STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL013-178	A. BUILDING: _____ B. WING _____	R 04/07/2022

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SERENITY HOUSE, A DIVISION OF HOPE HAVI	172 SPRING STREET, SW CONCORD, NC 28025

(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 limited follow-up survey for the Type A1 was completed on 4/7/22. This was a limited follow-up survey, only 10A NCAC 27G .0209(c) Medication Requirements (V118) with cross reference 10A NCAC 27G .0209(h) Medication Requirements (V123) were reviewed for compliance. The following were brought back into compliance: 10A NCAC 27G .0209(h) Medication Requirements (V123). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600E Supervised Living for Adults with Substance Abuse Dependency. This facility is licensed for 8 and currently has a census of 2. The survey sample consisted of audits of 2 current clients. The Statement of Deficiency is amended to correct the facility's licensed capacity	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;	V 117		

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V 117	Continued From page 1 (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. This Rule is not met as evidenced by: Based on records review, observations and interviews, the facility failed to ensure each prescription drug dispensed was properly labeled affecting 2 of 2 clients(#1, #2). The findings are: Review on 4/7/22 of the facility's medication policies revealed the following documented: "Medications may be 'packed out'(medications prepared by client to carry with them when they leave the facility for work or appointments) in situation where a client will not be on the premises for the time designated administration time. These medications(meds) are placed in a sealed envelope by the resident under the direct observation of the Medication Aide. They are documented in the EMR(Electronic Medical Record) by the Medication Aide at the appropriate time..." Interview on 4/6/22 with client #1 revealed:	V 117		

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V 117	Continued From page 2 -took meds in the morning and at night; -staff #1 packed his morning meds for him; -staff #2 put the four morning pills in the envelopes when client #1 took his night pills; -staff #1 packed out the morning meds at night and client #1 took the 4 pills in the am when he wakes up. Interview on 4/7/22 with client #2 revealed: -took Ibuprofen with him to work; -staff #1 put his Ibuprofen in a small brown envelope and gave to him. Interview on 4/6/22 and 4/7/22 with staff #1 revealed: -give meds mostly in the mornings and night time; -"I can pack it out sometimes;" -"like on the weekends, I do pack out the meds;" -"pack out in brown envelopes;" -client #2 leaves early to go to work at 6am, -"most of the time I pack it out for him(client #2);" -put the medications in a small brown envelope and gave to the clients. Observation on 4/6/22 at 11:41am revealed a pile of small brown envelopes on the desk in the office with no labels. This deficiency is cross referenced into 10A NCAC 27G .0209(e) MEDICATION REQUIREMENTS (V120) for a Type B rule violation and must be corrected within 45 days.	V 117		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall	V 118		

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V 118	Continued From page 3 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. This Rule is not met as evidenced by: Based on records review, observations and interviews, the facility failed to ensure medications were administered to a client on the written order of a person authorized by law to prescribe drugs and a MAR of all drugs administered to each client was kept current	V 118		

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V 118	Continued From page 4 affecting 1 of 2 clients(#2). The findings are: Review on 4/6/22 and 4/7/22 of client #2's record revealed: -admission date of 11/3/21; -diagnoses of Alcohol Use Disorder Severe, Unspecified Depressive Disorder and Opioid Use Disorder Severe; -a form dated 3/3/22 signed by a RN(Registered Nurse) for a physician listed the following medications: singulair 10 mg one tablet in the morning for allergies and ibuprofen 800mg four times a day as needed for pain; -a physician's order dated 2/17/22 for Fluticasone Propionate 50mcg two sprays in each nostril daily for allergies; -physician's order for client #2 to self-administrate dated 2/17/22. Observation on 4/6/22 at 11:12am of client #2's medications revealed: -singulair 10 mg one tablet in the morning dispensed 2/28/22; -ibuprofen 200mg four times a day as needed for pain over the counter with an expiration date of 11/2023; -Fluticasone Propionate 50mcg two sprays in each nostril daily dispensed on 2/28/22. Review on 4/6/22 of client #2's MARs from 3/13/22-4/6/22 revealed: -singulair 10mg documented as administered from 3/13-4/6 with no physician's order; -ibuprofen 200mg documented as administered from 3/5-3/16, 3/18-3/31, 4/1-4/6 with no physician's order; -Fluticasone Propionate 50mcg not documented as administered once daily on the following dates: 3/16, 3/17, 3/20-3/24,3/28-3/31, 4/4-4/6; -Fluticasone Propionate 50mcg listed on MARs	V 118		

