STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-331	A. BUILDING: _____ B. WING _____	04/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAT BRADLEY HOME	420 LYTLE COVE ROAD SWANNANOA, NC 28778

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V 000	INITIAL COMMENTS An annual and complaint survey was completed on 4/29/19. The complaint was unsubstantiated (Intake #NC149206). Deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G .5600F Supervised Living for Individuals of all Disability Groups/Alternative Family Living.	V 000		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner.	V 117		

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V 117	Continued From page 1 This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure all prescription medications available for administration were not expired and contained a current dispensing date for 2 of 2 clients (Clients #1 and #2). The findings are: Record review on 4/16/19 for Client #1 revealed: -Admission date of 2/5/11 with diagnoses of Severe Intellectual Disability, Autism, Epilepsy, Cerebral Palsy, Panic Disorder, Hypotonia, Hypogonadism, Low Bone Density and Gastroesophageal Reflux (GERD). Record review on 4/16/19 for Client #2 revealed: -Admission date of 7/10/18 with diagnoses of Borderline Intellectual Disability, Traumatic Brain Injury, Cognitive Disorder, Hypertension, Enuresis, Neurogenic Bladder and GERD. Observation on 4/16/19 at approximately 11am of medication containers for Client #1 at the facility revealed: -Ayr Nasal Gel Spray 2 sprays each nostril 3 times daily PRN dispensed 12/5/17. -Qvar 40mcg inhale 2 puffs twice daily dispensed 6/3/16. -Qvar 40mcg inhale 2 puffs twice daily dispensed 8/8/17. -Qvar inhaler without a box or label had expiration date of 2/2018. -Fluticasone Prop 50mcg 1-2 sprays each nostril daily dispensed 8/8/17.	V 117		

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V 117	Continued From page 2 -Fluticasone Prop 50mcg 1-2 sprays each nostril daily dispensed 9/5/17. -Fluticasone bottle without box or label had expiration date of 2/2017. -Pro Air inhaler 2 puffs every 4 hours as needed dispensed on 8/8/17. -Pro Air inhaler without a box or label had expiration date 3/2018. Interview on 4/16/19 with Staff #1 revealed: -She had no idea some of the medications were that old. She usually kept the medications separated that needed to be returned to the pharmacy. She had been meaning to clean all those out. -She did not know if the expired medications had been administered or not. Interview on 4/23/19 with the Qualified Professional (QP) revealed: -She reviewed medication administration records (MARs) and medications with Staff #1 quarterly. -She had never seen any medications in this facility this far expired. -"She (Staff #1) always brought out the client locked medication boxes-I never looked in the med cabinet." This deficiency is cross referenced into 10A NCAC 27G .0209 (c) Medication Requirements (V118) for a Type B violation and must be corrected within 45 days.	V 117		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall	V 118		

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V 118	Continued From page 3 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. This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to keep the MAR current, failed to ensure the MAR included the name and strength of each drug and failed to follow the written order of a physician affecting 2 of 2 clients (Clients #1 and #2). The findings are: CROSS REFERENCED: 10A NCAC 27G.0209	V 118		

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V 118	Continued From page 4 (b) Medication Requirements (V117). Based on observations, interviews, and record review, the facility failed to ensure all prescription medications available for administration were not expired and contained a current dispensing date for 2 of 2 clients (Clients #1 and #2). Record review on 4/16/19 for Client #1 revealed: -Admission date of 2/5/11 with diagnoses of Severe Intellectual Disability, Autism, Epilepsy, Cerebral Palsy, Panic Disorder, Hypotonia, Hypogonadism, Low Bone Density and Gastroesophageal Reflux (GERD). -Physician ordered medications included: --Quetiapine 50mg (antipsychotic) 1 tab in AM and noon and 2 tabs at bedtime. --Qvar 40mcg (lung infections) inhale 2 puffs twice daily. --Refresh Lacri-lube (dry eye) drop ½ inch line in each eye at bedtime ordered 4/4/19. --Refresh Artificial Tears (dry eye) one drop each eye twice daily ordered 4/4/19. Review on 4/16/19 of MARs for February-April 2019 revealed: --Quetiapine was not initialed as administered on 2/19/19 AM dose. --Qvar was not initialed as administered from March 1-April 16 (47 days). --Refresh Lacri-lube not included on April MAR and none in the facility (12 days). --Refresh Artificial Tears not included on April MAR and none in the facility (24 doses). Record review on 4/16/19 for Client #2 revealed: -Admission date of 7/10/18 with diagnoses of Borderline Intellectual Disability, Traumatic Brain Injury, Schizophrenia, Cognitive Disorder, Hypertension, Enuresis, Neurogenic Bladder and GERD.	V 118		

