

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-267</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  R <b>04/09/2020</b>
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**INDEPENDENT LIVING AT THOMPSON DRIVE**

**1712 THOMPSON DRIVE  
WINSTON SALEM, NC 27127**

(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	<b>INITIAL COMMENTS</b>  An annual and follow up survey was completed on 4/9/2020. Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.	V 000		
V 118	<b>27G .0209 (C) Medication Requirements</b>  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		

DHSR-Mental Health  
MAY 14 2020  
Lic. & Cert. Section

Division of Health Service Regulation

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

TITLE

(X6) DATE

STATE FORM

6899

MDE211

If continuation sheet 1 of 8

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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 ensure that administration of medications was documented immediately following administration affecting 2 of 3 clients (#2 &amp; #3). The findings are:</p> <p>Review on 3/11/2020 and 4/8/2020 of client #2's record revealed:</p> <ul style="list-style-type: none"> <li>- Admission date: 9/6/2017</li> <li>- Diagnoses: Bipolar I Disorder (D/O); Schizoaffective D/O, depressive type; Moderate Intellectual Disability; Asthma; Hypertension; and Tachycardia</li> <li>- Physicians orders for the following medications: <ul style="list-style-type: none"> <li>- Atorvastatin calcium 10 milligrams (mg), 1 tablet every day (QD), dated 10/16/2019;</li> <li>- Divalproex sodium ER 500 mg, 3 tablets every night at bedtime (QHS), dated 11/22/2019;</li> <li>- Hydroxyzine pamoate 50 mg. 1 tablet twice daily (BID), dated 11/22/2019;</li> <li>- Lithium carbonate ER 450mg, 2 tablets QHS, dated 11/22/2019;</li> <li>- Risperidone 4 mg, ½ tablet every morning (QAM) &amp; 1 tablet QHS, dated 11/22/2019.</li> </ul> </li> </ul> <p>Review on 3/11/2020 of client #2's MARs dated 1/1/2020 to 3/11/2020 revealed:</p> <ul style="list-style-type: none"> <li>- No documentation of administration of atorvastatin calcium, divalproex sodium ER, hydroxyzine pamoate, lithium carbonate ER, or risperidone at 8:00PM on 1/28/2020.</li> </ul> <p>Reviews on 3/11/2020 and 4/8/2020 of client #3's</p>	V 118	<p>The agency will ensure that the medications are documented as soon as the client is observed taking the medication. The agency will re-train staff on medication administration for those who do not demonstrate the skills needed. The QP will review the MARs to ensure that the staff is documenting</p>	5/1/2020

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V 118	<p>Continued From page 2</p> <p>record revealed:</p> <ul style="list-style-type: none"> <li>- Admission date: 9/3/2019;</li> <li>- Diagnoses: Disruptive Mood Dysregulation D/O; Oppositional Defiant D/O; Major Depressive D/O, recurrent, in partial remission; Post Traumatic Stress Disorder (PTSD); Mild Mental Retardation</li> <li>- Physicians' orders were present for the following medications: <ul style="list-style-type: none"> <li>- Cetirizine Hcl (hydrochloride) 10 mg, 1 tablet QHS, dated 9/19/2019;</li> <li>- Chlorpromazine 50 mg, 1 tablet QAM &amp; 2 tablets at 1:00PM, dated 1/31/2020;</li> <li>- Chlorpromazine 200 mg, 1 tablet every night (QPM), dated 1/31/2020;</li> <li>- Ferrex 150 mg, 1 tablet BID, dated 8/30/2019;</li> <li>- Gabapentin 400 mg, 1 tablet three times daily (TID), dated 9/16/2019;</li> <li>- Lithium 8 mEq (milliequivalent)/5ml (milliliter) solution, take 7.5 ml BID, dated 1/31/2020;</li> <li>- Niaspan ER 500 mg, 2 tablets QHS, dated 12/17/2019;</li> <li>- Omeprazole 20 mg, 1 tablet QD, dated 9/5/2019;</li> <li>- Prazosin 1 mg, 1 tablet QHS, dated 9/5/2019;</li> <li>- Stool softener 100 mg, 1 tablet BID, dated 1/21/2020;</li> <li>- Topiramate 100 mg, 1 tablet BID, dated 9/19/2019;</li> <li>- Trazodone HCL 50 mg, 1 tablet QHS, dated 1/31/2020;</li> <li>- Vitamin D 1,000 mg, 1 tablet BID, dated 9/19/2019.</li> </ul> </li> </ul> <p>Review on 3/11/2020 of client #3's MARs dated 2/1/2020 to 3/11/2020 revealed:</p> <ul style="list-style-type: none"> <li>- No documentation of administration of the following total medication doses in February and March 2020 for the following medications: <ul style="list-style-type: none"> <li>- Cetirizine Hcl 10 mg, 6 doses;</li> <li>- Chlorpromazine 50 mg, 15 doses;</li> </ul> </li> </ul>	V 118	<p>properly. This will be ongoing</p>	