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V 118	Continued From page 5 as "use as needed." Interview on 4/7/22 with client #2 revealed: -had Flonase nasal spray; -took as needed; -carry it in his pocket; -"If I need a booster" used it; -"told to do once a day regardless;" -usually used Flonase once a day after he left the facility for work and walked to the bus stop because of all his allergies and pollen; -used it more as he needed it; -can use up to 4 sprays as needed; -some days don't need it, -"it all balances out" Interview on 4/6/22 with the Program Manager revealed: -did not realize the "prescriber letter" form signed for singulair and ibuprofen was not signed by a physician; -client #2 did not use his Flonase everyday as he was on several allergy medications; -had been using the Flonase until he was put on the additional allergy medications. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	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	V 120		

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V 120	Continued From page 6 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client; (D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. This Rule is not met as evidenced by: Based on records review, observations and interviews, the facility failed to ensure medications were stored in a secure manner if approved by a physician for a client to self-medicate affecting 2 of 2 clients(#1 and #2). The findings are: Cross Reference: 10A NCAC 27G .0209(b) Medication Requirements(V117). Based on records review, observations and interviews, the facility failed to ensure each prescription drug dispensed was properly labeled affecting 2 of 2 clients(#1, #2). Review on 4/6/22 and 4/7/22 of client #1's record revealed: -admission date of 9/30/20; -diagnoses of Alcohol Use Disorder Severe and Opioid Use Disorder Severe; -a reassessment dated 10/11/21 documented client #1 had a history of opiate use and snorted	V 120		

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V 120	Continued From page 7	V 120		

up to $120.00 of heroin. He drank a fifth of liquor and a six pack of beer. He took least 80mg of Oxycontin pills and benzodiazepine orally. Client #1 also had a history of depression and took prescribed medication to assist with his mental health issues;
-physicians' orders dated 2/8/22 for the following medications(meds): amlodipine besylate 10mg one tablet in the morning for high blood pressure, aspirin 81mg one tablet in the morning for heart health, lisinopril 20mg one tablet in the morning for high blood pressure and sertraline 50mg one tablet in the morning for mood;
-physician's order for client #1 to self-administrate dated 8/18/20.

Interview on 4/6/22 with client #1 revealed:
-took meds in the morning and some at night;
-staff #1 packed out(medications prepared by client to carry with them when they leave the facility for work or appointments) his morning meds at night when he took his night meds;
-he kept the morning meds "right on top of my dresser right beside my bed" so he could take them in the morning when he woke up;
-took his morning meds as soon as he woke up at 8am;
-staff #1 packed out his meds for this am and he took them.

Review on 4/6/22 and 4/7/22 of client #2's record revealed:
-admission date of 11/3/21;
-diagnoses of Alcohol Use Disorder Severe, Unspecified Depressive Disorder and Opioid Use Disorder Severe;
-admission assessment dated 8/18/21 documented client #2 had a history of drinking a 12 pack of beer daily and use of percocets. He spent a year in jail for driving while impaired and

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V 120	Continued From page 8 was placed on probation. Client #2 was involuntarily committed in 2021 due to suicidal ideation; -physicians' order dated 2/17/22 for the following medications: omeprazole 40mg one tablet in the morning for GERD(Gastroesophageal reflux disease) and Meloxicam 15mg one tablet in the morning for pain. A form dated 3/3/22 signed by a RN(Registered Nurse) for a physician listed the following medications: singulair 10mg one tablet in the morning for allergies and ibuprofen 200mg four times a day as needed for pain; -physician's order for client #2 to self-administrate dated 2/17/22. Interview on 4/7/22 with client #2 revealed: -took meds in the morning and in the evening; -took ibuprofen as needed during the daytime; -left the facility before 6:30am to go to work 5 days a week; -took his allergy medication, meloxicam and omeprazole in the mornings; -took his morning meds at 6:00am; -"[staff #1] doesn't like to get up at 6:00(am) but that's his job;" -took ibuprofen pills with him; -kept meds in his pocket. Interview on 4/6/22 and 4/7/22 with staff #1 revealed: -gave meds to the clients mostly in the mornings and night time; -sometimes clients had to go in to work at 6:00am; -"I can pack it(meds) out sometimes;" -"like on weekends, I do pack out the meds;" -"not all the time I do it(pack out meds);" -"pack out" in brown envelopes; -did meds at night at 9pm and packed out meds for the am;	V 120		

