HOPE HAVEN

May 26, 2021

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

DHSR - Mental Health
JUN 3 2021
Lic. & Cert. Section

Re: Statement of Deficiencies with the Plan of Correction

Villages of Hope Haven, 3815 N. Tryon Street, Charlotte, NC 28206

MHL # 060-381

Intake#172281

Dear Ms. McLain,

Please find enclosed the statement of deficiencies form, the plan of correction, and supporting documents. Also the below requirements are included in the documentation.

- The measures that will be put in place to prevent the problem from occurring again.
- Staff that will monitor the situation to ensure it will not occur again.
- The frequency the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Sincerely,

Kristin Blinson

Kristin Blinson
President / CEO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL060-381	A. BUILDING: ______ B. WING ______	R 05/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLAGES OF HOPE HAVEN	**3815 NORTH TRYON STREET CHARLOTTE, NC 28206**

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V 000	INITIAL COMMENTS An annual, complaint and follow-up survey was completed on 5/10/21. The complaint was unsubstantiated (intake #NC172281). A deficiency was cited. This facility is licensed for the following service categories: 10A NCAC 27G .4100 Residential Recovery Programs for Individuals with Substance Abuse Disorders and 10A NCAC 27G .4300 Therapeutic Community.	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.	V 118		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE
Kristin Glasson 5/26/21

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V 118	Continued From page 1 (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. This Rule is not met as evidenced by: Based on records review, observations and interviews, the facility failed to ensure medications were administered with a signed prescription order and failed to ensure a MAR of all drugs administered to each client was kept current affecting 9 of 9 audited clients (#1, #2, #3, #4, #5, #6, #7, #8, #9). The findings are: Interview on 4/20/21 and 4/28/21 with the Medication Assurance Coordinator(MAC) revealed: -was hired in 11/2020 to the position of MAC; -administered medications(meds), communicated with the Nurse Practitioner(NP), scheduled appointments for clients with the NP, coordinated refills with pharmacies and managed the facility's medication room; -clients got their medications from different places/pharmacies; -some clients wanted to have medications discontinued but wouldn't go see the NP; -after 30 days, clients were responsible for getting their own refills and orders; -ran into issues with clients going to pick up their refills due to working, problems or delays with physicians' refilling meds and issues with the pharmacies; -now have Kipu EMR(electronic medical records);	V 118	Hope Haven has recently completed a conversion of papercharts to an EMR system (KIPU) that started in January 2021. A part of this conversion was inputing each client and all their prescribed medication. The process of inputing and merging of the medication in the system started in March 2021. This was a process was that was estimated to take approximately 45-60 days. During this implementation there were areas of documentation that were identified that needed modification. While this process was being instituted the quality of care of all clients and the administration of their medication was the elemental priority was to ensure each client received their appropriate medication as prescribed.	

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V 118	Continued From page 2 -the NP has access to Kipu system; -did incident reports for missed meds; -"Kipu has been a learning experience;" -"N/A" means staff did not check "yes" or "no;" -if staff did not put "yes" or "no", Kipu went to "N/A;" -could mean out of med "possibly;" -could mean client did not take medication; -there was a section to add a note or comment; -if a medication count was zero and no refills are put in the system, then the system did not give the option to check "yes" or "no;" -if you have no option, you have to add a transaction; -had to discontinue the order, then create the exact same order; -"No" meant the client did not have the medication to take; -in the Kipu system, she had access to the day before but not the next day; -had started completing daily reports of clients who did not come in for their medications. Finding #1: Review on 4/19/21 of client #1's record revealed: -admission date of 1/7/21; -diagnoses of Alcohol use Disorder Severe, Cocaine Use Disorder Severe and Major Depressive Disorder; -admission assessment dated 1/6/21 documented client #1 was homeless, was unemployed, used cocaine daily, had depression, high cholesterol, high blood pressure and had completed 45 days in substance abuse treatment; -treatment plan dated 1/20/21 documented the goal to maintain freedom from addiction; -review of monthly progress notes from 1/2021-3/2021 revealed no documentation of any issues with medication compliance.	V 118	1. All Hope Haven clinical staff received training on Monday 5/10/21 that included transcription/medication audit procedure. This training included how to monitor and enter specific documentation related to any medication administration for clients. Clinical staff also received a medication check list for each of their perspecitve clients to increase quality assurance in documentation of medication. (see attached). This checklist will require weekly review with their supervisor to ensure client is current on all medications. This check list will be in effect on Monday 5/10/21 with the first review on Friday 5/17/21. Hope Haven has contracted a new NP that will provide additional oversight on a monthly basis of the presriber orders. 2. All Clinical staff completed an in service training on 5/19/21 to develop the additional skillset of completing a weekly medication compliance audit for each client.This weekly audit will be followed by a progress note that indicates any areas of improvement to include refills, discontiuation appointments with NP, or additional referrals. 3. Hope Haven has contracted a Consulting RN who has developed and implemented various policies to include the controlled substance policy and Medication/Prescription/Transcribing/ Monitoring Policy. All clinical staff was trained during the implementation phase during the week of 5/24/21. (See attached)	5/10/21 5/17/21 5/24/21

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V 118	Continued From page 3 Review on 4/20/21, 4/23/21, 4/26/21 and 5/10/21 of client #1's facility medical records revealed the following Physician/NP's orders and other documents regarding medications: -undated form faxed to the facility on 12/10/20 and signed by a physician with no dosing instructions for the following medications: amlodipine 2.5mg(milligram) for HTN(hypertension), Lisinopril 10mg for HTN, haloperidol 5mg for MDD(Mood Dysregulation Disorder), sertraline 150mg for MDD and Vistaril 50mg for anxiety; -self-administer order dated 4/24/21; -order dated 2/26/21 for haloperidol 5mg one tablet at bed with "discontinued" stamp on the order dated 4/26/21; -order dated 2/26/21 for metoprolol tartrate 50mg one tablet twice daily for high blood pressure(HBP); -order dated 2/26/21 for atorvastatin calcium 80mg one tablet daily for high cholesterol; -order dated 4/23/21 for omeprazole 20mg two tablets at bed for acid reflux; -order dated 3/20/21 for bupropion HCL(hydrochloride) XL(extended release) 150mg one in the am for mood; -order dated 3/20/21 for doxycycline hyclate 100mg one tablet twice daily for infections; -discontinue order dated 4/24/21 for haloperidol 5mg one tablet a bed; -unsigned print-out from a medical provider dated 1/19/21 listed the following medications: amlodipine besylate 5mg one half tablet daily, metoprolol tartrate 50mg one tablet daily, atorvastatin 40mg two tablets daily, gabapentin 300mg two tablets twice daily for pain; -order dated 5/8/21 for the following medications: omeprazole 20mg two tablets at bed, Aspirin 81mg one tablet daily, atorvastatin 80mg one tablet daily, metoprolol 50mg one tablet twice	V 118	4. The medication coordinator in conjunction with medication technicians will conduct weekly physical checks of the medication containers for each client to ensure proper disposal of discontinued medication or empty bottles.	ongoing

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V 118	Continued From page 4 daily and sertraline 50mg 4 tablets daily. Observation on 4/20/21 at 10:45am of client #1's medications revealed: -haloperidol 5mg one tablet at bed dispensed 2/9/21 empty bottle with no refills; -amlodipine besylate 5mg one half tablet daily dispensed 3/12/21; -metoprolol tartrate 50mg one tablet twice daily dispensed 3/24/21; -atorvastatin calcium 80mg one tablet daily dispensed 3/24/21; -omeprazole 20mg two tablets at bed dispensed 3/24/21; -bupropion HCL XL 150mg one in the am dispensed 4/13/21; -doxycycline hyclate 100mg one tablet twice daily dispensed 4/13/21; -gabapentin 300mg two tablets twice daily dispensed 4/13/21; -lisinopril 5mg one tablet daily dispensed 3/21/21; -sertraline HCL 50mg 4 tablets daily dispensed 2/9/21. Review on 4/20/21 of client #1's handwritten 2/2021 MAR revealed the following dosing dates left blank with no explanation on the form: -metoprolol tartrate 50mg one tablet twice daily on 2/2-2/8(am), 2/19-2/25(am/pm); -haloperidol 5mg one tablet at bed on 2/19-2/25; -amlodipine besylate 5mg one half tablet daily on 2/19-2/25; -atorvastatin calcium 80mg one tablet daily on 2/19-2/25; -omeprazole 20mg two tablets at bed on 2/19-2/25; -doxycycline hyclate 100mg one tablet twice daily for on 2/20-2/25(am/pm); -gabapentin 300mg two tablets twice daily on 2/19-2/25(am/pm);	V 118		

