

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0601328	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/09/2021
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NAME OF PROVIDER OR SUPPLIER HOPEWAY	STREET ADDRESS, CITY, STATE, ZIP CODE 1717 SHARON ROAD WEST CHARLOTTE, NC 28210
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V 000	<p>INITIAL COMMENTS</p> <p>A complaint survey was completed on 12-9-21. The complaint was unsubstantiated (intake #NC0182840). A deficiency was cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .1100 Partial Hospitalization for Individuals Who Are Acutely Mentally Ill and 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.</p> <p>The survey sample consisted of audits of 2 current clients and 1 former client.</p>	V 000		
V 118	<p>27G .0209 (C) Medication Requirements</p> <p>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</p>	V 118		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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V 118	<p>Continued From page 1</p> <p>(E) name or initials of person administering the drug.</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews the facility failed to administer medications as prescribed by the prescribing physician affecting 1 of 3 audited clients (Former Client #1). The findings are:</p> <p>Review on 12/6/21 of Former Client (FC) #1's record revealed: -Admission date: 9/13/21; -Diagnoses: Attention Deficit Hyperactivity Disorder, Mild episode of recurrent Major Depressive Disorder, Chronic Hepatitis C, Substance Abuse in remission, Major Depressive Disorder, recurrent, severe, with psychosis; -physician orders for modafinil (Provigil) (for focus and Attention Deficit Hyperactivity Disorder symptoms) 200mg (milligram) tablet three times daily.</p> <p>Review on 12/6/21 of FC#1's MAR for 9/13/21 - 9/19/21 revealed: -modafinil 200mg tablet, not administered during the 3 drug administration times for 9/15/21; -received modafinil 200mg tablets as ordered for 9/13/21, 9/14/21, 9/16/21, 9/17/21, 9/18/21, and 9/19/21.</p>	V 118		

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V 118	<p>Continued From page 2</p> <p>Review on 12/7/21 of FC#1's Incident Report dated 9/17/21 revealed:</p> <ul style="list-style-type: none"> -FC#1 brought medication modafinil into the facility upon admission; -admissions intake of medications was completed by Former RN #1; -medication storage error for modafinil 200mg tablets occurred due to the medication being stored at the wrong nurse's station and not logged in as a controlled medication at FC#1's assigned nurse's station; -on 9/13/21 and 9/14/21, Former RN#1 was assigned to FC#1 and medications were administered properly; -Former RN#1 was off duty on 9/15/21 and had not stored the medication at the correct nurse's station and medication could not be located by assigned RN; -modafinil was located at another nurse's station and was restarted on 9/16/21; -the attending physician was notified and restarted modafinil 200mg three times daily on 9/16/21. <p>Review on 12/7/21 of Former RN#1's personnel record revealed:</p> <ul style="list-style-type: none"> -disciplinary action with a written warning dated 10/15/21 for violation of company policy for FC#1's medication misplacement resulting in a medication error on 9/15/21; -employee completed a review of the Medication Storage, Medication Administration/Self Administration, Controlled Medication Accountability, and Medication Information Management Policies; -assigned to retake training for Prevention of Medication Errors by 10/30/21; -former RN#1 terminated on 11/9/21 for abandonment of job duties and insubordination. 	V 118		

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V 118	<p>Continued From page 3</p> <p>Attempted interviews on 12/8/21 and 12/9/21 with FC#1 revealed: -messages left for FC#1 via phone; -received no return calls.</p> <p>Attempted interview on 12/8/21 and 12/9/21 with Former RN#1 revealed: -messages left for Former RN#1 via phone; -received no return calls.</p> <p>Interview on 12/6/21 with RN#2 revealed: -transitioned from the Director of Nursing (DON) position to a 1st shift RN position in early September 2021; -was aware that Former RN#1 had some issues with medications errors and some of the nurses had concerns with her not wanting to be a team player; -had no knowledge of missing medications; -was not aware of any current medication problems, errors, or concerns; -an incident report was completed for every facility medication error and the DON completed follow up with that RN for the medication error.</p> <p>Interview on 12/6/21 with the DON revealed: -FC#1 brought in medications from home upon admission; -FC#1 brought in a controlled substance that was not stored at the proper nurse's station and could not be located on 9/15/21 for administration; -FC#1 missed 3 doses of modafinil on 9/15/21 but the medication was located late that day at another nurse's station and was restarted on 9/16/21; -reviewed medication protocols and issued discipline to the assigned admitting RN (Former RN#1); -Former RN#1 was terminated on 11/9/21 for job abandonment and insubordination.</p>	V 118		

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