

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-071	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 12/11/2019
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NAME OF PROVIDER OR SUPPLIER WEST MARION SUPERVISED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 145 LUKIN STREET MARION, NC 28752
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V 000	<p>INITIAL COMMENTS</p> <p>A complaint and follow up survey was completed on 12/11/19. The complaints were substantiated (#NC 157678 and NC157791). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Intellectual and Developmental Disabilities.</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</p>	V 118		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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V 118	<p>Continued From page 1</p> <p>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 observation, record review and interviews, failed to follow the written order of a physician affecting 3 of 3 clients (Client #1, Client #2 and Client #3). The findings are:</p> <p>Record review on 12/10/19 for Client #1 revealed: -Admission date of 6/19/18 with diagnoses of Mild Intellectual Disability, Schizoaffective Disorder, Hyperlipidemia, Chronic Obstructive Pulmonary Disease (COPD) and Type II Diabetes. -Physician ordered medications on 8/8/19 included: --Famotidine 20mg take two tabs every morning. --Lisinopril 5mg take one tab every morning. --Metformin 1000mg one tab twice daily. --Nabumetone 500mg one tab twice daily. --Spiriva Handihaler 18mcg inhale 1 capsule every morning. --Symbicort 80-4.5mcg inhale 2 puffs twice daily. --Trazadone 50mg take one tab three times daily. --Aspirin EC 81mg take one tab every night. --Atorvastatin 20mg take one tab every night (ordered 11/7/19). --Gabapentin 300mg take one tab twice daily. --Levemir 100unit inject 40 units sub-Q every evening. --Melatonin 3mg take one tab every night. --Mirtazapine 15mg take one every night. --Trazadone 50mg take 2 tabs at bedtime (ordered 11/28/19).</p>	V 118		

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V 118	<p>Continued From page 2</p> <p>Review on 12/10/19 of MARs for October-December 2019 revealed: --Famotidine was blank on 11/1/19. --Lisinopril was blank on 11/1/19. --Metformin was blank on 11/1/19 am dose and 12/5/19 pm dose. --Nabumetone was blank on 11/1/19 am dose and 12/5/19 pm dose. --Spiriva Handihaler was blank on 11/1/19. --Symbicort was blank on 11/1/19 and 12/5/19 pm dose. --Trazadone was blank on 11/1/19 am dose and 12/5/19 bedtime dose. --Aspirin was blank on 12/5/19. --Atorvastatin was blank on 12/5/19. --Gabapentin was blank on 12/5/19. --Levemir was blank on 12/5/19. --Melatonin was blank on 12/5/19. --Mirtazapine was blank on 12/5/19.</p> <p>Record review on 12/10/19 for Client #2 revealed: -Admission date of 9/18/19 with diagnoses of Mild Intellectual Disability and Schizophrenia. -Physician ordered medications on 11/28/19 included: --Lorazepam 1mg take one tab twice daily.</p> <p>Review on 12/10/19 of MARs for October-December 2019 revealed: --Lorazepam was blank on 11/28/19 pm dose and 11/29/19 pm dose.</p> <p>Record review on 12/10/19 for Client #3 revealed: -Admission date of 5/13/13 with diagnoses of Moderate Intellectual Disability, Hyperthyroidism, Hyperlipidemia, Anxiety Disorder and Dementia. -Physician ordered medications on 9/26/19 included: --Fish Oil 1000mg take one cap three times daily.</p>	V 118		

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V 118	<p>Continued From page 3</p> <p>Review on 12/10/19 of MARs for October-December 2019 revealed: --Fish Oil was blank on 12/8/19 4pm dose.</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>Interview on 12/10/19 with Client #1 revealed: -He always received his medications.</p> <p>Interview on 12/10/19 with Client #2 revealed: -He always got his meds on time.</p> <p>Interview on 12/10/19 with Client #3 revealed: -Staff never forgot to give him his medications. He always got them.</p> <p>Interview on 12/10/19 with the Qualified Professional/ Registered Nurse (QP/RN) revealed: -She was in/out of the facility multiple time during the week to make sure MARs are complete and order refills as needed. -"On-call 24/7. Staff called her constantly even for silly things." Unsure why staff did not contact her if meds were actually refused or forgotten. -Felt that clients did receive their ordered meds but staff simply forgot to click the electronic MAR.</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, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit;</p>	V 120		

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V 120	<p>Continued From page 4</p> <p>(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. (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 interview and observation, the facility failed to keep client medications locked in secure area affecting 1 of 3 clients (Client #1). The findings are:</p> <p>Observation on 12/10/18 between 4:30-4:45 pm of the prescribed medications revealed: -1 box of Trulicity and 1 box of Levemir pens (for Client #1) on refrigerator door in kitchen.</p> <p>Interview on 12/10/18 with the Qualified Professional/ Registered Nurse (QP/RN) revealed: -She was not aware that medications that required refrigeration also needed to be locked. -Would have a small refrigerator put in back room beside the med cart for storage.</p>	V 120		
V 123	<p>27G .0209 (H) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION</p>	V 123		

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V 123	<p>Continued From page 5</p> <p>REQUIREMENTS</p> <p>(h) Medication errors. Drug administration errors and significant adverse drug reactions shall be reported immediately to a physician or pharmacist. An entry of the drug administered and the drug reaction shall be properly recorded in the drug record. A client's refusal of a drug shall be charted.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure medication errors were reported immediately to a physician or pharmacist and charted in the client record affecting 1 of 3 clients (Client #2). The findings are:</p> <p>Record review on 12/10/19 for Client #2 revealed: -Admission date of 9/18/19 with diagnoses of Mild Intellectual Disability and Schizophrenia. -Physician ordered medications on 11/28/19 included: --Lorazepam 1mg take one tab twice daily.</p> <p>Review on 12/10/18 of the facility incident reports between 10/1/19 to 12/10/19 revealed: -2 medication error reports - Client #3 missed med on 10/30/19 and Client #2 missed med on 10/30/19. -Client #2 med error report did not note that physician or pharmacist was contacted.</p> <p>Interview on 12/10/18 with the Qualified Professional/ Registered Nurse (QP/RN) revealed: -She had been notified of the mistake but did not document her contact with their contracted Nurse</p>	V 123		

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V 123	Continued From page 6 Practitioner.	V 123		