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V 118	Continued From page 5 -lisinopril 5mg one tablet daily on 2/19-2/25; -sertraline HCL 50mg 4 tablets daily on 2/19-2/25. Review on 4/20/21, 4/23/21 and 4/26/21 of client #1's electronic MARs from 2/25/21-4/19/21 revealed the following dosing dates with the documentation of "No" or "N/A(not applicable)" with no explanation/comment in the electronic system for the missed medication: -metoprolol tartrate 50mg one tablet twice daily for am doses on 2/2 3/2, 3/7, 3/8, 3/9, 3/10, 3/11, 3/12, 3/16, 3/17, 3/18, 3/19, 3/23, 3/24, 3/25, 3/26, 3/27, 3/28, 3/29, 3/30, 3/31, 4/1, 4/5, 4/6, 4/7, 4/8, 4/9, 4/12, 4/14, 4/15, 4/16, 4/19; -metoprolol tartrate 50mg one tablet twice daily for pm doses on 2/28, 3/7, 3/22, 3/23, 3/24, 3/25, 3/26, 3/27, 4/19; -haloperidol 5mg one tablet at bed on 2/28, 3/7, 3/24-4/19; -amlodipine besylate 5mg one half tablet daily on 2/28, 3/7; -atorvastatin calcium 80mg one tablet daily on 2/28, 3/7, 3/13, 3/18, 3/19, 3/22-4/1, 4/3, 4/7, 4/8, 4/10, 4/12, 4/15, 4/17-4/19; -omeprazole 20mg two tablets at bed on 2/28, 3/7, 3/12, 3/13-3/18, 3/22-3/28; -doxycycline hyclate 100mg one tablet twice daily missed am doses on 2/27, 2/28, 3/2,3/7, 3/9, 3/10, 3/11, 3/15, 3/16, 3/17, 3/18, 3/19, 3/22, 3/23, 3/24, 3/25, 3/26, 3/29, 3/31, 4/1, 4/5, 4/6, 4/7, 4/12, 4/15, 4/16, 4/19; -doxycycline hyclate 100mg one tablet twice daily missed pm doses on 2/28, 3/7, 3/22, 3/26; -gabapentin 300mg two tablets twice daily missed am doses on 2/27, 3/1, 3/2, 3/7, 3/8, 3/9-3/12, 3/15, 3/16, 3/18, 3/19, 3/20, 3/21-3/27, 3/29-4/10, 4/12, 4/14-4/19; -gabapentin 300mg two tablets twice daily missed pm dose on 3/7, 3/16, 3/19, 3/24-3/26, 3/30-4/10, -lisinopril 5mg one tablet daily on 2/28, 3/7,	V 118		

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3/23("Yes" and N/A" documented for same times/date), 3/24("Yes" and N/A" documented for same times/date), 3/25("Yes" and N/A" documented for same times/date), 3/26("Yes" and "No" documented for same date/time), 3/27(Yes" and "No" documented for same date/time), 3/28("Yes" and N/A" documented for same times/date);
-sertraline HCL 50mg 4 tablets daily on 2/28, 3/5, 3/6, 3/7;
-bupropion HCL XL 150mg one in the am on 4/7.

Review on 4/16/21 and 4/20/21 of the facility's incident reports and missed medication daily reports from 2/1/21-4/20/21 revealed documentation client #1 missed his medications on 3/21(refused med), 3/22, 3/23, 3/25(refused gabapentin) 3/26, 3/29, 4/13, 4/14, 4/15, 4/16 and 4/19.

Interview on 4/26/21 with client #1 revealed:
-took his medications at 8:15am and 8:00pm;
-try to not miss his medications;
-took his medications daily;
-anytime he runs out, he can get his med refills without a problem.

Finding #2:
Review on 4/19/21 of client #2's record revealed:
-admission date of 1/20/21;
-diagnoses of Cannabis Use Disorder Severe, Opioid Use Disorder Severe, Amphetamine-type Substance Use Disorder Severe, Post Traumatic Stress Disorder(PTSD), Unspecified Depressive Disorder and Unspecified Anxiety Disorder;
-admission assessment dated 1/14/21 documented client #2 had a history of suicidal ideation, victim of abuse and rape, history of Hepatitis C, victim of domestic violence(DV), on probation, history of legal issues and ten year

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V 118	Continued From page 7	V 118		

heroin use daily;
-treatment plan dated 1/20/21 documented the goal to maintain freedom from addiction;
-review of monthly progress notes from 1/2021-3/2021 revealed no documentation of any issues with medication compliance.

Review on 4/20/21, 4/23/21, 4/26/21 and 5/10/21 of client #2's facility medical records revealed the following Physician/NP's orders and other documents regarding medications:
-order dated 12/8/20 for the following medications: venlafaxine 75mg one tablet twice daily for mood; quetiapine 100mg one tablet at bed for mood and Trazadone 50mg one tablet a bed for sleep;
-order dated 2/2/21 and 2/24/21 for levetiracetam 500mg one tablet twice daily for seizures with "discontinued" stamp on the order dated 4/12/21;
-order dated 2/24/21 for venlafaxine 75mg two tablets twice daily with "discontinued" stamp on the order dated 3/25/21;
-orders dated 2/24/21 and 3/23/21 for quetiapine 100mg two tablets in the am, one tablet at noon and two tablets in pm with "discontinued" stamp on the order dated 4/9/21;
-order dated 2/24/21 for doxycycline hyclate 100mg one tablet twice daily for infection with "discontinued" stamp on the order dated 3/4/21;
-form undated and unsigned for gabapentin 300mg one tablet three times daily for pain;
-orders dated 5/8/21 for omeprazole 20mg one tablet in the am for acid reflux, venlafaxine 75mg two tablets twice daily, Trazadone 50mg three tablets at bed for sleep, quetiapine 100mg one tablet in the am, one tablet at 1pm and two tablets at bed;
-discontinue order dated 3/2/21 for doxycycline hyclate 100mg one tablet twice daily.

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Observation on 4/20/21 at 11:45am of client #2's medications revealed:
-levetiracetam 500mg one tablet twice daily dispensed 4/7/21;
-venlafaxine 75mg two tablets twice daily dispensed 3/25/21;
-quetiapine fumerate 100mg two tablets in the am, one tablet at noon and two tablets in pm dispensed 3/26/21;
-Trazadone 50mg three tablets at bed dispensed 4/7/21;
-gabapentin 300mg one tablet three times daily dispensed 3/25/21.

Review on 4/20/21 of client #2's handwritten 2/2021 MAR revealed the following dosing dates left blank with no explanation on the form:
-levetiracetam 500mg one tablet twice daily on 2/2-2/3, 2/4;
-quetiapine fumerate 100mg two tablets in the am, one tablet at noon and two tablets in pm for 2/11 at 1pm;
-Trazadone 50mg three tablets at bed for 2/1-2/3.

