

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL009-041</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>11/14/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>BLADEN COUNTY #2 RIVERWOOD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>706 WEST SWANZY STREET ELIZABETHTOWN, NC 28337</b>		
(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 survey was completed on November 14, 2019. Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G.5600C Supervised Living for Adults with Developmental Disabilities.	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 with a physician.	V 118			

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Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*James H. Holcomb*

*Administrator*

*12/5/2019*

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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, maintain current MARs, or record medications immediately after administration affecting 3 of 3 clients audited (clients #2, #4, #5. The findings are:</p> <p>Finding #1: Review on 11/7/19, 11/8/19, and 11/13/19 of client #5's record revealed: -42 year old male admitted 10/22/18. -Diagnoses included traumatic brain injury, mood disorder, dementia, and mild intellectual developmental disorder. -Orders dated 8/12/19 included:     -Clonazepam 0.5 mg (milligrams) at bedtime (Anticonvulsant)     -Olanzapine 20 mg every evening (Antipsychotic/Antimanic)     -Valproic Acid Solution 250 mg/ml (milliliter), 10 ml's twice daily (Anticonvulsant) -Order dated 8/12/19 for Amoxicillin 500 mg, take 2 capsules at once, then 1 every 6 hours for 10 days. (Antibiotic) -Order dated 10/3/19 for Amoxicillin 500 mg, take 2 capsules at once, then 1 every 6 hours until gone. Dispense 40 tablets.</p> <p>Review on 11/7/19 of client #5's November 2019 MARs revealed: -Clonazepam 0.5 mg, Olanzapine 20 mg, and Valproic Acid Solution 250 mg/ml, 10 ml's were scheduled to be administered at 8 pm daily. -On 11/7/19 at 4:30 pm all medications scheduled</p>	V 118			

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V 118	<p>Continued From page 2</p> <p>to be administered at 8 pm on 11/7/19 had been documented as administered.</p> <p>Review on 11/13/19 and 11/14/19 of client #5's August and October 2019 MARs revealed: -In August 2019 Amoxicillin 500 mg had been scheduled and documented as administered at 8 am, 2 pm, and 8 pm for 10 days beginning at 8 pm on 8/12/19 and ending on 8/22/19 at 8 pm. -In October 2019 Amoxicillin 500 mg had been scheduled and documented as administered at 8 am, 2 pm, and 8 pm for 8 days beginning at 8 pm on 10/4/19 and ending on 10/12/19 at 8 pm. The scheduled dose for 10/6/19 at 8 am was not documented as administered.</p> <p>Finding #2: Review on 11/7/19, 11/8/19, and 11/13/19 of client #4's record revealed: -49 year old male admitted 7/1/11. -Diagnoses included schizophrenia, anxiety disorder, insomnia, intellectual developmental disorder-moderate, hypercholesterolemia, osteoarthritis, sinusitis, allergic rhinitis, diabetes, gastroesophageal reflux disease (GERD), diabetes. -Orders dated 8/21/19 included: -Atorvastatin 10 mg at bedtime (lowers cholesterol) -Benzotropine 1 mg twice daily (reduce symptoms of Parkinson's disease or involuntary movements) -Clonazepam 0.5 mg twice daily -Clozapine 100 mg, 2 tablets at bedtime (used to treat certain mental/mood disorders, i.e. schizophrenia) -Senna Plus 50-8.6 mg at bedtime (constipation) -Keppra 750 mg twice daily (anticonvulsant) -Singulair 10 mg at bedtime (reduce allergy</p>	V 118		

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V 118	<p>Continued From page 3 symptoms)</p> <p>Review on 11/7/19 of client #4's November 2019 MARs revealed: -Atorvastatin 10 mg, Benztropine 1 mg, Clonazepam 0.5 mg, Clozapine 100 mg, 2 tablets at bedtime, Senna Plus 50-8.6 mg, Keppra 750 mg, and Singulair 10 mg were scheduled to be administered at 8 pm daily. -On 11/7/19 at 4:30 pm all medications scheduled to be administered at 8 pm on 11/7/19 had been documented as administered.</p> <p>Finding #3: Review on 11/7/19, 11/8/19, and 11/13/19 of client #2's record revealed: -29 year old male admitted 10/26/19. -Diagnoses included mild intellectual developmental disorder, mild neurocognitive disorder due to multiple etiologies. -Orders dated 10/15/19 included: -Depakote 1500 mg at bedtime (anticonvulsant) -Keppra 1000 mg at bedtime</p> <p>Review on 11/7/19 of client #2's November 2019 MARs revealed: -Depakote 1500 mg and Keppra 1000 mg were scheduled to be administered at 8 pm daily. -On 11/7/19 at 4:30 pm Depakote 1500 mg and Keppra 1000 mg scheduled to be administered at 8 pm on 11/7/19 had been documented as administered.</p> <p>Interview on 11/7/19 the Group Home Manager stated: -He had been in a hurry the morning of 11/7/19 and documented the 8 pm medications in error. -Staff #2 had failed to document medications given the prior day and he had the staff fill in the</p>	V 118			

