Registered Nurses (RNs) or Licensed Practical Nurses (LPNs) or employees who have successfully completed the agency's training in medication transcription. When applicable, medication transcription training is required one time only. However, if a transcription error is made the staff making the error must take the medication transcription class again and will not transcribe medication orders until the class is successfully completed.

Once medication has been transcribed, a witness must verify the information prior to implementation of any new orders. If the facility has assigned nursing services, the transcription must be verified by Nursing Services.

Behavioral Health Crisis Units

A Registered Nurse or Licensed Practical Nurse will transcribe all orders received from the Physician's Order form. The transcription of new orders will be verified by another RN to ensure accuracy of transcription.

Standing and PRN medication orders will be added to the Medication Administration Record (MAR) book for the individual when orders are implemented by the admitting provider, with signature of RN or LPN and verification by an additional RN for accuracy. If there is only one RN on a shift, the orders will be verified at shift change by the on-coming RN.

Assertive Community Based Treatment Team (ACTT):

- When a provider documents new orders, the provider will place the charts that have new or updated orders in the designated place for review by nurses on the team. The nurses will review orders and update the electronic chart. Any new orders will be implemented and documentation that the order has been "noted (date, time, nurse's name) and faxed" will be entered on the order sheet below the actual order.

Outpatient Clinics

- The medication order for injections is verified at the time of the injection and transcribed onto the ***Injection Assessment and Administration Record*** by the nurse.

MEDICATION ADMINISTRATION RECORD (MAR):

- The MAR will include the following:
  - Name of person to receive the medication
  - Name, strength, and quantity of the medication
  - Instructions for administering the medication
  - Date and time the medication is scheduled and administered
- Name and initials of person administering the medication
  Documentation of medication administration on the MAR shall occur immediately upon completion of the medication pass.
- Regardless of the key located on the actual MAR, the person who attempts to administer the medication will place his or her initials in the appropriate place on the MAR. Each person administering medications will also sign and initial the appropriate space on the MAR, authenticating initials. No other code should be used.
  - If the administration is completed as ordered, documentation of the administration is completed.
    - If additional information such as location of an injection needs to be indicated, instead of a code on the MAR, the comments section should be utilized to specify details.
  - If administration of the medication is not completed for any reason, the person attempting administration will circle his/her initials on the MAR and indicate in the comment section why the medication administration was not successful.
    - Reasons may possibly include refusal, out of facility, hospitalized, on therapeutic leave, or any other situation when the medication was not administered as ordered.
- If a program is closed, for example a day site on an observed holiday or due to weather, the fact that the program is closed should be clearly indicated on the MAR.
  - This can be accomplished either by writing "CLOSED" across the date in question or by documenting as indicated above and commenting "CLOSED due to ___" on the back.
  - There is no key/code for closure.

Note: Anytime an individual refuses a dose of medication, complete a level 1 incident report for the missed dose.

Long Term Services and Supports (LTSS)

- Standing orders will be received pre-printed from the pharmacy or staff will use the pre-printed Monarch standing orders.
  - Standing orders may be given within the guidelines set by the provider.
  - All PRN orders may be given within the guidelines set by the provider.

- In facilities where no nursing support is assigned, staff will contact the on-call supervisor prior to giving any PRN for orders that are not standing orders.
- A Standing order may be given by the staff as written on the standing order form.
- The On-call Supervisor or Nursing staff, as appropriate, will be contacted only if the standing order medication does not have the desired effects as documented on the back of the MAR by staff.

In transitional housing services only:

- If people receiving services do not receive medical or medication supports from Monarch, standing orders are not required for the person to maintain and use over the counter medications. Dosing of this medication shall be at the determination of the person receiving services.
- If employees are providing medication supports to people served, orders must be obtained for all over the counter medications and these medications must be maintained in the employee's care.

Authorization for giving over the counter medications may be provided by the Lead Employee on duty in lieu of the on-call supervisor.

Behavioral Health Crisis Units

- A Registered Nurse will obtain a copy of the standing orders and Crisis MARs, enter the individual's name, record number, month/year on the form, enter the provider's name authorizing implementation of the orders, initial and sign the MAR, and place in the appropriate section of the medication administration notebook upon receiving orders from the admitting provider. Authentication of orders must be completed by designated provider within 72 hours.

EMPLOYEE STANDARDS:

Long Term Services and Supports (LTSS)

Medications shall be administered only by staff members who have been certified in medication administration. This certification shall be obtained by all of the following:

- Attending medication training offered by Monarch;
- Passing grade of 80% or higher on written medication test;
- Performing 3 successful medications passes while being observed by the residential manager. Medication Observation forms will be forwarded to Education upon successful completion to education@monarchnc.org.

One staff member will be designated as the assigned medication passer. During this time the employee will be responsible for ensuring the security of the medication and compliance to the administration schedule.

Any staff filling in as a sub must have completed the required Medication Administration class and must also be watched or observed one time per home that they are subbing in before giving medications.