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V 118	<p>Continued From page 3</p> <ul style="list-style-type: none"> <li>- Chlorpromazine 200 mg, 10 doses;</li> <li>- Ferrex 150 mg, 10 doses;</li> <li>- Gabapentin 400 mg, 20 doses;</li> <li>- Lithium 8 mEq/5ml solution, 10 doses;</li> <li>- Niaspan ER 500 mg, 3 doses; 1/31/2020</li> <li>- Omeprazole 20 mg, 5 doses;</li> <li>- Prazosin 1 mg, 2 doses;</li> <li>- Stool softener 100 mg, 7 doses;</li> <li>- Topiramate 100 mg, 7 doses;</li> <li>- Trazodone HCL 50 mg, 2 doses;</li> <li>- Vitamin D 1,000 mg, 6 doses.</li> </ul> <p>Due to the failure to accurately document medication administration it could not be determined if clients received medications as ordered by their physicians.</p> <p>Interview on 3/11/2020 with client #2 revealed:</p> <ul style="list-style-type: none"> <li>- As far as he knew, he had been administered his medications every day as ordered.</li> </ul> <p>Interview on 3/11/2020 with client #3 revealed:</p> <ul style="list-style-type: none"> <li>- Client #3 thought that she did not always get her dose of lithium "because I don't think they know what they are doing ... the night person doesn't give me my lithium in the morning ..."</li> </ul> <p>Interview on 3/13/2020 with staff #1 revealed:</p> <ul style="list-style-type: none"> <li>- If staff #1 found blanks on clients' MARs, she would let the TL know;</li> <li>- As far as staff #1 knew, she had not made any medication errors;</li> <li>- Clients #2 and #3 had been administered their medications correctly on staff #1's shifts.</li> </ul> <p>Interview on 3/12/2020 with the Team Leader (TL):</p> <ul style="list-style-type: none"> <li>- If the TL found blanks on MAR's he would call</li> </ul>	V 118		

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V 118	Continued From page 4  the staff responsible to address the blanks; - The TL thought the blanks were left by a staff that was recently terminated from employment.  Interview on 4/8/2020 with the Qualified Professional (QP) revealed: - Clients at the facility had been administered all of their medications correctly; - The TL was supposed to check MARs for accuracy and completeness; - The QP did not know why blanks were left on clients #2 and #3's MARs.  Interviews on 4/8/2020 and 4/9/2020 with the Director revealed: - The TL was supposed to check MARs to ensure they were completed correctly; - Some blanks on client #3's February MAR could have been when she was in the hospital for behavioral health stabilization; - The Director did not know why there were blanks on client #3's MAR other than the dates she was hospitalized; - The Director thought that clients #2 and #3 had been administered their medications correctly;	V 118		
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; (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	V 120		

