

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/28/2019
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NAME OF PROVIDER OR SUPPLIER EDWARDS GROUP HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 408 EAST MAIN STREET HOOKERTON, NC 28538
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V 000	<p>INITIAL COMMENTS</p> <p>An annual and a follow up survey was completed on February 27, 2018. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.</p>	V 000		
V 118	<p>27G .0209 (C) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(c) Medication administration:</p> <p>(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.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(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.</p> <p>(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:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p> <p>(D) date and time the drug is administered; and</p> <p>(E) name or initials of person administering the drug.</p> <p>(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.</p>	V 118		

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V 118	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to administer medications as ordered by the physician, and maintain a current/accurate MAR with medications recorded immediately after administration, affecting 3 of 3 audited clients (#4, #5 and #6). The findings are:</p> <p>Finding #1: Review on 2/26/19 of client #4's record revealed: -33 year old male admitted 6/2/18. -Diagnoses included schizoaffective d/o, bipolar type; gastroesophageal reflux disease (GERD), and vitamin D deficiency. -Orders dated 6/2/18 included: -Clonazepam 1 mg (milligram) twice daily (seizures, panic disorder, movement disorder) -Divalproex Sod ER (extended release) 500 mg the morning and 1000mg at bedtime (manic episodes associated with bipolar disorder, epilepsy, migraine headaches) -Olanzapine 20 mg (Zyprexa) at bedtime (mental/mood conditions, i.e. schizophrenia, bipolar disorder) -Propranolol 10 mg twice daily (high blood pressure, atrial fibrillation) -Topiramate 100 mg (Topamax) twice daily (seizures (epilepsy), prevent migraine headaches) -Trazodone 200 mg at bedtime (depression, insomnia, anxiety, panic attacks) -Vitamin D 3 5000 IU daily (supplement)</p> <p>Review on 2/26/19 of client #4's MARs for December 2018, January and February 2019</p>	V 118		

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V 118	<p>Continued From page 2</p> <p>revealed:</p> <ul style="list-style-type: none"> -Medications ordered twice daily were scheduled to be administered at 8 am and 8 pm. -Medications ordered to be administered at bedtime were scheduled to be administered at 8:30 pm. -None of client #4's medications scheduled to be administered at 8 pm were documented as administered on 2/25/19 at 8 pm. -None of client #4's medications scheduled to be administered at 8 am had been documented as administered on 2/26/19 at 8 am. <p>Review of client #4's Controlled Substance Record revealed:</p> <ul style="list-style-type: none"> -Clonazepam 1 mg had not been signed out on the log for 2/25/19 8 pm or 2/26/19 for 8am. -The quantity of medication on hand was documented to be 5. -There were only 4 Clonazepam 1 mg tablets remaining. <p>Finding #2:</p> <p>Review on 2/26/19 of client #5's record revealed:</p> <ul style="list-style-type: none"> -44 year old male admitted to the facility 1/25/19. -Diagnoses included Psychotic Disorder, Traumatic Brain Injury, and Arthritis. -Signed Physician's orders dated 1/25/19 for Prolixin (antipsychotic) 10 mg at bedtime. <p>Review of client #5's MARs for December 2018 - February 2019 revealed:</p> <ul style="list-style-type: none"> -Medications ordered to be administered at bedtime were scheduled to be administered at 8:00 pm. -No documentation that Prolixin was administered as bedtime as ordered 2/25/19. <p>Finding #3:</p> <p>Review on 2/26/19 of client #6's record revealed:</p>	V 118		

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V 118	<p>Continued From page 3</p> <ul style="list-style-type: none"> -36 year old male admitted 6/2/18. -Diagnoses included Schizophrenia, paranoid type. -Signed Physician's order dated 10/3/18 for benztropine (Cogentin, can treat side effects of other drugs) 1 mg at bedtime and chlorpromazine (Thorazine, antipsychotic) 100 mg three times daily. -Signed Physician's orders dated 1/18/19 and 2/22/19 for benztropine 1 mg twice daily; haloperidol (Haldol, antipsychotic) 5 mg, take 2 tablets (10 mg) at bedtime; olanzapine (Zyprexa, antipsychotic) 10 mg at bedtime; and Trazodone (anti-depressant) 100 mg at bedtime. <p>Review on 2/26/19 of client #6's MARs for December 2018 - February 2019 revealed:</p> <ul style="list-style-type: none"> -Transcription for benztropine 1 mg, one tablet by mouth at bedtime. -Medications ordered to be administered three times daily were scheduled to be administered at 8:00 am, 2:00 pm, and 8:00 pm. -Medications ordered to be administered at bedtime were scheduled to be administered at 8:00 pm. -No documentation that 8:00 pm/bedtime medications were administered 2/25/19. <p>Interview on 2/26/19 the Group Home Manager stated:</p> <ul style="list-style-type: none"> -He came on duty at 8 am. -He would review MARs and count the medications on hand. -He had administered the 8 am medications on 2/26/19. -If he found a medication had not been "signed off" he would immediately call the responsible staff and ask the staff what their count had been. If their counts matched they are "good to go" and he (Group Home Manager) would sign the 	V 118		

