

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL049-123</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/04/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HELMS HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>611 PRESBYTERIAN ROAD MOORESVILLE, NC 28115</b>
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V 000	<p>INITIAL COMMENTS</p> <p>An annual survey was completed on 12-4-19. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p>	V 000		
V 117	<p>27G .0209 (B) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(b) Medication packaging and labeling:</p> <p>(1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible;</p> <p>(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;</p> <p>(3) The packaging label of each prescription drug dispensed must include the following:</p> <p>(A) the client's name;</p> <p>(B) the prescriber's name;</p> <p>(C) the current dispensing date;</p> <p>(D) clear directions for self-administration;</p> <p>(E) the name, strength, quantity, and expiration date of the prescribed drug; and</p> <p>(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.</p>	V 117		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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V 117	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record reviews, interviews, and observation, the facility failed to ensure the packaging label of each medication contained the required information affecting 1 of 3 audited clients (#3). The findings are:</p> <p>Review on 12-2-19 of Client #3's record revealed: -Admitted on 10-1-19; -Age 13 -Diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), Major Depressive Disorder, recurrent severe without psychotic features, Disruptive Mood Dysregulation, Bi-polar Disorder II; -A physician's order for Taytulla 1 milligram (mg) capsule (used for birth control) once daily, ordered on 11-19-19.</p> <p>Observation at approximately 11:45am on 12-3-19 of Client #3's medication revealed: -A box of Taytulla capsules with no packaging label was in Client #3's medication bin; -The box of Taytulla did not include client's name, the prescriber's name, the dispensing date, the name, address, and phone number of the pharmacy or dispensing location, administration instructions, and the name of the dispensing practitioner.</p> <p>Interview on 12-2-19 with Client #3 revealed: -She was taking birth control but did not give the name of the birth control; -She was, "Trying to stay on top of her medications."</p>	V 117		

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V 117	<p>Continued From page 2</p> <p>-Staff administered her medications to her daily.</p> <p>Interview on 12-3-19 with the Qualified Professional (QP) revealed:</p> <p>-Client #3's medication was originally delivered to the facility in a zip lock bag with the packaging label attached;</p> <p>-The baggie was thrown away;</p> <p>-The QP would ensure that the baggie remained with the medication box in the future.</p> <p>Interview on 12-3-19 of the Operations Manager revealed:</p> <p>-Client #3's medication was originally delivered to the facility in a zip lock bag with the packaging label attached;</p> <p>-The facility staff threw the baggie away;</p> <p>-The pharmacy would be delivering a new package label for the Taytulla.</p>	V 117		
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</p>	V 118		

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V 118	<p>Continued From page 3</p> <p>current. Medications administered shall be recorded immediately after administration. The MAR is to include the following:</p> <p>(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.</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> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure MARs were kept current and medications administered were recorded immediately after administration affecting 2 of 3 audited Clients (#1 and #3). The findings are:</p> <p>Review on 12-2-19 of Client #1's record revealed:</p> <ul style="list-style-type: none"> <li>- Admission date: 3-25-19</li> <li>- Diagnoses: Post-Traumatic-Stress Disorder; Disruptive Mood Dysregulation Disorder</li> <li>- Age: 15</li> <li>- Physicians orders for the following medications: <ul style="list-style-type: none"> <li>- Abilify 10 milligrams (mg), 1 tablet every night at bedtime (QHS), dated 3-25-19;</li> <li>- Lavonar/Seasonale Quasense (birth control), 1 tablet every day (QD), dated 10-22-19;</li> <li>- Vitamin D 2,000 units, 1 tablet QD, dated 10-22-19;</li> <li>- Buspar 7.5 mg, 1 tablet twice daily (BID), dated 5-7-19;</li> <li>- Zantac 150 mg, 1 tablet BID, dated 5-7-19;</li> </ul> </li> </ul>	V 118		

