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	MHL012-068	A. BUILDING: _____ B. WING _____	04/12/2019

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SCI - MORGANTON RESPITE CENTER	806 BETHEL ROAD MORGANTON, NC 28680

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V 000	INITIAL COMMENTS An annual survey was completed on 4/12/19. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G.5100 Community Respite Services for Individuals of All Disability Groups.	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	V 118		

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V 118	Continued From page 1 with a physician. This Rule is not met as evidenced by: Based on record review, observation and interview the facility failed to administer medications on the written order of a physician affecting one of two clients (Client #1). The findings are: Review on 4/11/19 of Client #1's record revealed: -date of admission 4/4/19; -diagnoses included Mild Intellectual Developmental Disability, Attention Deficit Hyperactivity Disorder, Autism Spectrum Disorder, Major Mood Difficulty and Anxiety Disorder; -physician's orders dated 4/4/19 included Abilify 15 milligrams (mg) - 1 tablet daily and Seroquel 400 mg - 2 tablets at bedtime. Review on 4/11/19 of Client #1's Provider Plan with an implementation dated of 3/15/19 revealed: -a short range goal "After an initial prompt when feeling upset, [Client #1] will practice using self-calming techniques until he is able to calmly discuss his concern with staff ..." Observation on 4/11/19 at approximately 1:30 p.m. of Client #1's medications revealed: -there was no Abilify or Seroquel in the box with his current medications. Review on 4/11/19 of Client #1's Medication Administration Record (MAR) for April 2019 revealed:	V 118		

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V 118	Continued From page 2 -Abilify - 15 mg - initials with a circle around them in each box from 4/4/19 - 4/10/19 (7 days); -Seroquel 400 mg - initials with a circle around them in each box from 4/6/19 - 4/10/19 (5 days); -the key at the top of the MAR indicated "...0 (RED) = Omit Dose (Put your initial inside circle)...." Interview and observation on 4/11/19 at 1:30 p.m. with Client #1 revealed: -he met surveyor at the door as entered the facility and complained that his stomach was hurting and he had just vomited; -he paced around the living room stating he may have to go to the emergency room if his stomach did not quit hurting; -he threw up two times yesterday; -the Emetrol the facility gave him had not helped. Observation on 4/11/19 at approximately 2:30 p.m. revealed: -a staff member bringing in a bag with Client #1's Seroquel and Abilify. Interview on 4/11/19 with the Respite Facility Administrator revealed: -Client #1 was admitted due to an emergency situation at a sister facility in Murphy; -upon check-in on 4/4/19 it was discovered the client had no Abilify in his pill bottle, and only 4 Seroquel - 2 nights worth; -the pharmacy in Murphy was called in order to get his prescriptions transferred to a local pharmacy; -the local pharmacy could not refill the prescriptions due to needing the doctor's authorization; -the doctor would not give authorization due to the client missing his past 3 appointments; -he missed his last 3 appointments when he was	V 118		

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V 118	Continued From page 3 living at a previous facility; -since the client's admission she had been calling the doctor, and the pharmacist every hour to check the status of getting an approval; -it was their policy to have enough medications for their entire stay at the facility; -they usually had 2 weeks to get medications ready before admitting a client; -she did not handle Client #1's admission and since it was an emergency they did not have the 2 weeks to get ready. Review on 4/12/19 of an Internal Incident Report revealed: -date of incident - 4/4/19 - 4:40 p.m. to 4/11/19 1:36 p.m. -"...Type of Medication Error: missed doses. Medication unavailable due to issues with physician and prior auth [authorization]..." -4/5/19 - notified psychiatrist office Medicaid denied payment as prior authorization was needed; -"...no prior authorization was received before the psychiatrist office or pharmacy closed... -4/6/19 and 4/7/19 - Saturday and Sunday - "Psychiatrist office closed." -4/8/19 - sent another fax to psychiatrist office requesting authorization - psychiatrist not in today; -4/9/18 - psychiatrist said prior authorization completed, however this was not showing up in the system; -4/10/19 - prior authorization received, just as the pharmacy was closing; -4/11/19 - notified by pharmacy the client's Abilify and Seroquel were refilled and ready to be picked up. Interview on 4/12/19 with Client #1 revealed: -the first thing he said when asked to speak to	V 118		

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V 118	Continued From page 4	V 118		

him again was "I finally got my Seroquel back;"
-he had been out since last Saturday (4/6/19);
-he was not sure how long he had been without Abilify;
-he was told he didn't have it because of "the pharmacy, the doctor, Medicaid wouldn't pay for it...I don't know."
-he was feeling better and had not thrown up since surveyor saw him yesterday.