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V 118	Continued From page 4  MARs on 11/7/19. They did not document these entries as late entries. He was sure staff #2 had given the medications because they log a medication count in addition to the MAR documentation.  Interview on 11/14/19 the Licensed Practical Nurse (LPN) stated: -Client #5's dentist had ordered the antibiotics in August and October 2019. -The dentist had said for them not to awaken client #2 in the middle of the night to give his antibiotics. -She scheduled the antibiotics on the MARs. -She had not thought of choosing scheduled dosing times that would avoid waking the client during the night, but making sure the client received the medications as ordered.  Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician.	V 118			
V 366	27G .0603 Incident Response Requirments  10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days;	V 366			



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V 366	Continued From page 5  (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal	V 366		

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V 366	Continued From page 6  review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as	V 366		

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V 366	<p>Continued From page 7</p> <p>applicable; and (F) any other authorities required by law.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to implement policies for response to incidents as required. The findings are:</p> <p>Review on 11/7/19, 11/8/19, and 11/13/19 of client #5's record revealed: -42 year old male admitted 10/22/18. -Diagnoses included traumatic brain injury, mood disorder, dementia, and mild intellectual developmental disorder. -Medical Appointment Consultation Record dated 7/30/19 documented: -client #5 fell and had tooth pain and left knee pain -client #5 had abrasion/contusion of left knee and right cheek, and a chipped tooth right upper tooth. -dental evaluation needed within 48 hours -Dental consultation Record dated 7/31/19 documented client #5 fractured tooth #7 off below the alveolar crest and required an extraction. -Medical Appointment Consultation Record dated 8/12/19 documented tooth #7 was extracted.</p> <p>Review of facility incident reports from 4/1/19 - 11/7/19 revealed no internal incident report or incident response documented for client #5's fall in July 2019.</p> <p>Interview on 11/14/18 the Qualified Professional</p>	V 366			



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V 366	Continued From page 8  stated: -Client #5's gait was getting worse. She had reported this to the nurse. -In July 2019 he fell at the group home. -There was no level incident report done.	V 366			
V 367	27G .0604 Incident Reporting Requirements  10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business	V 367			

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V 367	Continued From page 9  day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in	V 367		

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V 367	<p>Continued From page 10</p> <p>the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to report Level II incidents as required to the LME (Local Management Entity) within 72 hours. The findings are:</p> <p>Review on 11/7/19, 11/8/19, and 11/13/19 of client #5's record revealed: -42 year old male admitted 10/22/18. -Diagnoses included traumatic brain injury, mood disorder, dementia, and mild intellectual developmental disorder. -Medical Appointment Consultation Record dated 7/30/19 documented client #5 required a dental extraction of a tooth fractured in a fall:</p> <p>Review of the North Carolina Incident Response Improvement System (IRIS) reports for July 2019 revealed there was not IRIS report for client #5's fall in July 2019.</p> <p>Interview on 11/14/18 the Qualified Professional state there was not level 2 incident report done.</p> <p>See V366 for additional details.</p>	V 367			



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**

ROY COOPER • Governor

MANDY COHEN, MD, MPH • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

November 26, 2019

Tammie Hollingsworth  
RHA Health Services NC, LLC  
2003 Godwin Avenue  
Lumberton, NC 28358

Re: Annual Survey completed November 14, 2019  
Bladen County #2 Riverwood, 706 West Swanzy Street, Elizabethtown, NC 28387  
MHL # 009-041  
E-mail Address: tammie.hollingsworth@rhanet.org

Dear Ms. Hollingsworth:

Thank you for the cooperation and courtesy extended during the annual survey completed November 14, 2019.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

**Type of Deficiencies Found**

- All tags cited are standard level deficiencies.