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V 118	<p>Continued From page 4</p> <ul style="list-style-type: none"> <li>- Prilosec 40 mg, 1 tablet QHS, dated 5-7-19;</li> <li>- Sertraline (Zoloft) 100 mg, 2 tablets (=200 mg), dated 5-7-19;</li> <li>- Melatonin 10 mg, 1 tablet QHS, dated 5-7-19;</li> <li>- Clindamycin HCL (hydrochloride) (antibiotic medication) 300 mg, 1 tablet every 6 hours for 10 days, dated 11-28-19.</li> </ul> <p>Review on 12-2-19 of Client #1's MARs dated 9-1-19 to 12-2-19 revealed:</p> <ul style="list-style-type: none"> <li>- No documentation of administration of the following medications: <ul style="list-style-type: none"> <li>- Abilify at 8:00PM on 9-13-19, or 10-5-19;</li> <li>- Seasonale Quasense at 8:00PM on 9-4-19, 9-13-19, 10-5-19, 11-5-19, 11-8-19, 11-24-19, or 12-1-19;</li> <li>- Vitamin D at 7:00AM on 9-28-19;</li> <li>- Buspar 7.5 mg at 8:00AM on 9-28-19; and at 8:00PM on 9-13-19, or 10-5-19;</li> <li>- Zantac at 8:00AM on 9-28-19, and 11-31-19; or at 8:00PM on 9-13-19, or 10-5-19;</li> <li>- Prilosec at 8:00PM on 9-13-19, and 10-5-19;</li> <li>- Zoloft at 8:00PM on 9-13-19, 9-28-19, 9-29-19, 10-5-19, 10-27-19, and 10-31-19;</li> <li>- Melatonin at 8:00PM on 9-13-19, 9-28-19, 9-29-19, 10-5-19, 10-27-19, and 10-31-19;</li> </ul> </li> <li>- Clindamycin was not listed on the December MAR, although the order specified that it was to be administered for 10 days (through 12-8-19).</li> </ul> <p>Review on 12-2-19 of Client #3's record revealed:</p> <ul style="list-style-type: none"> <li>-Admitted on 10-01-19;</li> <li>-Age 13;</li> <li>-Diagnoses of Major Depressive Disorder, recurrent severe without psychotic features, Other Persistent Mood Disorders, Attention Deficit Hyperactivity Disorder, combined type, Unspecified Mood Disorder;</li> </ul>	V 118		

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V 118	<p>Continued From page 5</p> <p>-Physician's orders for the following medications:            -Fluoxetine (Prozac) 20mg tablet, 1 tablet QD, dated 10-2-19;            -Melatonin 3mg tablet, 1 tablet QHS, dated 11-6-19;            -Vyvanse 20mg capsule, 1 capsule QD, dated 11-11-19;            -Aripiprazole (Abilify) 5mg tablet, 1 tablet QD at 7:00am, dated 10-2-19;            -Aripiprazole 2.5mg tablet, 1 tablet QD at 1:00pm, dated 10-2-19;            -Glucophage (Metformin) 500mg tablet, 1 tablet QD, dated 9-30-19;            -Lamotrigine (Lamictal) 20mg tablet, 1 tablet QD, dated 9-30-19 with physician orders changed to Lamictal 75mg QD on 11-7-19 and physician orders changed to Lamictal 100mg QD on 11-20-19;</p> <p>Review on 12-2-19 of Client #3's MAR dated 9-30-19 to 11-30-19 revealed:            -There was no documentation that Lamictal, Abilify, Metformin, Prozac, and Vyvanse were administered at 8:00am on 10-28-19, 11-17-19, 11-27-19, 11-28-19, 11-29-19, 11-30-19;            -There was no documentation that Abilify 2.5mg was administered at 1:00pm on 10-28-19, 11-17-19, 11-18-19, 11-26-19, 11-27-19, 11-28-19, 11-29-19, or 11-30-19;            -There was no documentation that Melatonin 3mg was administered at 8:00pm on 11-13-19, 11-16-19, 11-27-19, 11-28-19, 11-29-19, and 11-30-19.</p> <p>Interview on 12-2-19 with Client #1 revealed:            - Facility staff had forgotten to give her birth control medication at times;            - When she was not administered her medication, it was "on accident";            - She could not remember the names of all of her</p>	V 118		

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V 118	<p>Continued From page 6</p> <p>medications.</p> <p>Interview on 12-3-19 with Client #3 revealed: -Did not know the names of her medications; -Staff administered her medications to her daily; -If staff forgot to give Client #3 her medications, she would ask for them.</p> <p>Interview on 12-3-19 with Staff #1 revealed: - Staff #1 thought that the Associate Professional (AP) was responsible for reviewing MARs for accuracy and entering newly ordered medications onto MARs; - When new medications were ordered, information about the medication was entered onto a "shift update" form to ensure all staff knew when to administer the medication; - If Staff #1 saw a blank space on a client's MAR, she notified the AP.</p> <p>No interview was completed with the AP due to the AP having been on vacation during the time of the survey.</p> <p>Interview on 12-4-19 with the Qualified Professional (QP) revealed: -The QP had noticed that there were "lots of blanks" on Client #1's MARs; -When noticing blanks on the MARs she would "check dates and ask staff why they had not signed off and it should be in red and documented on the back of the MAR." -The AP is supposed to be doing med checks on the MARs every week; -The QP put the MARs in the book for December and noticed that they were missing the orders and Clindamycin for December MAR; -The QP has asked the Pharmacy for new December MARs for Client #1 that listed all December 2019 medications;</p>	V 118		

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V 118	<p>Continued From page 7</p> <p>"She [Client #1] is getting it (Clindamycin) but it was not transcribed onto the December MAR."</p> <p>Interview on 12-3-19 with the Operations Manager revealed:</p> <ul style="list-style-type: none"> <li>-The Licensee agency had a Registered Nurse (RN) employed who reviewed MARs quarterly;</li> <li>-The RN had not yet reviewed the facility's MARs for the quarter;</li> <li>-She was not sure why initials were missing from the MARs.</li> </ul> <p>Due to lack of documentation it was unable to determine if the medications were administered as written on physician orders.</p>	V 118		