Review on 4/20/21, 4/23/21 and 4/26/21 of client #2's electronic MARs from 2/25/21-4/19/21 revealed the following dosing dates with the documentation of "No" or "N/A(not applicable)" with no explanation/comment in the electronic system for the missed medication for some dates:
-quetiapine fumerate 100mg two tablets in the am on 2/27, 3/11, 3/20, 3/23-4/5, 4/6("Yes" and N/A" documented for same date/am dose);
-quetiapine fumerate 100mg one tablet at noon on 3/3, 3/11, 3/11, 3/15, 3/20, 3/23-4/5, 4/6("Yes" and N/A" documented for same date/am dose);
-quetiapine fumerate 100mg two tablets in pm on 2/24, 3/7, 3/11, 3/11, 3/15, 3/20, 3/23-4/5, 4/6("Yes" and N/A" documented for same

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V 118	Continued From page 9 date/am dose); -quetiapine fumerate all doses missed on 3/21 and 3/22 with noted comments client #2 was out of her medication with no refills; -venlafaxine HCL 75mg two tablets twice daily for am dose on 2/27, 3/11-3/15, , 3/19, 3/21, 3/23-3/25; -venlafaxine HCL 75mg two tablets twice daily for pm dose on 3/3, 3/11-3/15, 3/16, 3/17, 3/18, 3/19, 3/20, 3/21, 3/23-3/25, 3/31; -venlafaxine HCL 75mg doses missed on 3/16, 3/17, 3/18 and 3/22 with noted comments client #2 was out of her medications; -doxycycline hyclate 100mg one tablet twice daily on 2/27(am), 2/28(pm), 3/1(pm); -Trazadone 50mg three tablets at bed on 3/7, 3/9, 3/10, 4/9, 4/12, 4/13; -levetiracetam 500mg 500mg one tablet twice daily for am on 2/27, 3/8, 3/9, 3/10, 3/11, 4/9; 4/10-4/11(Yes" and "No" documented for same date/time all doses); -levetiracetam 500mg 500mg one tablet twice daily for pm on 3/7, 3/8, 3/9, 3/10, 3/11, 4/10-4/11(Yes" and "No" documented for same date/time all doses); -gabapentin 300mg one tablet three times daily on 3/8(1pm/9pm), 3/9-3/24(all doses), 3/24(am/1pm), 4/16(1pm), Review on 4/16/21 and 4/20/21 of the facility's incident reports and missed medication daily reports from 2/1/21-4/20/21 revealed documentation client #2 missed medications on 3/21(no refills), 3/23, 3/25, 3/24, 3/25, 3/26 and 3/29. Interview on 4/26/21 with client #2 revealed: -takes her medications at 7:00am, 1:00pm and 9:00pm; -first couple of weeks missed some of her	V 118		

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medications;
-not missed any medications recently;
-only had a problem once because physician forgot to put amount on script.

Finding #3
Review on 4/19/21 of client #3's record revealed:
-admission date of 9/15/20;
-diagnoses of Cocaine Use Disorder Severe, Alcohol Use Disorder Severe, Cannabis Use Disorder Mild, Depression and PTSD;
-admission assessment 8/19/20 documented client #3 used alcohol and drugs for fifteen years, was homeless, had a criminal history, had a history of suicidal/homicidal ideation, had limited coping skills and completed 28-day recovery treatment;
-treatment plan dated 9/15/20 documented the following goal to dose medications as prescribed;
-review of monthly progress notes from 1/2021-3/2021 revealed no documentation of any issues with medication compliance.

Review on 4/20/21, 4/23/21, 4/26/21 and 5/10/21 of client #3's facility medical records revealed the following Physician/NP's orders and other documents regarding medications:
-orders dated 8/19/20 for sertraline 100mg one tablet daily for depression, pantoprazole 40mg one tablet daily for GERD(gastroesophageal reflux disease), quetiapine 50mg 3 tablets at bed for depression and trazadone 50mg one tablet prn(as needed) for insomnia;
-order dated 10/5/20 for hydroxyzine 25mg two tablets at bed for anxiety and Trazadone 100mg one tablet at bed;
-order dated 2/25/21 for Trazadone 100mg one tablet at bed with "discontinued stamp" on the order dated 3/29/21;
-order dated 2/25/21 for hydroxyzine 25mg two

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tablets once a day with "discontinued" stamp on the order dated 3/29/21;
-order dated 2/25/21 for quetiapine fumerate 25mg six tablets daily;
-order dated 3/8/21 for gabapentin 300mg one tablet three times daily for pain with "discontinued" stamp on the order dated 3/18/21.
-order dated 3/13/21 for gabapentin 300mg two tablets three times daily;

Review on 4/20/21 of client #3's handwritten 2/2021 MAR revealed the following dosing dates left blank with no explanation on the form:
-sertraline 100mg one tablet daily on 2/13 and 2/14;
-hydroxyzine 25 mg two tablets at bed on 2/4 and 2/13;
-Trazadone 100mg one tablet at bed on 2/4 and 2/14;
-quetiapine fumerate 25mg six tablets daily on 2/4 and 2/1.

Review on 4/20/21, 4/23/21 and 4/26/21 of client #3's electronic MARs from 2/25/21-4/19/21 revealed the following dosing dates with the documentation of "No" or "N/A(not applicable)" with no explanation/comment in the electronic system for the missed medication:
-sertraline 100mg one tablet daily on 2/28, 3/12, 3/15, 3/16, 3/18-3/29, 4/12, 4/18;
-hydroxyzine 25 mg two tablets at bed on 2/25, 3/23, 3/24-3/28, 4/5, 4/11, 4/13, 4/17, 4/18;
-Trazadone 100mg one tablet at bed on 2/25, 3/24, 3/25, 3/28, 4/5, 4/11, 4/13, 4/17, 4/18;
-quetiapine fumerate 25mg six tablets daily on 2/25, 3/23, 3/24-3/28,4/5, 4/11, 4/13;
-gabapentin 300mg two tablets three times daily for am dose on 3/12, 3/15, 3/16, 3/19, 3/20, 3/24, 3/25, 3/29, 4/11, 4/12, 4/17-4/19;
-gabapentin 300mg two tablets three times daily

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for pm dose on 3/14, 3/16, 3/27, 3/28, 3/29, 4/2, 4/3, 4/5, 4/1, 4/12, 4/13, 4/17-4/19.

Review on 4/16/21 and 4/20/21 of the facility's incident reports and missed medication daily reports from 2/1/21-4/20/21 revealed documentation client #3 missed medications on 3/21(no refill sertraline), 3/22, 3/23, 3/26, 3/29, 4/13, 4/18, 4/19.

Interview on 4/26/21 with client #3 revealed:
-took his medications as prescribed;
-not missed any medications;
-no problems with refills;
-always shows up for medication call;
-if medications were not taken, got a write-up from counselor.

Finding #4
Review on 4/19/21 of client #4's record revealed:
-admission date of 2/25/21;
-diagnoses of Stimulant Use Disorder Severe, Opioid Use Disorder Severe, Alcohol Use Disorder and Unspecified Mood Disorder;
-admission assessment 1/26/21 documented client #4 was unemployed, was a DV victim, had a criminal history, had Hepatitis C, IV(intravenous) use daily of opioids, past involvement with Social Services regarding her children and completed prior substance abuse treatment;
-treatment plan dated 2/16/21 documented the goals to dose on medications as prescribed and complete Hepatitis C treatment;
-review of monthly progress notes from 2/2021-3/2021 revealed no documentation of any issues with medication compliance.

Review on 4/20/21, 4/23/21, 4/26/21 and 5/10/21 of client #4's facility medical records revealed the

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following Physician/NP's orders and other documents regarding medications:
-order dated 2/20/21 for lamotrigine 150mg one tablet daily for mood;
-order dated 2/20/21 for pantoprazole 40mg one daily acid reflux;
-order dated 2/20/21 for ferrous sulfate 325mg one tablet daily for iron deficiency;
-order dated 2/20/21 for multivitamin one tablet daily;
-order dated 2/20/21 for vitamin C one tablet daily;
-discontinue order dated 5/8/21 for multivitamin one tablet daily;
-discontinue order dated 5/8/21 for vitamin C one tablet daily.

Observation on 4/20/21 at 11:50am of client #4's medications revealed:
-lamotrigine 150mg one tablet daily dispensed 3/3/21;
-pantoprazole 40mg one daily dispensed 3/3/21;
-ferrous sulfate 325mg one tablet daily dispensed 4/2/21;
-multivitamin one tablet daily not on site;
-vitamin C one tablet daily not on site.