**Time Frames for Compliance**

- Standard level deficiencies must be **corrected** within 60 days from the exit of the survey, which is January 13, 2020.

**What to include in the Plan of Correction**

- Indicate what measures will be put in place to **correct** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to **prevent** the problem from occurring again.
- Indicate **who will monitor** the situation to ensure it will not occur again.
- Indicate **how often** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and***

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603

MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718

www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

## Appendix 1-B: Plan of Correction Form

Plan of Correction			
Please complete <u>all</u> requested information and mail completed Plan of Correction form to:		In lieu of mailing the form, you may e-mail the completed electronic form to:	
Provider Name:	RHA HEATH SERVICE Inc. LLC	Phone:	910-739-1468
Provider Contact Person for follow-up:	Tammie Hollingsworth, Administrator	Fax:	910-739-6134
		Email:	Tammie Hollingsworth tammie.hollingsworth@rhanet.org
Address:	706 West Swanzy Street Elizabethtown, NC		
Provider # MHL#009-041			
Finding	Corrective Action Steps	Responsible Party	Time Line
<p>V118 27G .0209 (C) Medication Requirements-The facility failed to administer medications on the written order by the physician, maintain current MARs, or record medications immediately after administration affecting 3 of 3 clients audited (client #2, #4, #5).</p>	<ol style="list-style-type: none"> <li>1. The facility will administer medication on the written order of a physician and will keep the MARs current.</li> <li>2. Director of Nursing will in service the LPN on ensuring medication is transcribed onto the MAR appropriately per policy and accordingly to the physician order.</li> <li>3. Nursing will re-in-service all staff at Bladen #2 on how to properly document on the MARs immediately after administration. They will understand the importance of accurate documenting the MARs so to determine clients are receiving their medications as ordered by the physician.</li> <li>4. The administrator and LPN will check the MARs twice a month to ensure proper documentation. The LPN, Home Manager will check and compare the old MARs to the new MARs. If any discrepancies are found, the</li> </ol>	<p>Kola Oxendine, LPN</p> <p>Robin Correll, RN Corporate Director of Nursing</p> <p>Rashida Prather, QP</p> <p>Tammie Hollingsworth Administrator,</p>	<p>Implementation Date: December 9, 2019</p> <p>Projected Completion Date: December 30, 2019</p>

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## Appendix 1-B: Plan of Correction Form

Plan of Correction			
Please complete <u>all</u> requested information and mail completed Plan of Correction form to:		In lieu of mailing the form, you may e-mail the completed electronic form to:	
Provider Name:	RHA HEALTH SERVICE Inc. LLC		Phone: 910-739-1468
Provider Contact Person for follow-up:	Tammie Hollingsworth, Administrator	Fax: 910-739-6134	Email: Tammie Hollingsworth tammie.hollingsworth@rhanet.org
Address:	706 West Swanzy Street Elizabethtown, NC		
Provider # MHL#009-041			
Finding	Corrective Action Steps	Responsible Party	Time Line
<p>V118 27G.0209 (C) Medication Requirements- The facility failed to administer medications on the written order by the physician, maintain current MARs, or record medication immediately after administration affecting 3 of 3 clients audited (client #2, #4, #5).</p>	<ol style="list-style-type: none"> <li>1. The facility will administer medication on the written order of a physician and will keep the MARs current.</li> <li>2. Director of Nursing will in service the LPN on ensuring medication is transcribed onto the MAR appropriately per policy and accordingly to the physician order.</li> <li>3. Nursing will re-in-service all staff at Bladen #2 on how to properly document on the MARs immediately after administration. They will understand the importance of accurate documenting the MARs so to determine clients are receiving their medications as ordered by the physician.</li> <li>4. The administrator and LPN will check the MARs twice a month to ensure proper documentation. The LPN, Home Manager will check and compare the old MARs to the new MARs. If any discrepancies are found, the</li> </ol>	<p>Kola Oxendine, LPN</p> <p>Robin Correll, RN Corporate Director of Nursing</p> <p>Rashida Prather, QP</p> <p>Tammie Hollingsworth Administrator,</p>	<p>Implementation Date: December 9, 2019</p> <p>Projected Completion Date: December 30, 2019</p>