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V 118	Continued From page 5 -Physician ordered medications included: --Montelukast 10mg (asthma) once daily; --Fluticasone 50mcg (asthma) 2 sprays each nostril daily; --Docusate 100mg (stool softener) twice daily; --Verapamil ER 180mg (antihypertensive) twice daily; --Symicort 80/4.5mcg (asthma) inhale 2 puffs twice daily; --Clonidine 0.1mg (antihypertensive) three times daily; --Carbamazepine 200mg (bipolar) 1 ½ tabs three times daily; --Risperidone 1mg (antipsychotic) at bedtime ordered 3/1/19 changed to 2mg at bedtime on 3/29/19; --Calcitrate 950mg (supplement) daily at 3pm; --Vitamin D3 2000iu (supplement) 2 tabs daily; --Simvastatin 20mg (high cholesterol) daily; --Multivitamin (supplement) once daily; --Bupropion XL 150mg (antidepressant) daily; --Sertraline 100mg (antidepressant) once daily; --Fish Oil 1000mg (supplement) 2 caps daily; --Esomeprazole DR 40mg (GERD) daily in morning; --Clozapine 100mg (antipsychotic) 5 tabs at bedtime ordered 2/5/19 changed to 6 tabs at bedtime on 2/6/19; --Desmopressin 0.1mg (antidiuretic) at bedtime; --Trazodone 50mg (antidepressant/sedative) 1-2 tabs at bedtime PRN changed to 150mg at bedtime PRN on 2/6/19. Review on 4/16/19 of MARs for February-April 2019 revealed: -None of the 18 non-PRN medications listed above were initialed as administered on 3/31/19. -Docusate was ordered twice a day but initialed as administered April 1-16 in AM only (15 doses). -Risperidone was ordered 3/1/19 but was not	V 118		

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V 118	Continued From page 6 documented on March MAR (30 days). -Order for Bupropion was written 2/6/19 for twice daily but February MAR was completed as administered only once at 8am (missed 22 doses). Order changed 3/1/19 to once daily but March MAR was completed as administered twice daily in the morning and at 2pm. Staff #1 initialed both AM and PM doses of this medication for March 1-30 (30 extra doses). -Order for Clozapine 100mg 6 tabs at bedtime was written on 2/6/19 but was not given at this dose until 3/1/19. (22 days) -Order for Trazodone 150mg was written on 2/6/19 but continued to be administered at previous dose (50-100mg) for 22 days. Interview on 4/16/19 with Staff #1 revealed: -Was unaware there were blanks on the MARs, she "must not have had her glasses on." -"The pharmacy sent the correct medications and dosages when they were ordered. I did not change the MAR like I should have but I believe meds were given as they were ordered." -"I just got new orders for Client #1 from the doctor but they did not add PRN note on the orders." -Client #1's "QVAR started as PRN but changed to daily and not changed back to PRN. He takes it when he has pneumonia. Gave it in February to prevent major sinus infection." -She thought the prescription for Refresh eye drops and Lacri-lube had been electronically submitted to the pharmacy. Found out on 4/15/19 the prescriptions had not been sent and faxed the scripts she had been given. -Client #2 had to have lab work every 2 weeks taking Clozaril. "When the doctor increased the order to 6 tabs the pharmacy just sent a bottle with 30 tabs to add to the bubble pack. I'm pretty sure he had 6 tabs for February."	V 118		

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V 118	Continued From page 7 -"Pretty sure [Client #2] got the Risperdal. It was so crazy in the house during that time. I don't remember when he began the 2mg" Interview on 4/16/19 with Qualified Professional (QP) #1 revealed: -Staff #1 had been providing care for a long time and knew what she was doing. She never had concerns about client care in this facility. -She made on site visits quarterly to review documentation, medications and MARs. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. Review on 4/23/19 of Plan of Protection dated 4/23/19 and signed by the Executive Program Director revealed: "What immediate action will the facility take to ensure the safety of the consumers in your care? 1. QP completed an immediate review of all client areas in home and disposed of any expired medications. 2. AFL provider, Pat Bradley, will be retrained on medication administration within one week. Ms. Bradley will not administer any medications in the home until she has been re-trained in medication administration and has passed the training test. Other trained staff will administer all medications in the AFL home until Ms. Bradley has been retrained. 3. QP completed an immediate review of all medications, physician orders, and client MARs in the AFL home, updated the MARs according to the physician orders, and reviewed the current physician orders, updated MARs, and medications with alternate Direct Support	V 118		

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V 118	Continued From page 8 Professionals who will be administering medications until Ms. Bradley is retrained. Describe you plans to make sure the above happens. 1. QP will review the MARs, physician orders and medications in the home once per week for three weeks to ensure above actions are taking place. 2. QP supervisor will complete one unannounced visit to the AFL during the next month to review the MARs, physician orders, and medications to ensure the above actions are taking place." Client #1 took 15 medications on a daily basis as well as 6-10 PRNs for seizures, hypothyroid, coagulation disorder, digestive disease, dry eye, hypotonia, low bone density, allergies, anxiety and behaviors. He missed 47 days of his inhaled steroid to prevent lung infections. He also was not given medication for his severe dry eyes for 12 days. Client #2 took 18 medications on a daily basis as well as 8-10 PRNS for asthma, hypertension, neurogenic bladder, digestive disease, depression and psychosis. He missed 18 medications that were not administered on 1 day; missed 15 doses of stool softener in April; missed 30 days in March of antipsychotic (Risperidone); antidepressant (Bupropion) was not given for 22 doses in February and received 30 extra doses in March; antipsychotic (Clozapine) was given at 500mg rather than the ordered 600mg for 22 days and although an antidepressant (Trazadone) was PRN, Client #2 only received partial dose of what was ordered for 22 days. Failure to follow physicians' orders for significant medical and mental health issues and keep current non -expired medications on hand are detrimental to health, safety and welfare and constitute a Type B rule violation. If the violation is not corrected within 45 days, an administrative	V 118		

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V 118	Continued From page 9 penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 118		