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
	MHL065-269	A. BUILDING: ______ B. WING ______	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROJECT TRANSITION-WILMINGTON	**1514 DOCTOR'S CIRCLE WILMINGTON, NC 28401**

(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 An annual and complaint survey was completed on October 24, 2022. The complaint was substantiated (intake #NC00192786). Deficiencies were cited. This facility is licensed for the following service category: 10 A NCAC 27 G .1100 Partial Hospitalization for Individuals Who Are Acutely Mentally Ill. This facility has a current census of 19. The survey sample consisted of audits of 2 current clients and 2 former clients.	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;	V 118		

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V 118	Continued From page 1 (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 record review, interview, and observation, the facility failed to administer medications as ordered by the physician and maintain an accurate MAR affecting 1 of 2 current clients audited (client #15) and 1 of 2 former clients (FC) audited (FC#24). The findings are: Finding #1: Review on 10/21/22 of client #15's record revealed: -55 year old female admitted 9/29/22. -Diagnoses included bipolar disorder in partial remission, most recent episode depressed; post traumatic stress disorder; and substance use disorder. Review on 10/21/22 of client #15's medication orders and September and October 2022 MARs revealed: -Order dated 10/13/22 for spironolactone 100 mg (milligrams) daily. (High Blood Pressure) -No documentation spironolactone 100 mg had been administered from 10/17/22 - 10/21/22. -No documentation if spironolactone 100 mg had been held because client #15's blood pressure	V 118		

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V 118	Continued From page 2 was 90/60 or lower. -Order dated 9/30/22 for doxycycline 100 mg twice daily (BID) for 10 days, which would equal a total of 20 doses. (Antibiotic) -A total of 25 doses of doxycycline 100 mg was documented as administered over over 21 days as follows: 10/1/22 documented BID; no Doxycycline documented on 10/2/22; client #15 was in the hospital 10/3/22-10/5/22; no Doxycycline documented 10/6/22 and 10/7/22; 10/8/22 documented BID, 10/9/22 documented once daily; 10/10/22 and 10/11/22 documented BID, 10/12/22 and 10/13 documented once daily; 10/14/22 -10/17/22 documented BID; 10/18/22 documented once; and 10/19/22 - 10/20/22 documented BID; and 10/21/22 documented at 10:58 am. -Order dated 10/13/22 for sulfamethoxazole 800 mg - Trimethoprim 160 mg BID for 5 days. One dose documented on 10/15/22. (Antibiotic) Observation on 10/21/22 at 2:30 pm of client #15's medications on hand revealed: -The pharmacy packaged all medications in one blister pack compartment for each dosing time for each day. -Doxycycline 100 mg and Spironolactone were printed as medications packaged in the blister packs. -The blister pack had a dispense date of 10/16/22. Interview on 10/20/22 client #15 stated: -The staff administered her medications with the exception of insulin which she administered herself and kept in her possession. She was also independent in performing her finger stick blood sugar testing. -She had been hospitalized for 3 days "about 2 weeks" prior and had a paracentesis with 3 liters	V 118		

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V 118	Continued From page 3 of fluid removed. This was due to her "bad liver." -The program was "excellent." and she felt it had been a "blessing." Finding #2: Review on 10/21/22 of FC#24's record revealed: -44 year old female admitted 8/24/22 and discharged 9/22/22. -Diagnoses included bipolar disorder. -Medication orders dated 8/24/22 included: -Atomoxetine 40 mg every morning. (Cognition-enhancing medication; can treat attention deficit hyperactive disorder) -Benztropine 1 mg daily. (Anti-Tremor medication) -Levothyroxine 100 mcg (micrograms) every morning. (Hypothyroidism) -Lithium Carbonate 600 mg twice daily. (Bipolar disorder) -Semaglutide 7 mg daily. (Type 2 diabetes; long term weight management) Review on 10/21/22 of FC#24's August and September 2022 MARs revealed: - Atomoxetine 40 mg every morning had not been documented as follows: 8/31/22, 9/6/22, and 9/21/22 - Benztropine 1 mg daily had not been documented as follows: 8/31/22, 9/1/22, 9/6/22, and 9/21/22. -Levothyroxine 100 mcg every morning had not been documented as follows: 9/6/22, 9/17/22, and 9/21/22. -Levothyroxine 100 mcg every morning had been documented as given twice on 8/30/22 and 9/7/22. -Lithium Carbonate 600 mg twice daily had not been documented as administered on 8/25/22 and 9/6/22. -Lithium Carbonate 600 mg twice daily had been	V 118		

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documented as administered once a day as follows: 8/24/22, 8/27/22, 8/30/22, 8/31/22, 9/5/22, 9/13/22, and 9/21/22.
-Lithium Carbonate 600 mg twice daily had been documented as administered 3 times a day on 8/28/22 and 9/17/22.

Interview on 10/21/22 the Lead Residential Advisor stated:
-The Nurse Practitioner (NP) was the only person that could enter orders into the electronic medication system.
-He had identified there were times the medications dispensed and the medications printed on the electronic MAR were not the same.
-He had started reconciling the MARs and the NP orders with the NP to make sure the clients received the correct medications and that the documentation was accurate.
-He always took client #15's blood pressure before administering her blood pressure medications and would decrease her dose if needed. He had to decrease her dosage once for a low blood pressure and he informed the NP.
-The NP was readily available to staff when she was called.

Interview on 10/24/22 the Residential Advisor stated there had been times the medications the clients received had not printed on the electronic MAR.

Interview on 10/21/22 the Program Manager stated:
-When the NP entered medication orders into the facility computer system, the orders were electronically transmitted to the pharmacy and would populate the electronic MAR for staff to administer and document when given.
-Only the NP could enter medication orders.

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V 118	Continued From page 5 -It had been identified on some occasions the medication orders sent to the pharmacy and dispensed in the blister packs would not appear on the MAR; therefore, not correctly documented but administered. -She had sent the NP a message and the NP had contacted the pharmacy and confirmed that client #15's sulfamethoxazole 800 mg - Trimethoprim 160 mg had been dispensed and was completed. -There was a comment field in the MAR that staff could use to document reasons a medication was not given (i.e. held because of a low blood pressure.) -It was an easy mistake to document a duplicate medication administration with the current system and she believed that was the issue and not staff administering additional does when it appeared extra doses of medication had been administered for FC#24. Interview on 10/21/22 the NP stated: -She had instructed staff to hold client #15's Spironolactone 100 mg if her blood pressure was 90/60 or lower. -This order to hold client #15's spironolactone was not entered electronically. -The staff had made her aware when client #15 had experienced some low blood pressures. -She had taught staff how to access an on line resource to identify medications in case they needed to remove a medication that was packaged with other medications in the blister packs. Due to the failure to accurately document medication administration, it could not be determined if clients received medications as ordered by the physician.	V 118		

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V 752	Continued From page 6	V 752		
V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit. This Rule is not met as evidenced by: Based on observations and interview the facility failed to maintain water temperatures in areas accessed by clients between 100 - 116 degrees Fahrenheit. The findings are: Observations on 10/20/22 between 11:30 am and 11:45 am revealed the sink water temperatures in 2 restrooms and the kitchen registered 70 degrees Fahrenheit. Interview on 10/20/22 the Program Manager stated: -These restrooms and the kitchen were areas used by clients. -She was not aware there was no hot water. -She contacted facility maintenance and submitted a work request for repair.	V 752		