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V 120	<p>Continued From page 5</p> <p>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 record reviews and interviews, the facility failed to ensure medications were stored securely affecting 1 of 3 clients (#3). The findings are:</p> <p>Reviews on 3/11/2020 and 4/8/2020 of client #3's record revealed: - Admission date: 9/3/2019 - Diagnoses: Disruptive Mood Dysregulation D/O; Oppositional Defiant D/O; Major Depressive D/O, recurrent, in partial remission; Post Traumatic Stress Disorder (PTSD); Mild Mental Retardation; - Client #3 was admitted to a local hospital on 2/7/2020 for behavioral health stabilization; - Physicians orders for the following medications: - Ferrex 150 mg (milligrams) , 1 tablet twice daily (BID), dated 8/30/2019; - Gabapentin (Neurontin) 400 mg, 1 tablet three times daily (TID), dated 9/16/2019.</p> <p>Review on 3/11/2020 of client #3's MARs dated 2/1/2020 to 3/11/2020 revealed: - The only medications scheduled for administration at 2:00PM every day were Ferrex and gabapentin;</p>	V 120	<p>The staff will be re-trained on the safe storage of medications. The OP will monitor the staff by doing clinical supervisions. This will be ongoing</p>	5/1/2020



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V 120	<p>Continued From page 6</p> <ul style="list-style-type: none"> <li>- The February MAR revealed that client #3 was at the hospital from 2/7/2020 to 2/13/2020.</li> </ul> <p>Review on 3/13/2020 of the on-line Incident Response Improvement System (IRIS) reports for the facility revealed:</p> <ul style="list-style-type: none"> <li>- On the morning of 2/7/2020, staff #2 prepared a "pill pack" with client #3's 2:00PM medications to be transported to a day program with client #3;</li> <li>- At 8:00AM, the pill pack was left unsecured on the kitchen table while staff #2 went outside with clients #1, #2 and #3 for a smoke break;</li> <li>- 2 minutes later, client #3 walked back into the facility while staff #2 and clients #1 and #2 remained outside;</li> <li>- Client #3 took the pill pack from the table and went to her bedroom;</li> <li>- Clients #1, #2 and #3 were transported to the day program without staff #2 discovering that client #2's pill pack was missing;</li> <li>- At the day program, client #3 showed day program staff the empty pill pack and reported that she had taken the pills;</li> <li>- Client #3 was transported to a local hospital for treatment of a suicide attempt;</li> <li>- An allegation of neglect by staff #2 was investigated, and it was determined that staff #2 would receive re-training on unspecified topics.</li> </ul> <p>Interview on 3/11/2020 with client #3 revealed:</p> <ul style="list-style-type: none"> <li>- Client #3 did not think that staff #2 administered all of client #3's medications correctly;</li> <li>- Client #3 did not provide any information about the incident on 2/7/2020.</li> </ul> <p>Interview attempt on 4/8/2020 with staff #2 was unsuccessful due to staff #2 not returning the Surveyors call by the exit date.</p> <p>Interview on 4/8/2020 with the Qualified</p>	V 120		

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V 120	<p>Continued From page 7</p> <p>Professional (QP) revealed:</p> <ul style="list-style-type: none"> <li>- Medications were supposed to be locked up securely'</li> <li>- On 2/7/2020, client #3's 2:00PM medications had been prepared by staff #2 in order to take them to the day program for client #3;</li> <li>- Client #3's 2:00PM medications were on the kitchen table because clients were about to leave for the day program;</li> <li>- There had not been any other issues with medication storage.</li> </ul> <p>Interviews on 4/8/2020 and 4/9/2020 with the Director revealed:</p> <ul style="list-style-type: none"> <li>- On 2/7/2020, staff #3 was getting ready to take facility clients to the day program and had the meds out on the table;</li> <li>- Client #3 did not have any health problems from taking the two medications that she took from the table;</li> <li>- Client #3 was hospitalized for behavioral health stabilization after the incident;</li> <li>- Medications were usually locked up.</li> </ul>	V 120		