PRINTED: 07/07/2020
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601328	A. BUILDING: _____ B. WING _____	C 06/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPEWAY	1717 SHARON ROAD WEST CHARLOTTE, NC 28210

(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 A complaint survey was completed on 6/26/20. The complaint was substantiated (intake #NC001165922). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.	V 000		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (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; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (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.	V 117	In order to correct the deficiency cited, this facility has taken the following steps. 1. On 07/03/2020, this facility contracted with a new pharmacy, which packages and dispenses client medications on a daily basis. The daily packaging and dispensing process ensures the packaging label of each prescription drug dispensed contains all of the required information for administration. 2. On 07/03/2020, this facility updated the Medication Administration/Self-Administration policy. 3. On 07/21/2020 and 07/22/2020, pharmacy staff trained facility nursing staff to the new medication packaging system. 4. On 07//23/2020, this facility implemented the updated Medication Administration/ Self-Administration policy. 5. Beginning on 07/23/2020 through 08/07/2020, this facility's nursing and medical staff members will complete a competency quiz on the updated Medication Administration/Self-Administration policy.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE CEO/CMO. (X6) DATE 07/24/20

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V 117	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the packaging label contained required information for administration affecting 1 of 1 former clients (FC#1). The findings are: Review on 6-25-20 of Former Client (FC) #1's record revealed: - admitted 2-20-20; - diagnoses of Bipolar Disorder (with psychosis during manic episodes); - physician order dated 3-2-20 revealed Clozapine (used to treat mental/mood disorders) 50mg (milligrams), 1 tablet daily at bedtime. Review on 6-17-20 of the facility's Incident Report dated 3-2-20 revealed: - Registered Nurse (RN) #9 completed an inventory of medication bottles for FC#1; - RN #9 noticed that the Clozapine order on the medication bottle for FC#1 did not match the physician order; - due to the medication bottle label not matching the written physician order for Clozapine, FC#1 only received 25mg of Clozapine instead of the ordered dose of 50mg. Review on 6-24-20 of the employee personnel file for RN #9 revealed: - training dated 1-29-19 on Safe Patient Care: Preventing Medication Errors; - training dated 4-29-19 on the facility's Employee Policy and Employee Handbook Acknowledgement;	V 117	In order to prevent the deficiency from occurring again, this facility will take the following steps. 1. Continue with weekly medication order audits performed by staff nurses and reviewed by the Director of Nursing or Associate Director of Nursing on a monthly basis (or sooner if indicated). 2. Contact prescriber (or on-call provider) within 12-24 hours for any noted discrepancies between packaging label for prescription drugs and prescriber's orders to obtain clarification. 3. Conduct medication cart audits every three (3) months (or sooner if indicated), which will be conducted by the Director of Nursing (and/or Associate Director of Nursing) and pharmacy staff jointly.	

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V 117	Continued From page 2 - training dated 4-5-20 of review on Safe Patient Care: Preventing Medication Errors. Interview on 6-24-20 with RN #9 revealed: - employed 2-11-19; -"orders don't always match the label on the medication bottles;" - clients bring their medication bottles from home and if the physician changes the dosing of medication, the label may or may not get changed; - had received one medication error since employment; - medication error received was due to a physician's order changing the medication dose in the system but the label on the bottle was not changed; - an incident report and medication variance report was completed when the medication error occurred; - complete weekly medication checks to verify that the orders in the computer system match the labels on the medication bottles. Interview on 6-15-20 with RN #1 revealed: - hired 9-10-19; - "medication bottles originate with resident and we use the medication until the bottle is empty, no matter what the order is changed to;" - "bottles don't get relabeled when orders change." Interview on 6-17-20 with Associate Director of Nursing (ADON) #2 revealed: - hired 4-3-18; - "if a client has a change in med dose the physician puts in the change, writes the order, faxes it to the pharmacy and the pharmacy will send over new labels for meds they have filled previously;"	V 117		

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V 117	Continued From page 3 - "if our pharmacy didn't fill the original medication, they will not send over a new label when a medication dose is changed." Interview on 6-18-20 with RN #3 revealed: - hired 9-30-19; - reported no problems with medication bottle labels not matching the physician orders within the computer system. Interview on 6-18-20 with RN #4 revealed: - hired on 3-6-18; - "bottles sometimes don't get new labels if medication is dispensed by another pharmacy." Interview on 6-17-20 with Licensed Practical Nurse (LPN) #5 revealed: - hired on 6-1-20; - still in training; - worked along side a charge nurse on each shift; - has not witnessed any problems with bottle labels not matching the physician orders in the computer system. Interview on 6-17-20 with LPN #6 revealed: - hired on 3-11-19; - no knowledge of any medication labels not matching the physician orders in the computer system. Interview on 6-17-20 with LPN #7 revealed: - hired on 11-22-19; - all medication labels matched the physician orders in the computer system. Interview on 6-26-20 with RN #8 revealed: - hired on 11-5-19; - "probably once weekly I have doctors change orders so that things match;" - "I double and triple check everything before	V 117		

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V 117	Continued From page 4 dosing." - Interview on 6-17-20 with the Director of Nursing (DON) revealed: - hired on 3-26-18; - promoted to Director of Nursing in January 2020; - medication reconciliation is completed with the Wellness RN upon each admission; - "if orders are changed, the system is updated, script is faxed to the pharmacy, new order are entered, if insurance will not cover a different dose of medication, we will have to score the medication...but the majority of the time the medications come from the pharmacy when there are changes;" - "the pharmacy won't relabel medications that don't come from them;" - "to my knowledge this hasn't caused confusion;" - has issued 1 medication error due to an RN administering the wrong dose of medication due to the label on medication not matching the physician's order in the computer system; - "switching to a new pharmacy on 7-22-20... new pharmacy will rectify the problem because they dispense meds on a daily basis and everything will be aligned."	V 117		