STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL059-071	A. BUILDING: _____ B. WING _____	R-C 12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST MARION SUPERVISED LIVING	145 LUKIN STREET MARION, NC 28752

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V 000	INITIAL COMMENTS A complaint and follow up survey was completed on 12/11/19. The complaints were substantiated (#NC 157678 and NC157791). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Intellectual and 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	V 118		

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V 118	Continued From page 1 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, failed to follow the written order of a physician affecting 3 of 3 clients (Client #1, Client #2 and Client #3). The findings are: 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).	V 118	Client #1 admission date is 11/1/2019. Client #1 was admitted after morning dose of medications. No medications were administered by NCOGH staff for morning medications.	01/16/20

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V 118	Continued From page 2 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. 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. 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. 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.	V 118	1/15/20 Facility was using Caresuite EMAR. During internet outage system does not sync w/o a restart of software failure to do so will result in undocumented MAR. Staff educated on importance of this step and	

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V 118	Continued From page 3 Review on 12/10/19 of MARs for October-December 2019 revealed: --Fish Oil was blank on 12/8/19 4pm dose. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician. Interview on 12/10/19 with Client #1 revealed: -He always received his medications. Interview on 12/10/19 with Client #2 revealed: -He always got his meds on time. Interview on 12/10/19 with Client #3 revealed: -Staff never forgot to give him his medications. He always got them. 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.	V 118	On documenting On provided back up paper MARS. New EHR system will be implemented on 2/4/2020 with daily monitoring of documentation and continuing education for staff.	
V 120	27G .0209 (E) Medication Requirements 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;	V 120		

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V 120	Continued From page 4 (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. 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: 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. 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.	V 120	Small refrigerator moved to locked med room for medications requiring refrigertion 1/14/20	
V 123	27G .0209 (H) Medication Requirements 10A NCAC 27G .0209 MEDICATION	V 123		

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V 123	Continued From page 5 REQUIREMENTS (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. . 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: 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. 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. 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	V 123	QP/RN created a step by step manual for permanent placement of facility and educated staff on steps to be taken if a med error occurs. Continuing education provided to staff on what is a med error how to report to dr/pharmacist & how to correctly document. 1/15/20	

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V 123	Continued From page 6 Practitioner.	V 123		