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V 120	Continued From page 9 -client #2 left early to go to work at 6:00am and he took am meds; -"most of the time I pack it out for him, or I get up and give it to him;" -packed out the meds in a small brown envelope; -put pills in the envelope; -used to pack out client #2's meds for morning the night before, -sometimes packed out client #1's am meds at night; -packed out client #2's am meds at night for the next morning the day before yesterday; -packed out client #1's am meds at night for the next day about 2 nights ago; -did not know where client #2 kept his packed out am meds over night; -client #2 kept his meds in his pocket; -"how we used to do it(pack out meds) with the manager before;" -"since we got the new manager, I know I'm supposed to do the meds in the mornings;" -"I kinda figured it(pack out meds) wasn't the right way, I went along with the flow;" -"don't pack it(meds) out no more, used to do that." Interview on 4/6/22 with the Program Manager revealed: -client #1 was at the facility most mornings; -client #1 went into work on Saturday and Sundays at 6:00am; -was not aware staff #1 was packing out meds for client #1 during the week; -under the assumption staff #1 was packing out client #2's ibuprofen only; -meds were supposed to be packed out at the time when the clients were headed out the door of the facility; -medications were not supposed to be packed out the night before;	V 120		

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V 120	Continued From page 10 -not sure why staff #1 was packing out meds for clients #1 and #2 on the night before; -will address this issue with staff #1 immediately. Additional interview on 4/7/22 with the Program Manager revealed he met with staff #1 and went over the pack out procedures and expectations. Review of documentation dated 4/7/22 completed by the Program Manager revealed the following documented: -"April 6, 2022 a conversation with [staff #1] was conducted about the proper procedure for packing out medication for any client of Serenity House;" -"Any time a client meds are packed out for them, that client must not take the medications to their room or any place on the campus of Serenity House;" -"All pack-out medications must be taken off the campus of Serenity House;" -"Staff agreed to his mistake and assure it will not happen again." Review on 4/7/22 of a Plan of Protection dated 4/7/22 and completed by the Vice President of Clinical Services revealed the following documented: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Hope Haven(licensee) is committed to providing quality care for all residents that we serve in all capacities of their treatment and service. Effectively immediately the below has been completed 1. What immediate action will the facility take to ensure the safety of the consumers in your care? A. Serenity House manager conducted a meeting with the staff to discuss the medication pack out procedure. This meeting occurred on	V 120		

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V 120	Continued From page 11 4/7/202 B. Serenity House staff will have a training on the appropriate procedure of packing out medication, labeling dose of said medication that will be secured and security of medication. The training is scheduled for 4/8/2022 at 1030am C. Serenity House will have secured locked boxes provided to each client that will have pack out medication. The supplies will be ordered on 4/7/2022 to be delivered directly to Serenity House upon receipt; 2. Describe your plans to make sure the above happens? A. All medications that are packed out will be done in a secure manner via a lockbox. B. Pack outs will only be done in the instance that a client is leaving the facility for appointments or scheduled work that would prevent them from receiving their medication at the scheduled time at Serenity House." Clients #1 and #2 had diagnoses which included Alcohol Use Disorder Severe, Opioid Use Disorder Severe and Unspecified Depressive Disorder. Client #1 had a history of depression and Client #2 had a history of suicidal ideation. Staff #1 was providing client #1 and client #2 their morning medications in unlabeled small brown envelopes the night before when they took their night medications. The medications included sertraline, meloxicam, amlodipine besylate, aspirin, lisinopril, omeprazole, singulair and ibuprofen. Client #1 kept his medications on his dresser in his room when he slept. Client #2 kept his medications in his pocket. Management was unaware this was occurring at the facility. The facility's failure to ensure medications were securely stored, locked and properly labeled in a substance abuse treatment facility constitutes a Type B rule violation which is detrimental to the	V 120		

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V 120	Continued From page 12 health, safety and welfare of the clients. If this violation is not corrected within 45 days, an administrative penalty of $200.00 per day will be imposed for each day the facility is out of compliance beyond the 45th day.	V 120		