Review on 4/20/21, 4/23/21 and 4/26/21 of client #4's electronic MARs from 2/25/21-4/19/21 revealed the following dosing dates with the documentation of "No" or "N/A(not applicable)" with no explanation/comment in the electronic system for the missed medication:
-lamotrigine 150mg one tablet daily on 4/16;
-pantoprazole 40mg one tablet daily on 4/16;
-ferrous sulfate 325mg one tablet daily on 4/16;
multivitamin one tablet daily not listed on MARs;
-vitamin C one tablet daily not listed on MARs.

Review on 4/16/21 and 4/20/21 of the facility's

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incident reports and missed medication daily reports from 2/1/21-4/20/21 revealed documentation client #4 missed medications on 4/16.

Interview on 4/26/21 with client #4 revealed:
-takes her medications;
-no issues with getting refills;
-never missed her medications.

Finding #5
Review on 4/19/21 of client #5's record revealed:
-admission date of 2/8/21;
-diagnoses of Alcohol Use Disorder Severe, Cannabis Use Disorder Severe, Cocaine Use Disorder Severe;
-admission assessment 2/65/21 documented client #5 had completed 28 days of substance abuse treatment, smoked crack/cocaine daily, drank alcohol weekly, used cannabis daily, had HTN and experienced stress regarding his family;
-treatment plan dated 2/16/21 documented the following goal to maintain freedom from addiction;
-review of monthly progress notes from 2/2021-3/2021 revealed no documentation of any issues with medication compliance.

Review on 4/20/21, 4/23/21, 4/26/21 and 5/10/21 of client #5's facility medical records revealed the following Physician/NP's orders and other documents regarding medications:
-orders dated 2/5/21 for amlodipine 10mg one tablet daily for HTN, Losartan 25mg one tablet daily for HTN, Naltroxene 50mg one tablet daily for cravings and Prazosin 1mg one tablet at bed for nightmares;
-order dated 3/2/21 for mirtazapine 30mg one tablet at bed for mood/sleep;
-order dated 2/9/21 for quetiapine fumerate 100mg one tablet at bed for bipolar disorder;

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-order dated 3/8/21 for duloxetine HCL 30mg two tablets daily for depression/anxiety with "discontinued" stamp on the order dated 3/25/21;
-form dated 3/5/21 for gabapentin 300mg one tablet three times daily for pain with "approved" by NP, original prescriber's name on the form and a "discontinued" stamp on the order dated 3/7/21;
-order dated 3/6/21 for gabapentin 300mg two tablets three times daily;
-order dated 5/8/21 for Losartan 50mg one tablet daily for HBP;
-order dated 3/5/21 and 5/8/21 for Metformin 500mg one tablet twice daily for diabetes.

Observation on 4/20/21 at 12:05pm of client #5's medications revealed:
-gabapentin 300mg two tablets three times daily dispensed 3/24/21;
-mirtazapine 15mg two tablets at bed dispensed 3/4/21 bottle empty with "no refills" on label;
-quetiapine fumerate 100mg one tablet at bed dispensed 4/6/21;
-Naltroxene 50mg one tablet daily dispensed 3/25/21;
-Metformin 500mg one tablet twice daily dispensed 3/31/21;
-Losartan 25mg one tablet daily dispensed 4/9/21;
-amlodipine besylate 10mg one tablet daily dispensed 3/19/21;
-duloxetine 30mg two tablets in the am dispensed 3/25/21 bottle empty with "no refills" on label;
-Prazosin 1mg one tablet at bed not on site.

Review on 4/20/21 of client #5's handwritten 2/2021 MAR revealed the following dosing dates left blank with no explanation on the form:
-quetiapine 100mg one tablet at bed for 2/9-2/14;
-Naltroxene 50mg one tablet daily for 2/9-2/15;
-amlodipine 10mg one tablet daily for 2/10-2/15;

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-Losartan 25mg one tablet daily for 2/9-2/15.

Review on 4/20/21, 4/23/21 and 4/26/21 of client #5's electronic MARs from 2/25/21-4/19/21 revealed the following dosing dates with the documentation of "No" or "N/A(not applicable)" with no explanation/comment in the electronic system for the missed medication on some dates:
-duloxetine 30mg two tablets daily on 3/10, 3/12-3/26, 4/19(client out of med);
-Metformin 500mg one tablet twice daily on 3/11(pm), 3/26(am), 4/5(pm), 4/6(am), 4/7(pm);
-gabapentin 300mg two tablets three times daily for am dose on 3/21, 3/23-3/25, 3/26, 4/6(am);
-gabapentin 300mg two tablets three times daily for pm dose on 3/12, 3/15, 3/22, 3/23-3/25, 3/30, 4/8, 4/11, 4/12;
-Naltroxene 50mg one tablet daily on 3/19-26;
-mirtazapine 15mg two tablets at bed on 4/4-4/19;
-amlodipine 10mg one tablet daily on 3/26, 4/6;
-Losartan 25mg one tablet daily on 3/26, 4/6.

Review on 4/16/21 and 4/20/21 of the facility's incident reports and missed medication daily reports from 2/1/21-4/20/21 revealed documentation client #5 missed medications on 3/22-3/26, 4/13, 4/20.

Interview on 4/26/21 with client #5 revealed:
-takes his medications at 8:00am, 12:30pm, and 8:00pm;
-overslept one time and missed his medications;
-big line in the mornings to get medications;
-ran out of some medications;
-had a hard time getting in touch with the doctor for refills;
-started feeling bad;
-ran out of mirtazapine, duloxetine for about a week;
-both were for anxiety;

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-ran low on Metformin and gabapentin;
-missed his blood pressure medication one day;
-responsible for getting his own refills;
-he has to call the doctor to write a prescription and the pharmacy did not get it;
-the NP emailed and called the doctor to help him.

Finding #6
Review on 4/19/21 of client #6's record revealed:
-admission date of 3/22/21;
-diagnoses of Alcohol Use Disorder Severe and Crack/Cocaine Use Disorder;
-admission assessment dated 3/12/21 documented client #6 was unemployed, was a victim of DV, was homeless, had past overdoses in 2016 and 2018, past history of suicidal ideation, had blackouts from alcohol, past diagnoses of PTSD and Depression and history of substance abuse treatment;
-treatment plan dated 3/22/21 documented the goal to abstain from drug and alcohol use;
-review of monthly progress notes revealed no documentation of any issues with medication compliance.

Review on 4/20/21, 4/23/21, 4/26/21 and 5/10/21 of client #6's facility medical records revealed the following Physician/NP's orders and other documents regarding medications:
-orders dated 3/8/21 for gabapentin 300mg two tablets three times daily for pain and mirtazapine 15mg one tablet at bed for depression;
-order dated 3/23/21 for Keflex 500mg one tablet twice daily for 7 days for infection;
-order dated 3/30/21 for Prozac 40mg two tablets daily for depression.

Observation on 4/20/21 at 12:15pm of client #6's medications revealed:

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-gabapentin 300mg two tablets three times daily dispensed 3/22/21;
-mirtazapine 15mg one tablet at bed dispensed 3/17/21;
-Prozac 40mg two tablets daily dispensed 3/17/21;

Review on 4/20/21, 4/23/21 and 4/26/21 of client #6's electronic MARs from 3/22/21-4/19/21 revealed the following dosing dates with the documentation of "No" or "N/A(not applicable)" with no explanation/comment in the electronic system for the missed medication:
-gabapentin 300mg two tablets three times daily on 3/22(pm), 3/25(pm), 3/30(pm), 4/3(am), 4/10(pm), 4/11(pm);
-mirtazapine 15mg one tablet at bed on 3/30, 4/10;
-Prozac 40mg two tablets daily on 3/30;
-Keflex 500mg one tablet twice daily for 7 days on 3/23(pm), 3/24(am/pm), 3/25(am), 3/30(pm), 4/2(am/pm), 4/3(am), 4/3(pm-comment "finished).