Behavioral Health Crisis Units and Out Patient Clinics

- Medications will only be administered by persons lawfully authorized to do so. This program recognizes and authorizes the following licensed staff to administer medications:
  - Physician (or Physician Extender, such as a Physician's Assistant or Nurse Practitioner
  - Registered Nurse
  - Licensed Practical Nurse

MEDICATION ADMINISTRATION:

General:

- All medications administered to an individual must have a current provider's order/prescription and have a current expiration date. See Monarch's *Medication Order* policy.

Long Term Services and Supports (LTSS)

- 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***.
  - An employee must have successfully completed the agency's medication administration training and passed three (3) observations prior to giving medications.
  - The observations must be conducted by a supervisory level staff that is also currently in good standing with medication administration training.
  - Employees who are supporting people who require injections will complete additional agency training in the person's condition and how to properly give injections.

*** ***Note: IM injections may only be administered by a nurse.***

- Sample medications may ONLY be administered if the medication has a label on it identifying the following information needed and listed in the policy for labeling including: name of individual, name of medication, strength of medication, route for administration, quantity of medication, directions for administration, and expiration date.
  - If there is not a label on the sample medication identifying the person, dose, route and strength, the medication can ONLY be distributed to the individual by an RN (who will verify this is the correct medication prescribed by the provider and ensure identifying information is attached) and can then only be given to the person for self-administration.

    - The sample medication CANNOT be administered without the identifying information.
- Each person supported shall be monitored for desired and undesired effects of the medication.
- Undesired effects shall be reported and documented to the RN, provider, pharmacist, and family member/legal guardian
- Staff responsible for medication administration shall not pre-pour medications.
- Borrowing of medications from another person's medication supply is not allowed.
- Unless otherwise indicated by the ordering provider, medications will be given at the following times:

  Daily: 8 AM
  Twice daily: 8 AM and 8 PM
  Three times a day: 8 AM, 4 PM and 8 PM
  Four times a day: 8 AM, 12N, 4 PM and 8 PM
  Bedtime: 8 PM
  Before meals: 1/2 hour before scheduled mealtime

- Staff shall indicate the administration times on the MAR.
- Medications will be administered one (1) hour before to one (1) hour after the time designated on the provider's order and/or Medication Administration Record.

Behavioral Health Crisis Units

- All medications will be administered as prescribed by the attending provider.
- Unless otherwise indicated by the ordering provider, medications will be given at the following times:

  Daily: 9:00 am
  Twice Daily: 9:00 am and 9:00 pm
  Three times daily: 9:00 am 3:00 pm and 9:00 pm
  Four times daily: 6:00 am 12:00 noon 6:00 pm and 12:00 midnight
  Bedtime: 9:00 pm

- Medications will be administered one (1) hour before to one (1) hour after the time designated on the provider's order and/or Medication Administration Record.
- Staff responsible for medication administration shall not pre-pour medications.
- Borrowing of medications from another person's medication supply is not allowed. Each person supported shall be monitored for desired and undesired effects of the medication.
    - Undesired effects shall be reported to the RN, provider, pharmacist, and family member/legal guardian, and an incident report shall be completed if adverse reactions are noted.

Administration:

The procedure for passing medications shall be as follows:

- Staff shall wash hands (following Centers for Disease Control and Prevention (CDC) Hand Hygiene Guidelines described in Monarch's ***Hand Hygiene*** policy.) before passing medications, between passing medications, and at the completion of the medication pass.
    - Staff may use hand sanitizer in lieu of basic hand washing during medication administration.
    - Antibacterial soap and water shall be used before and after the medication process.
- During medication preparation, staff will visually inspect medication for particulates, discoloration, or other loss of integrity. Should concern for the integrity of the medication be identified, staff should not administer the medication, identify it for destruction, and contact the pharmacy to obtain replacement medication.
- Medication will be administered at the medication area whenever possible. When this is not possible, staff shall ensure that the medication area is secure before leaving the area.
- Each person shall be individually asked to come to the medication area to receive medication, to assure privacy.
- Prior to the administration of any medication, consent must be obtained and education provided.
- Staff may provide educational information as outlined in the agency policy on medication education, to include: what medication(s) the individual is taking, what it is for, and possible side effects of the medication.
    - Written consent and acknowledgement of medication education shall be filed in the record.
- People receiving support with medication will be encouraged to manage medication as independently as possible.
- The following will be verified during each medication pass:

    - **Right person** - Staff will utilize two identifiers to ensure the correct person is receiving the medication: the person's name (or picture identification) and date of birth. **For Group Homes and Crisis Units**, an updated picture of the individual with the individual's name and birthdate may be utilized for these identifiers. In **Outpatient Clinics**, the individual may show a picture ID and/or state name and date of birth. Picture ID will be available through the electronic health record. For **ACT Teams**, individual will identify self by stating name and date of birth unless assessed as unreliable historian, in which case a picture of the individual with name and date of birth will be implemented for correct identification.

    - **Right medication**
    - **Right dosage**
    - **Right time**
    - **Right route** of administration
    - **Right method** of documentation.

- The MAR will be checked three (3) times prior to giving the medication. Staff will ensure the medication administration was completed as ordered.
- Staff will immediately document all medication administration on the MAR.

