STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-103	A. BUILDING: _____ B. WING _____	R 01/27/2023

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on January 27, 2023. The complaint was substantiated (intake #NC 00197019). A deficiency was cited. This facility is licensed for the following service Category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. This facility is licensed for 6 and currently has a census of 4. The survey sample consisted of audits of 3 current 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; (D) date and time the drug is administered; and	V 118		

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V 118	Continued From page 1 (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 reviews and interviews, the facility failed to ensure prescription medications were administered on the written order of a person authorized by by law to prescribe drugs and failed to keep the MARs current affecting 2 of 3 audited clients (Client#2 and Client#3). The findings are: Review on 1/27/23 of Client#2's record revealed: -Date of Admission: 2/2/16. -Diagnoses: Major Depressive Disorder, Recurrent, Severe without Psychotic Features; Type II Diabetes Mellitus; Bipolar Disorder, Unspecified; Insomnia; Gastro-Esophageal Reflux Disease (GERD); Chronic Pancreatitis; Disease of Pancreas, Unspecified. -Physicians' orders included: -Zoloft/sertraline (treats depression) 100 milligrams (mg) 2 tablets by mouth daily ordered 10/21/22. -Vistaril/hydroxyzine (treats anxiety) 50 mg 1 by mouth three times per day ordered 10/21/22. -Fioricet/acetaminophen, butalbital, caffeine (treats pain) 50/300/40 mg 1 by mouth three times per day ordered 12/6/22. -Ambien/zolpidem (treats insomnia) 10 mg 1	V 118		

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V 118	Continued From page 2	V 118		

by mouth at bedtime ordered 11/18/22.
-Prudoxin/doxepin hydrochloride (HCL) (treats mood/insomnia) 10 mg 1 by mouth three times per day ordered 1/18/23.
-Humalog/lispro 100 units/milliliter (ml) (treats diabetes) sliding scale before meals at breakfast, lunch and supper with the following instructions: for blood sugar 151-200: 2 units; 201-250 4 units; 251-300 6 units; 301-350 8 units; 351-400 10 units; greater than 400 12 units ordered 10/13/22.

Review on 1/26/23 of Client #2's November 2022 through January 2023 MARs revealed:
-Zoloft/sertraline 100 mg and Vistaril/hydroxyzine 50 mg was documented as not administered on 1/8/23 and 1/9/23.
-The dosing strength of Fioricet/acetaminophen, butalbital, caffeine was not documented.
-The dosing frequency of Ambien/zolpidem was not documented.
-Prudoxin/doxepin HCL 10 mg by mouth three times daily as needed was documented on the MAR with "(Not PRN)" handwritten beside the the instructions.
-The instructions for Humalog/lispro 100 units/ml were to "inject 2 units subcutaneously for every 50 points over glucose level of 150" with no documentation of the frequency, or documentation to indicate the amount of each sliding scale dose administered.

Review on 1/27/23 of facility incident reports revealed:
-Client #2 missed his morning and night dose of hydroxyzine and sertraline on 1/8/23 and 1/9/23 due to the pharmacy being unable to deliver medication. The Qualified Professional (QP) and nursing were notified. Client #2's medical provider was notified and stated there were no side effects and gave instructions to continue to monitor.

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V 118	Continued From page 3 Review on 1/27/23 of Client#3's record revealed: -Date of Admission: 4/1/21. -Diagnoses: Schizophrenia, Unspecified; Alcohol Use, Unspecified with Alcohol-Induced Disorder; Allergic Rhinitis. -Physicians' orders included: -Vitamin D3 2000 international units (IU's) (dietary supplement) 2 capsules (4000 IU's) by mouth daily ordered 12/7/22. -Clozaril/clozapine 100 mg (treats symptoms of psychosis) 1 1/2 tablets (150 mg) by mouth at bedtime ordered 11/7/22. -Luvox/fluvoxamine (treats obsessive thoughts) 25 mg 3 tablets by mouth at bedtime ordered 12/16/22. Review on 1/26/23 of Client#3's November 2022 through January 2023 MARs revealed: -Vitamin D3 2000 IU's 2 capsules by mouth daily was transcribed on the MAR as a total dose of 400 IU's instead of 4000 IU's. -Clozaril/clozapine 100 mg 1 1/2 tablets by mouth at bedtime was transcribed on the MAR as a total dose of 175 mg instead of 150 mg. -Luvox/fluvoxamine 25 mg "Take 3 tablets... by mouth every night at bedtime" was typed on the MAR for the dates of 1/11/32-1/16/23 originally indicating an accurate total dose of 75 mg, however the dose had been crossed out with ink and included a handwritten note indicating a dose of 100 mg which had also been marked through with ink. There was no documentation of which dose had actually been administered for these dates. -Luvox/fluvoxamine 25 mg "Take 3 tablets (25 mg) by mouth every night at bedtime" was transcribed on the MAR for the dates of 1/17/23-1/25/23.	V 118		

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V 118	Continued From page 4 Interview on 1/26/23 with Client #2 revealed: -There were 2 days in January 2023 that he did not receive 2 of his medications for anxiety. -The missed doses "didn't really matter, or make a difference...it was a minor issue." -The facility recently transitioned to having a different pharmacy fill the medication orders. -The issue with medications had been resolved. Interview on 1/26/23 with Client #3 revealed: -"I steadily receive my medicine. I never had a problem with getting my medicine the whole time I have been here." Interview on 1/26/23 with Staff #6 revealed: -She received medication administration training by a nurse upon being hired for the facility. -Staff were supposed to notify nursing if any medications were "running low." -She was aware Client#2 had missed doses of two medications. -A staff member failed to notify nursing that Client#2 was in need of medication refills. -The staff member no longer worked at the facility. -"We recently changed pharmacies and the new pharmacy has kept our supply up ahead of time." Interview on 1/27/23 with the QP revealed: -The facility recently started using a new pharmacy for client medications. -The new pharmacy sent a pharmacy technician "to check the MARs but he did not pick up on errors." -The licensee hired a registered nurse (RN) this week, "she is currently in orientation and will be providing oversight for the MARs from here on out." -Plans were being implemented to ensure MARs are correct prior to allowing them to be sent to	V 118		

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V 118	Continued From page 5 each facility. -There was a delay in getting two of Client#2's medications filled when the facility switched pharmacies. -Client#2 missed 2 doses of two medications due to the delay. -Since then the new pharmacy has been timely in sending medications each month. -Group home managers and staff would soon be required to count every medication in every facility every week. -The facility should never run low on the quantity of pills. -Direct care staff will no longer be allowed to transcribe medication instructions onto the MARs. -Transcription of orders onto the MAR would only be completed by the RN. -All physician orders would be scanned into the facility's electronic system to allow staff to have easier access of prescription information. -Every staff member will have "inservice training" in the new process. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		