Review on 4/16/21 and 4/20/21 of the facility's incident reports and missed medication daily reports from 2/1/21-4/20/21 revealed no documentation for client #6's regarding medications.

Interview on 4/26/21 with client #6 revealed:
-take her medications three times a day at 8:00am, 1:00pm and 9:00pm;
-forgot to take her medications one time;
-came in with established medication refills.

Finding #7
Review on 4/19/21 of client #7's record revealed:
-admission date of 7/21/20;
-diagnoses of Opioid Use Disorder, Alcohol Use Disorder and Bipolar Disorder;

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-admission assessment dated 6/26/20 documented client #7 had a history of diagnosis of Bipolar-Manic Depressive Disorder, was employed, had a criminal history, lived in hotels, used alcohol and opioids daily and completed substance abuse treatment;
-treatment plan dated 7/21/20 had the goal to dose on medications as prescribed;
-review of monthly progress notes from 1/2021-3/2021 revealed no documentation of any issues with medication compliance.

Review on 4/20/21, 4/23/21, 4/26/21 and 5/10/21 of client #7's facility medical records revealed the following Physician/NP's orders and other documents regarding medications:
-order dated 12/5/20 for amlodipine 10mg one tablet daily for HBP;
-order dated 12/5/20 for bupropion 300mg one tablet in the am for depression;
-order dated 3/3/21 for Suboxone 8/2mg once a day for opioid addiction;
-no order for Prazosin 2mg three tablets at bed for HBP.

Observation on 4/20/21 at 2:00pm of client #7's medications revealed:
-amlodipine 10mg one tablet daily bottle empty with 2 refills;
-bupropion 300mg one tablet in the am bottle empty with 2 refills;
-Prazosin 2mg three tablets at bed bottle empty with 2 refills
-Suboxone 8/2mg once a day at 6pm.

Review on 4/20/21, 4/23/21 and 4/26/21 of client #7's electronic MARs from 2/1/21-4/19/21 revealed the following dosing dates with the documentation of "No" or "N/A(not applicable)" with no explanation/comment in the electronic

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system for the missed medication:
-amlodipine 10mg one tablet daily on 3/11, 3/12, 3/13, 3/14, 3/15, 3/16, 3/17, 3/18, 4/19;
-bupropion 300mg one tablet in the am on 3/11,3/12, 3/13, 3/14, 3/15, 3/16, 3/17, 3/18, 4/19;
-Prazosin 2mg three tablets a bed on 3/7, 3/10, 3/11, 3/13, 3/14, 3/15, 3/16, 3/17, 4/19;
-Prazosin 2mg three tablets at bed documented as administered without a physician's order on 2/1-3/6, 3/8, 3/9, 3/12, 3/18-4/18;
-Suboxone 8/2mg once a day not listed on MARs on 2/26-3/2.

Review on 4/16/21 and 4/20/21 of the facility's incident reports and missed medication daily reports from 2/1/21-4/20/21 revealed documentation client #7 missed medications on 4/19.

Interview on 4/26/21 with client #7 revealed:
-got his medications on time;
-not missed any medications;
-"I stay on top of it;"
-"make sure I get all my refills."

Finding #8
Review on 4/19/21 of client #8's record revealed:
-admission date of 7/20/20;
-diagnoses of Alcohol Use Disorder Severe, Cocaine Use Disorder Severe, Unspecified Anxiety Disorder, Unspecified Trauma and Stressor Related Disorder, Unspecified Depressive Disorder;
-admission assessment 7/16/20 documented client #8 was homeless, was victim of DV, used alcohol daily, had pending criminal charges, had limited coping skills, prior diagnosis of depression, had a history of inpatient psychiatric treatment in 6/2020, had history of suicidal ideation and had the following medications: HTN,

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COPD(Chronic Obstructive Pulmonary Disease), high cholesterol and reflux;
-treatment plan dated 1/20/21 documented the goal to dose on medications as prescribed;
-review of monthly progress notes from 1/2021-3/2021 revealed no documentation of any issues with medication compliance.

Review on 4/20/21, 4/23/21, 4/26/21 and 5/10/21 of client #8's facility medical records revealed the following Physician/NP's orders and other documents regarding medications:
-orders dated 7/10/20 for Lisinopril 20mg one tablet daily for HBP, amlodipine 10mg one tablet daily for HBP, omeprazole 40mg one tablet daily for heartburn, fluoxetine HCL 20mg one tablet daily for depression, quetiapine fumerate 100mg one tablet at bed for depression;
-order dated 8/1/20 for loratadine 10mg one tablet daily for allergies;
-unsigned print-out from a medical provider dated 1/18/21 listed mirtazapine 15mg one tablet at bedtime for depression;
-orders dated 5/8/21 for Ferrous Sulfate 325mg one tablet twice daily for iron deficiency and mirtazapine 15mg one tablet at bedtime.

Observation on 4/20/21 at approximately 1:45pm of client #8's medications revealed:
-Lisinopril 20mg one tablet daily dispensed 4/6/21;
-amlodipine 10mg one tablet daily dispensed 4/6/21,
-omeprazole 40mg one tablet daily dispensed 4/6/21;
-fluoxetine HCL 20mg one tablet daily dispensed 4/16/21;
-quetiapine fumerate 100mg one tablet at bed dispensed 9/30/20;
-loratadine 10mg one tablet daily dispensed

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1/11/21;
-Ferrous Sulfate 325mg one tablet twice daily dispensed 3/26/21;
-mirtazapine 15mg one tablet at bedtime dispensed 4/16/21.

Review on 4/20/21, 4/23/21 and 4/26/21 of client #8's electronic MARs from 2/25/21-4/19/21 revealed the following dosing dates with the documentation of "No" or "N/A(not applicable)" with no explanation/comment in the electronic system for the missed medication for some dates:
-Lisinopril 20mg one tablet daily on 2/27, 2/28, 3/15, 3/20, 3/29, 4/1;
-amlodipine 10mg one tablet daily on 2/27, 2/28, 3/4, 3/15, 3/20, 3/29, 4/1;
-omeprazole 40mg one tablet daily on 2/27, 2/28, 3/4, 3/15, 3/20, 4/1;
-fluoxetine HCL 20mg one tablet daily on 2/28, 3/4, 3/15, 3/20, 3/23, 3/25, 3/26, 3/27, 3/30, 3/31, 4/1, 4/2, 4/3, 4/5, 4/6, 4/7, 4/8, 4/9, 4/10, 4/11, 4/12, 4/13, 4/14, 4/15, 4/16, 4/17, 4/18, 4/19;
-quetiapine fumerate 100mg one tablet at bed on 2/25, 3/4, 3/7, 3/12, 3/15, 3/22, 3/29, 4/19("N/A" and "Yes"documented for same time/date);
-loratadine 10mg one tablet daily on 2/27, 2/28, 3/15, 3/20, 3/29, 3/13, 4/1;
-Ferrous Sulfate 325mg one tablet twice daily on 2/25, 2/27, 2/28, 3/4, 3/12, 3/15, 3/20, 3/21(comment "out of med"), 3/22-3/26, 3/29, 3/30, 4/1, 4/7;
-mirtazapine 15mg one tablet at bedtime on 2/25, 3/4, 3/7, 3/12, 3/15, 3/20, 3/21(comment "out of med"), 3/22, 3.23, 3/24, 3/25, 3/26, 3/27, 3/29, 3/30, 3/31, 4/2, 4/4-4/8, 4/11, 4/12-4/19.

Review on 4/16/21 and 4/20/21 of the facility's incident reports and missed medication daily reports from 2/1/21-4/20/21 revealed

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documentation client #8 missed medications on 3/25, 4/14, 4/15, 4/16.