CONTROLLED MEDICATIONS

Staff responsible for preparing medication administration paperwork shall ensure that a ***Controlled Substance Administration Record*** form is prepared for each controlled medication prescribed for an individual. Each time staff administer a controlled medication, an entry will be made on the Controlled ***Substance Administration Record*** form stating the date, time, amount of medication removed, and the amount of medication remaining. A count will be co-signed by both parties every time the medication keys change hands.

Controlled medications will be counted at the beginning of each shift with a staff member from the previous shift. The count will be documented on the ***Controlled Substance Administration Record*** form and both persons will sign the sheet. The RN/Nurse Manager and Residential Manager / Director of Program Operations will be notified immediately of any error in the controlled medication count.

Any missing controlled medication will be reported as a level 2 incident and an investigation will be conducted within required incident reporting timelines.

Behavioral Health Crisis Units

Controlled medications brought from home will be counted by two nurses and placed behind two locked storage areas.

Controlled medications are signed out as each dose is administered.
Controlled medication count will be completed by two nurses at every change of RN staff.

The RN or LPN administering medications during the shift will maintain possession of medication keys at all times.

Assertive Community Treatment Teams (ACTT)

Medications received from the pharmacy for individuals supported are logged into the Medication supply closet on the *Monarch ACTT Medication Tracking* form.

Medication received for individuals that are packaged in bubble packaging are inspected when received for intactness, ensuring that all medications are received for each individual from the pharmacy based upon provider orders and that they are properly labeled. These medications are kept in a locked cabinet (within the locked nurses' office) that is accessed only by ACTT nurses or medical providers.

Medications are logged out by the nurses when planned for delivery to individuals. The person supported signs the Medication Delivery Record when he or she receives the medication.

Medications removed from the individual's medication supply and unable to be delivered to the individual are returned to the individual's supply within the locked cabinet by one of the ACTT nurses, this is noted on the log out form, and medications are logged back into the individual's supply.

Outpatient Clinics

Any controlled medication samples received at an outpatient clinic must be kept in the locked sample closet, with an additional lock (always behind 2 locks) that is accessed only by authorized staff (RN, LPN, CMA or medical provider).

Controlled medication samples are logged in on the ***Monarch Sample Medication Tracking*** form.

Verification of inventory must be completed and documented at least monthly by Lead Nurse to ensure proper documentation of samples dispensed and current inventory. Any discrepancy in count for controlled sample medication count must be reported to respective Lead Nurse or Nursing Designee and local Operations Designee.

REVIEWS OF MEDICATION:

Long Term Services and Supports (LTSS)

It is the policy of Monarch that the assigned RN, or Residential Manager if no RN is assigned, is responsible for obtaining a review of the medication regimen of each person. In ICF-MR funded services, it is encouraged that the medication review is scheduled with the quarterly RN quarterly assessments.

In ICF-MR funded services all medication orders must be reviewed quarterly. Standing orders are renewed annually; all other medications are renewed annually. In non-ICF-MR funded services, all medication orders must be renewed/reviewed annually. Standing orders will be renewed annually.

Anyone that receives a psychotropic medication regardless of diagnosis or reason must have all medications evaluated/reviewed at least every 6 months by a physician/pharmacist. The team shall discuss and make recommendations concerning these medications.

Documentation of a review/renewal by a physician will be entered into the record through one of the following methods:

- receipt of new prescriptions or orders for all medications;
- order from physician to continue all medications (with medications listed); or
- progress note from the physician, noting all medications to be renewed.

Pharmacy Reviews:

In all services where a Pharmacist reviews medication, the review must be completed by a licensed pharmacist.

- The pharmacy review will consist of a review of all medications ordered for the person according to the review guidelines listed above and will evaluate effectiveness of the medication, interactions between medications, and side effects noted.

- The agency form, Pharmacy Review, may be utilized to document the review. Pharmacists may opt not to use the agency form and may provide the agency with a written report. This report will include: name of the participant, record number, date of the review, any areas requiring improvement, and then if applicable a plan of correction, time frame in which plan of correction shall be completed, person responsible for plan of correction, and individual responsible to ensure all corrections are completed. The Pharmacist completing the report shall sign and date the report.

A copy of the written medication review report shall be provided to the key manager of the site, Team Leader and Residential Manager. In addition, any other professionals who must take action in the plan of correction shall receive a copy of the written report. The original report will be filed in the medical record.

Assertive Community Treatment Teams (ACTT)
Current medications are review by the treatment team during each Treatment Plan Review.

Monarch
Helping Dreams Take Flight

November 4th, 2018

DHSR Survey and Complaint Section
2718 Mail Service Center
Raleigh, NC 27699-2718

Dear Ms Work,

Enclosed please find the Plan of Correction for Monarch's Windermere home in Kannapolis, NC. We have completed additional training and made the required corrections to our medication records. Monarch thanks you for your guidance and assistance in maintaining our records and keeping adequate records for the same.

Sincerely,

Cindy VanCamp
Residential Team Leader
Monarch

DHSR - Mental Health
NOV 13 2018
Lic. & Cert. Section