Interview on 4/12/19 with the Qualified Professional (QP) for the facility revealed:
-Client #1 was transported to the facility by the QP of a sister facility;
-she was unaware the client did not have all of his medications until he arrived at the respite facility;
-she was kept informed during the entire time the Respite Facility Administrator was trying to obtain Client #1's Seroquel and Abilify;
-this was a planned respite facility, however in Client #1's situation this was an immediate placement and their first concern was where they were going to place him;
-they had not discussed as a team on how to prevent a client from being admitted without having all their medications in the future, but they could certainly do this;
-they had a policy on their admission procedures regarding medications.

Review on 4/12/19 of the facility policy entitled "Respite Admission Procedure - Morganton Respite Facility" dated 8/10/18 revealed:
-"...Required Items- Medications with labels that match Physician's order (medications must be counted upon arrival to ensure there is enough for the scheduled stay prior to individual dropping client off leaves the facility)..."
-Page 4 of the respite application in bold capital letters - "ALL MEDICATIONS, CURRENT

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V 118	Continued From page 5 PRESCRIPTIONS, CURRENT MEDICATION ORDERS ARE REQUIRED PRIOR TO ADMISSION. IF MEDICATIONS AND MEDICATION INFORMATION IS NOT PRESENT ADMISSION CANNOT OCCUR." Interview on 4/12/19 with the local pharmacist revealed: -the delay in filling Client #1's medication was due to needing prior authorization from the physician which was obtained yesterday; -withdrawal symptoms of suddenly stopping Seroquel and/or Abilify included difficulty sleeping, agitation and nausea and vomiting. Review on 4/12/19 of the Plan of Protection dated 4/12/19 written by the QM Manager revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? "Upon [Client #1's] admission on 4/4/19, the respite admission procedure should have been followed. This was an emergency placement based on a neglect investigation that was substantiated. It was discovered that his Abilify bottle was empty but there was a physician order. Also, the Seroquel bottle only had 4 pills in the bottle, which would only cover 2 days. The facility administrator contacted the SCI QP, who in turn contacted the AFL staff and the pharmacy. It was learned that prior authorization was required for both medications. It was also learned that he had missed appointment that would allow automatic refills. SCI staff (QP, Executive Director, Facility Admin., and SCI RN) were in constant contact with the physician and the both pharmacy's (local to AFL and local to respite facility) to get the prescriptions written and filled. The pharmacist	V 118		

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V 118	Continued From page 6 provided education on side effects and withdrawal symptoms to use to monitor the individual and ensure his safety and well-being until the medication error could be resolved. All team members continued to be in contact throughout the waiting period get the medications filled. No adverse side effects were observed. The medications were filled on 4/11/19." "(please refer to incident report dated 4/4/19 for more specific details)." Describe your plans to make sure the above happens. "The Respite Admission Procedure will be followed correctly. All clients entering the respite facility must have current physician orders and enough medication for their entire stay at the facility. If refills are needed during the client stay it must be known prior to coming to facility and verified that there are refills remaining on prescriptions and that no prior authorizations are needed. If there are any conflicts or issues with the medications, they must be resolved 24 hours before the client will be allowed to enter the facility. The Facility Administrator or QP will be responsible for all respite admissions. The Respite Admission Procedure packets will be implemented to ensure that all criteria are met prior to a client being admitted to the facility. The Executive Director will approve all admissions prior to an individual coming to the facility. A member of the QM Team will review the admission procedure documentation on a quarterly basis to ensure the procedure is being implanted correctly. The Facility Administrator or QP will be present when an individual arrives at the facility for their stay to ensure that enough medications are	V 118		

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V 118	Continued From page 7 checked-in with the person. Should not enough medications be given to the facility to cover the stay, the Executive Director will be immediately contacted to make alternate accommodations." Client #1 had diagnoses including Major Mood Difficulty and Anxiety Disorder. After admission to the facility he missed 7 days of his anti-psychotic medication Abilify and 5 days of his Seroquel. Both medications were prescribed by a psychiatrist for Major Mood Difficulty. Client #1 complained of feeling nauseous and said he vomited a total of 3 times in 2 days; common side effects of both medications when suddenly stopped. Client #1 felt like he may need to go to the emergency room if he did not feel better soon. 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 will be imposed for each day the facility is out of compliance beyond the 45th day.	V 118		