Finding #9
Review on 4/19/21 of client #9's record revealed:
-admission date of 8/17/20;
-diagnoses of Alcohol Use Disorder Severe, Cocaine Use Disorder Severe, Bipolar Disorder and Major Depressive Disorder;
-admission assessment dated 7/22/20 documented client #9 was homeless, in and out of jail, inpatient psychiatric history for suicidal ideation, adopted, limited contact with family, victim of rape, completed 28 days of substance abuse treatment, history of Bipolar Disorder, Depression and Anxiety, use of alcohol, cocaine and cannabis, had COPD;
-treatment plan dated 8/24/20 documented the goal to dose on medications as prescribed;
-review of monthly progress notes from 1/2021-3/2021 revealed no documentation of any issues with medication compliance.

Review on 4/20/21, 4/23/21, 4/26/21 and 5/10/21 of client #9's facility medical records revealed the following Physician/NP's orders and other documents regarding medications:
-order dated 2/6/21 for bupropion HCL 150mg one tablet in the am for depression with discontinue order dated 3/9/21;
-order dated 3/9/21 for bupropion HCL 150mg two tablets in the am;
-order dated 1/6/21 for topiramate 50mg one tablet twice daily for Bipolar Disorder;
-order dated 10/31/20 for Strattera 40mg one tablet daily for attention deficient disorder;
-order dated 5/8/21 for Strattera 60mg one tablet in the am;
-order dated 1/23/21 for benzotropine 1mg one tablet twice daily for tremors;

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-discontinue order dated 4/15/21 for benzotropine 1mg one tablet twice daily.

Observation on 4/20/21 at1:30pm of client #9's medications revealed:
-bupropion HCL 150mg two tablets in the am dispensed 3/24/21;
-topiramate 50mg one tablet twice daily dispensed 4/16/21;
-Strattera 60mg one tablet in the am dispensed 2/15/21.

Review on 4/20/21, 4/23/21 and 4/26/21 of client #9's electronic MARs from 2/25/21-4/19/21 revealed the following dosing dates with the documentation of "No" or "N/A(not applicable)" with no explanation/comment in the electronic system for the missed medication for some dates:
-topiramate 50mg one tablet twice daily for 3/15;
-Strattera 60mg one tablet in the am for 3/15, 4/8, 4/16, 4/17, 4/18, 4/29;
-benzotropine 1mg one tablet twice daily for 3/5, 3/6("Yes'" and "No" documented for the same time/date-6pm), 3/7("Yes" and "N/A" documented for the same time/date-6pm), 3/8(Yes'" and "No" documented for the same time/date-6pm), 3/15, 3/22(comment "dosed"), 3/23, 3/24, 3/25, 3/26, 3/27(Yes" and "N/A" documented for the same time/date-6pm), 3/28(Yes'" and "No" documented for the same time/date-6pm), 4/5, 4/6, 4/7, 4/8-4/15;
-bupropion HCL 150mg one tablet in the am still listed on MARs from 3/9-3/26 with no comments documented despite being discontinued on 3/9/21.

Review on 4/16/21 and 4/20/21 of the facility's incident reports and missed medication daily reports from 2/1/21-4/20/21 revealed

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V 118	Continued From page 25 documentation client #9 missed medications on 3/15, 3/22, 3/23, 3/24, 3/25, 4/13, 4/14, 4/15. Interview on 4/26/21 with client #9 revealed: -take her medications daily; -take her medications as prescribed; -sometimes the faxes did not go through for refills; -got her medications from a local mental health provider. Further interview on 4/28/21 with the MAC revealed: -client #1 refused to take his am medications; -told client #1 he needed to see the NP; -client #1 was a no show for at last two appointments with the NP; -client #1 has an appointment scheduled this week with the NP; -the pharmacy would not provide refills for client #2 when she ran out of medications; -client #3 ran out of medications; -client #3 worked third shift and kept putting off going to pharmacy to pick up medications; -worked out a plan for client #3 to go pick up his medications; -client #5 was not on medications when he was first admitted; -client #5 saw the NP and was placed on medications; -client #5 only had a fifteen day supply of medications and ran out; -had to wait on the NP to write the scripts; -client #5 was always good to take medications; -client #6 was out of her medications a couple of days; -client #6 came late for medication call and missed her medications; -client #7 ran out of his medications and did not realize he needed refills;	V 118		

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V 118	Continued From page 26 -client #7 had to see the NP to get refills; -not sure why client #7's Suboxone was not listed on the MARs; -client #8 did not come to med calls; -client #9 ran out of her medications and had to wait on the pharmacy to deliver the refills; -client #9 was good to take her medications. Interview on 5/7/21 with the VP(Vice President) of Clinical Director revealed: -feel it was a data entry error in Kipu; -if a medication was discontinued, it was not entered by staff in Kipu; -clients also did not show up for medication calls; -having COVID cases and lockdown at the facility was also a factor for medication issues. Interview with 5/7/21 and 5/10/21 with the Director of Programming revealed: -if someone missed a medication, a report was generated; -if clients came in later and took the medication, it was not missed; -found some physicians' orders that were not located by the MAC; -the MAC did not have access to these areas in Kipu; -can produce more medication orders from Kipu system by looking in the admissions section; -there were other areas where physicians' orders were kept; -there were still some missing physicians' orders after searching in Kipu and paper records. Interview on 5/7/21 with the VP of Operations revealed: -discussions already taking place between Kipu representatives and staff to address issues in the system; -know a pharmacy that does medications for all	V 118		

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clients at other big facilities;
-can look into this as an option.

Interview with the CEO revealed:
-been an incredible year of change;
-hope headed in the right direction;
-during conversion from paper to electronic, was some "messiness;"
-had a part-time nurse for a few months;
-she was going through each clients' medications;
-she had to leave due to personal reasons;
-a challenge with all the different pharmacies clients use;
-would like to convert all residents to the same pharmacy;.
-need to address the record keeping piece;
-will address issues with clients not having medications;
-the NP comes tomorrow and can assist with this;
-can't believe there are that many missing medication orders and missing medications;
-physician orders should be in Kipu system.

Due to the failure to accurately document medication administration, it could not be determined if client #1, #2, #3, #4, #5, #6, #7, #8 and #9 received their medications as ordered by the physician/NP.

Review on 5/10/21 of the Plan of Protection dated 5/7/21 completed by the VP of Clinical Director revealed the following documented:
"What immediate actions will the facility take to ensure the safety of the consumers in your care? Hope Haven is committed to providing quality care for residents that we serve in all capacities of their treatment and services. Effectively immediately, 5/7/21, the medication coordinator, has been granted all access and privileges in our EMR system KIPU. This will allow for more

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V 118	Continued From page 28 efficient documentation with respect to all medication needs of each client served. Medication Coordinator will be given full access to all medical records including doctors orders, discontinued orders, permission to self-administer for all Hope Haven's medical clients. The VP of clinical services, the director of clinical services, and the medication coordinator have personally reviewed each clients' chart to include prescriber letters, MARs and medications that was documented incorrectly KIPU as listed as part of the audit;" "Describe your plan to make sure the above happens. All counselors will receive training on Monday 5/10/21 on how to monitor and enter specific documentation related to any medication administration for clients. Counselors will receive a medication check list for each of their clients which will require weekly review with their supervisor to ensure client is current on all medications. This check list will be in effect on Monday 5/10/21 with the first review on Friday 5/17/21. We also hired another NP that has been trained on documentation, and will be able to monitor all prescriber letters immediately." Clients #1, #2, #3, #4, #5, #6, #7, #8 and #9 were prescribed medications to address diagnoses which included substance abuse, Bipolar Disorder, Depression, Anxiety and PTSD. Client #1,#2, #3, #5, #7 and #8 were prescribed medications to address medical issues which included high blood pressure, HTN, GERD, pain, insomnia and COPD. There were missing physicians' orders for medications administered. There were dosing dates left blank with no explanation on the handwritten February 2021 MARS for clients. There were numerous discrepancies throughout the electronic MARS from 2/25/21-4/19/21 with no explanation for the	V 118		

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V 118	Continued From page 29 following: missed doses, medications documented as administered and documented as not administered on the same dosing date/time, discontinued medications still listed on MARS and medications listed as "N/A." There were empty bottles of prescribed psychotropic medications in the medication room for clients #1 and client #7. There were medications not on site with no corresponding discontinue orders. There were medications on site not listed on the MARs. Some clients were without their psychotropic medications for periods of several weeks. The Medication Assurance Coordinator did not have access to several areas of the electronic system in order to monitor client medication compliance and accurate medication administration. The failure of the facility to ensure medications were administered as ordered for clients #1-#9 and ensure the MARS were kept current constitutes a Type A1 rule violation for serious neglect which must be corrected within 23 days. An administrative penalty of $3,000.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the facility is out of compliance beyond the 23rd day.	V 118		

Controlled Substance Compliance Policy

In accordance with 10A NCAC 27G .0209, section (e) (2); Hope Haven, or any facility operating under the auspices of Hope Haven, does **NOT** and **WILL NOT** maintain stocks of Controlled Substances.