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V 118	<p>Continued From page 4</p> <p>MARs. He would make a black dot to notate he signed the MAR but did not give the medication. -He believed the count on client #4's Controlled Substance Record did not match the number of tablets on hand because he had to start using the medication on the card starting on 1/31/19 rather than 2/1/19, and he entered in the incorrect quantity on hand at the beginning of the month. He recorded a beginning balance of 56 when it should have been 55. He offered no explanation why Clonazepam 1 mg had not been signed out for the 8 pm dose scheduled for 2/25/19, or the 8 am dose scheduled to be administered on 2/26/19. -There was no explanation about the omissions of medication administration documentation on 2/25/19 or 2/26/19.</p> <p>During interview on 2/27/19 the Qualified Professional stated she clarified client #6's benzotropine order with the Psychiatrist. The Psychiatrist stated client #6 should only be taking benzotropine one time daily.</p> <p>Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician.</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 118		
V 120	<p>27G .0209 (E) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean,</p>	V 120		

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V 120	<p>Continued From page 5</p> <p>well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate.</p> <p>(2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments.</p> <p>This Rule is not met as evidenced by: Based on observations and interview, the facility failed to store all medications securely and separately for each client in a locked cabinet for 5 of 6 current clients (#1, #2, #3, #4, #6). The findings are:</p> <p>Observations on 2/26/19 between 10:00 am and 10:15 am revealed: -Inside an unlocked file cabinet in office area was a large white plastic bag containing bubble packs of medications. -Bubble packs labeled for clients and medications were as follows: -Client #1: 20 cards; medications included Geodon (ziprasidone), Haldol, Lithobid, Cogentin, Buspar, Trazodone, Depakote. -Client #2: 9 cards; medications included Cogentin, Zestril (Lisinopril), Banophen, Haldol, Seroquel, Aricept, Klonopin -Client #3: 15 cards; medications included</p>	V 120		

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V 120	<p>Continued From page 6</p> <p>Thorazine, Seroquel, Depakote, Cogentin -Client #4: 9 cards; medications included Inderal (propranolol), Depakote, Topamax (topiramate) -Client #6: 11 cards; medications included Thorazine, Cogentin, Trazodone, Ativan, Haldol, Seroquel -1 bubble pack had the client label torn away; the medication listed was Olanzapine 20 mg. -5 loose pills/caplets were in the bottom of the file cabinet.</p> <p>Interview on 2/26/19 The Group Home Manager stated: -The medications in the white plastic bag in the filing cabinet were to be discarded. -He was not sure how they were disposed; they would be sent to the Qualified Professional/Licensee. -They used medications from the bag if medications were late arriving from the pharmacy. They would only use a medication from the bag if on a card labeled for the client in need of the medication.</p>	V 120		
V 736	<p>27G .0303(c) Facility and Grounds Maintenance</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility</p>	V 736		

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V 736	<p>Continued From page 7</p> <p>was not maintained in a safe, clean, attractive and orderly manner. The findings are:</p> <p>Observations on 2/26/19 between 10:15 am and 10:30 am revealed:</p> <ul style="list-style-type: none"> -Client #1's 3 light fixture had only 1 working light bulb. -Client #2's bathroom light fixture had 3 sockets. Only 2 bulbs in the fixture; only 1 of the 2 bulbs worked. -Client #2's bed was very wobbly and unsteady; his comforter was ripped. -Client #5's bathroom light fixture had 3 sockets. Only 2 bulbs in the fixture. Mildew stains on the shower curtain. -Client #5's light switch plate in his bedroom was broken; 2 light bulbs in the 3 light fixture in his bedroom were not working. -Client #6's door was cracked approximately 6 inches in length. Multiple strips of lack plastic tape adhered to wall near bathroom entrance. -Approximately 1/3 of client #6's bathroom mirror had been broken away at the top leaving a sharp edge across the top. <p>Interview on 2/26/19 the Group Home Manager stated:</p> <ul style="list-style-type: none"> -The damage to client #6's door and mirror was done by the prior client who resided in the room. The former client also put the tape on the wall. -The former client who broke the mirror and door had been discharged 6 months prior. He had broken the door about 2 weeks prior to his leaving, and had broken the mirror about a week before he left. -To get things fixed he would ask the Qualified Professional/Licensee. She would ask if anyone was hurt and replace or repair as soon as possible. No one had been cut on the broken mirror. 	V 736		

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V 736	Continued From page 8 Interview on 2/27/19 the the Qualified Professional/Licensee stated: -The Group Home Manager gave incorrect information. -The damages to client #6's room had been reported to her the prior week end and had been done by client #6.	V 736		