In certain defined circumstances, a resident may be prescribed Buprenorphine/ Naloxone products, such as Suboxone, used as medication-assisted treatment for those diagnosed with opioid use disorder. Buprenorphine/ Naloxone products are Class III Controlled Substances and are thus maintained and monitored by qualified Hope Haven Medication Aides/ staff in the following manner:

1. Buprenorphine/Naloxone products are stored in a resident specific separate locked box which is then placed in the resident's medication bin which is housed in a separate locked cabinet in the Medication Room. (Double locked system).

2. Keys are maintained by the Medication Aides or designated staff.

3. All dispensed doses are documented in the KIPU EMR per standard procedure. Any missed doses are reported immediately to the VP of Clinical Services or designee.

4. In order to mitigate the risks of accidental overdose, misuse, and abuse, Buprenorphine/Naloxone products are inventoried by two staff members on a weekly basis.

5. Results of the resident's weekly inventory count is recorded in the Clinical Notes section of KIPU. Any discrepancy is reported immediately to the VP of Clinical Services or designee.

6. A controlled substance log sheet for each resident who is prescribed a controlled substance is maintained in the Medication Room in a separate binder. (Copy attached)

Narcotics, or other medications noted on the banned Hope Haven medication list, may be used in extremely time-limited and individual circumstances such as post-operative surgical pain, fractured bones, or painful dental procedures. Prior approval must be given by the VP of Clinical Services or designee in each case.

Maintenance and monitoring of these substances is identical to Buprenorphine/Naloxone products as outlined above.

Policy #HH0063
Reviewed: 9-8-16
Revised: 5-12-2121 by Jennifer Davidson MSN, RN

Approved by: ______________ Date: 5/12/21

Controlled Substance Log Form

One form for each drug or dosage changes **To be completed each Monday**

Resident Name: ______________________________ Month: ______________

Drug: ____________________ Dosage: __________ Prescriber: ___________

Instructions: ____

Week One

Date Started	Beginning # of doses	Additional # of doses	# Dispensed Per KIPU	Ending # of doses	Count is correct?	Document in Clinical Note
					Y N	Y N

Signatures: ________________ ____________________ Date: _________

Week Two

Date Started	Beginning # of doses	Additional # of doses	# Dispensed Per KIPU	Ending # of doses	Count is correct?	Document in Clinical Note
					Y N	Y N

Signatures: ________________ ____________________ Date: _________

Week Three

Date Started	Beginning # of doses	Additional # of doses	# Dispensed Per KIPU	Ending # of doses	Count is correct?	Document in Clinical Note
					Y N	Y N

Signatures: ________________ ____________________ Date: _________

Week Four

Date Started	Beginning # of doses	Additional # of doses	# Dispensed Per KIPU	Ending # of doses	Count is correct?	Document in Clinical Note
					Y N	Y N

Signatures: ________________ ____________________ Date: _________

Week Five

Date Started	Beginning # of doses	Additional # of doses	# Dispensed Per KIPU	Ending # of doses	Count is correct?	Document in Clinical Note
					Y N	Y N

Signatures: ________________ ____________________ Date: _________

***Notify VP of Clinical Services or designee immediately for any discrepancies.**

Policy #HH0063-Form
New: 5/12/21

Medication/Prescription/Transcribing/ Monitoring Policy:

Medical Orders:

Medications will be self-administered by consumers only when authorized in writing by an authorized medical provider, including Physician (MD/OD), Physician's Assistant (PA), or Nurse Practitioner (NP/ARNP).

All prescription and non-prescription (Over the Counter) drugs brought into, or ordered for, Hope Haven residents must:

1. Be accompanied by a signed order from an authorized medical provider.
2. Must be in a properly labeled container from a licensed pharmacy.
3. State how it is to be taken.
4. Frequency of usage.
5. Dosage.
6. Reason for prescribing.
7. Ability of consumer to self-administer.

Transcription of Medication Orders:

The Hope Haven Medication Aides will be responsible for transcribing medication orders and entering the order(s) in the Electronic Medical Record (EMR) within 72 hours of admission or immediately after a new prescription order is received. Hope Haven utilizes the KIPU EMR system. The Medication Aide will also review the status of medications if a resident has visited a provider as described above, or an emergency room or clinic, to assure that any changes to medication orders have been entered into the EMR. The procedures for entering medication orders can be found under the help tab in KIPU.

Transcription Oversight:

Hope Haven requires two-person authentication to verify that all new medication orders have been entered into the EMR correctly. The second authenticator can be a Medication Aide or the VP of Clinical Services (or designee). This should be completed within 24 hours of any medication change or new medication order. Once the order has been verified, the person will electronically sign the EMR in the designated area in KIPU. All orders must be signed in the EMR before a resident can be discharged from Hope Haven and final billing submitted.

Medication Aide Monitoring:

A minimum of 5 resident Medication boxes will be audited and compared with the information that was transcribed into the KIPU EMR system monthly to assure that:

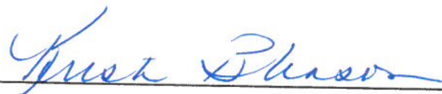
1. The two-person authentication process has been completed within 72 hours of admission or immediately after a new prescription order is received.
2. The information has been transcribed correctly and matches the instructions on the medication container.

The VP of Clinical Services will assign an appropriate individual to complete the monthly audit. Audit results will be delivered to the VP of Clinical Services by the end of each month for evaluation and corrective action if needed. The reports will be retained in the VP of Clinical Services Office.

Counselor Monitoring:

Counselors can review and monitor client medications by clicking on the Medication/Orders tab in KIPU. Any questions or concerns should be brought to the attention of the Medication Aides for clarification.

Revised: 11-19-2010
Reviewed: 8-2-2011
Reviewed: 9-8-2016
Revised: 5-11-2021 by Jennifer Davidson MSN, RN

Approved:  Date: 5/11/21

Transcription/Medication Audit Procedure and Audit Tool

Procedure:

1. Five medication boxes will be pulled at random by the assigned auditor each month. The auditor will confirm that the medication labels contain the following elements:

   Client Name
   Prescriber Name
   Name and Number of Pharmacy
   Name of Drug
   Dosage of Drug
   Frequency of use
   Reason for use
   How it is to be taken
   Refill parameters
   Discard date

2. Open the medication administration section of KIPU and check to see that what has been transcribed in KIPU matches the information on the medication container.

3. Assure that the ordering provider is documented correctly.

4. Assure that there is a second authenticating (verifying) signature has been correctly documented in KIPU.

5. Assure that discontinued medications are documented in KIPU and that bottles are not in the client medication box.

6. Complete the Audit Tool.

7. Submit the Audit Tool to the VP of Clinical Services by the last day of each month.

Policy #62 (B)

Original: 5/11/2021 by Jennifer Davidson MSN, RN

Approved: Kristi Blasor Date: 5/11/21

Transcription Audit Tool

Initials of Client	Labels/Bottles Contain 9 Elements Client name Prescriber name Name of pharm Name of drug Reason for drug Frequency How to take Refill info Discard date	Transcription in KIPU matches Label on Bottle.	Ordering Provider in KIPU matches ordering provider on bottle.	Discontinued Medications are properly documented and have been removed from the medication box.	Second verifying electronic signature has been completed within 72 hours of admission or within 24 hours of a new order.
1	Y N	Y N	Y N	Y N	Y N
2	Y N	Y N	Y N	Y N	Y N
3	Y N	Y N	Y N	Y N	Y N
4	Y N	Y N	Y N	Y N	Y N
5	Y N	Y N	Y N	Y N	Y N

Summary of findings: (include trends, concerns, suggestions, or general comments)

____

____

____

____

Signature of Auditor: ____________________________ Date: ________________

CHART REVIEW REPORT

CLIENT NAME______________ DATE REVIEWED___________
INTAKE DATE___________ DATE TO RETURN__________
REVIEWER_____________ COUNSELOR______________

INITIAL AUDIT: YES OR NO

DISCHARGE REVIEWED: YES OR NO **DATE REVIEWED**______________

CORRECTIONS REVIEWED WITHIN 10 DAYS: YES OR NO

ADMISSIONS:

ALL REQUIRED RELEASES COMPLETED WITHIN 72 HOURS OF ADMISSION **YES OR NO**

INITIAL TREATMENT PLAN COMPLETED AND SUBMITTED TO AUTHORIZATION ON DAY OF ADMISSION **YES OR NO**

INITIAL CRISIS PLAN COMPLETED AND SUBMITTED TO AUTHORIZATION ON DAY OF ADMISSION **YES OR NO**

INITIAL TAR COMPLETED AND SUBMITTED TO AUTHORIZATION ON DAY OF ADMISSION **YES OR NO**

NOTE DOCUMENTING THAT INTAKE WAS COMPLETED. **YES OR NO OR NA**

A COPY OF THE CCA IS UPLOADED IN CHART **YES OR NO**

INITIAL DRUG SCREEN DOCUMENTED IN KIPU **YES OR NO**

TREATMENT PLANNING

Is there an active tx plan in the chart? **YES or NO**
Are all required dimensions present on each plan. **YES or NO**
Does the individual treatment plan have a minimum of 3 goals **YES or NO**

____

Does tx plan reflect the problem areas identified in CCA? YES OR NO

Were appropriate referrals made to include medical, MH, if applicable was a safety plan completed? YES OR NO OR NA

____

Goals individualized, strength based, and expressed by the client? **YES OR NO**

____

Methods are measurable with amounts and frequency, time specific and attainable.
YES OR NO____

COUNSELING NOTES

Minimum of 1 note per month entered by the 5th of the following month? **YES OR NO**

___

Grammatically correct with no spelling errors. **YES or NO**

Are all sections of the note completely accurately and reflect tx plan ?

___

___

Does note inform reader of what is going in client's life as well as changes in level of care.
YES OR NO

___

DRUG SCREENS

Appropriate number of screens completed. YES OR NO

Are monthly drug screens documented in KIPU **YES OR NO**

___

Proper referrals made to medical staff. **YES OR NO OR NA**

___

CLIENT CARE OF SERVICES

Is client in the appropriate level **YES or NO**

Annual CCA scheduled or completed based on client's time in treatment health ax up to date.
YES or NO or NA

DOCUMENTATION

Are all appropriate ROI's signed and attached to file? **YES OR NO**

___

MEDICATION COMPLIANCE

Counselor reviewed medication in KIPU weekly for each client **Yes or No**

Counselor identified that each medication had a prescriber letter was present in the chart Yes or No

Counselor verified that all discontinued medication had an order **Yes or No or NA**

Counselor verified that client had documentation to self-administer medication **Yes or No**

MISC: Any questions, comments, etc on the client or chart review.

Dispensing of Medications/Administration of Medication/Storage of Medications

Dispensing Medications:

Hope Haven does not possess a stock of prescription legend drugs or dispense (provide or give out) prescription legend drugs, or OTC (over the counter) medications. Dispensing is restricted to registered pharmacists, physicians, or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy. In accordance with 10A NCAC 27G.0209 #4, physicians may keep a small, locked supply of prescription drug samples. Samples shall be dispensed, packaged, and labeled in accordance with state law and this Rule.

Administration of Medication:

A.) Medications will be self-administered by consumers only when authorized in writing by an authorized medical provider, including Physician (MD/OD), Physician's Assistant (PA), or Nurse Practitioner (NP/ARNP).

B.) All prescription and non-prescription (Over the Counter) drugs brought into, or ordered for, Hope Haven residents must:

1. Be accompanied by a signed order from an authorized medical provider as documented on the Hope Haven Provider letter, a printed discharge document from the prescribing provider, an actual paper script, or as indicated on the container presented upon admission.
2. Must be in a properly labeled container from a licensed pharmacy.
3. State how it is to be taken.
4. Frequency of usage.
5. Dosage.
6. Reason for prescribing.
7. Ability of consumer to self-administer.

C.) Residents will administer medications to him/herself under the supervision of a qualified clinical staff person as designated by the VP of Clinical Services.

D.) If a medication dose is reduced and can be cut into smaller doses, this will be done by the client while being overseen by the Medication Aide.

E.) Medication administration is recorded in the Kipu EMR per procedure at the time it was administered and signed off by the Medication Aide and the resident.

F.) Hope Haven maintains a dedicated medication administration schedule as follows:

Morning Medications:	8:00 AM (0800) – 9:00 AM (0900)
Afternoon Medications:	12:30 PM (1230) – 1:30PM (1330)
Evening Medications:	5:30 PM (1730) – 6:30 PM (1830)
Late Evening Medications:	8:30 PM (2030) – 9:30 PM (2130)

G.) If a resident does not present for prescribed medications at the prescribed time, it is considered a late occurrence. The late occurrence is reported immediately to the resident counselor. Unless the medication is deemed critical, such as heart medication, blood pressure medication, or diabetes medication, the medication will be administered during the next administration window and a missed medication incident report is filed.

H.) Medications may be "packed out" in situations where a client will not be on the premises for the designated administration time. These medications are placed in a sealed envelope by the resident under the direct observation of the Medication Aide. They are then documented in the EMR by the Medication Aide at the appropriate time. In addition, there is a paper "pack out" log sheet kept in the Medication Room that records client name, name of drug(s) packed out, date and time, and the name of the Medication Aide.

Medication Storage:

Each medication will be stored in a resident specific labeled container and placed in a locked cabinet in the Medication Room, as required by law. Each individual medication must be in a labeled tamper-proof package, bottle, or sleeve which includes a label with the following:

a. The clients name
b. The prescribers name
c. The current dispensing date
d. The name, strength, quantity, and expiration date
e. The name, address, phone number of the dispensing pharmacy or dispensing location, and name of the dispensing practitioner.
f. Clear instructions for frequency of administration and side effects
g. Intact manufacturer's label with an expiration date, the resident's name written in Sharpie, and a clearly visible expiration date on any OTC medication.

Medication which is required to be refrigerated will be kept in a dedicated medication refrigerator in the Medication Room which is kept between 36- and 46-degrees Fahrenheit. Temperature is monitored by the Medication Coordinator on a weekly basis. There may be specific instances where approval is given by the VP of Clinical Services for a resident to have a small refrigerator in their room for insulin or AIDS medications only, no food is permitted in the refrigerator. The resident is responsible for reporting any issues related to refrigeration to the Medication Coordinator.

When a resident has met the criteria for entering Level III, he/she may begin keeping approved medications in his/her possession if:

a. A QSAP has documented that this person is able to self-administer and maintain medications without supervision.
b. Adequate storage will be provided. Must not be accessible to children.
c. If medication is changed or discontinued, the resident will notify the Medication Coordinator who must obtain a written statement from the authorizing authority.

Policy #HH0060 – Combines Dispensing of Medication, Administration of Medication, Storage of Medication

Revised: 6/30/2009

Revised: 5/20/2021 by Jennifer Davidson MSN, RN

Approved by Date: 5/20/21