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	MHL058-022	A. BUILDING: _____ B. WING _____	R 04/12/2023

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AMANI RESIDENTIAL/HUMAN SERVICES, INC	105 ROBERSON DRIVE WILLIAMSTON, NC 27892

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{V 000}	INITIAL COMMENTS A follow up survey was completed on 4/12/23. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents. This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 3 current clients.	{V 000}	Amani and its staff will correct these deficiencies by requesting physician orders at each medication evaluation for each consumer to be kept in the MAR book and updated as needed and as required per the medication policy. The pharmacy Express Care Pharmacy will assist in this process. The MARs will be kept current. The electronic MAR system will be implemented by July 1, 2023. Amani will also correct this deficiency of V118 by [redacted] (the Director) and [redacted] overseeing the medication administration process as of 04/12/23. All staff (AP, QP, and CCO) will check and report to [redacted] weekly showing signatures on MAR's by all staff to bring organization back into compliance. There will be checks and balances system of the medication administration to bring everything back into compliance until everything is back into compliance. To ensure that this doesn't happen again: Staff Signatures-All trained staff will sign MARs after administration of each medication to the client. If MAR's are not signed by staff, there will be a disciplinary action assigned to the staff that is violating medication rules of 1st verbal warning, 2nd is a write-up, and 3rd is termination and/or as determined by the Amani Executive Team. Physician Orders/After-Visit Summary will be signed and dated by the doctor and Express Care Pharmacy will assist us with this process if needed. Amani is transitioning to eMar with ECP with the hopes of error-free Medication Administration. The physician order that was out of compliance was fixed on 4/11/23 and a copy given to the state as proof of compliance. Refills of medications for clients has already become compliant as of 4/11/23 with Express Care Pharmacy assigning agency to "batch" delivery. There will be a system designed for checks and balance—shift check off sheet so that each shift checks behind each other. This will be reflected through ongoing training of staff and in Amani's updated policies and procedures for systematic change.	June 1, 2023 [redacted] Director [redacted] CFO Ongoing Monitoring
{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	{V 118}		

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{V 118}	Continued From page 1 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 and interview the facility failed to administer medications on the written order of a physician for one of three audited clients (#3) and failed to keep the MAR current for three of three audited clients (#1, #2 & #3). The findings are: Review on 4/5/23 of client #1's record revealed: -Admitted: 5/28/22 -15 years old -Diagnoses: Post Traumatic Stress Disorder (PTSD), Conduct Disorder, Attention Deficit Hyperactivity Disorder (ADHD) Review on 4/5/23 of client #2's record revealed: -Admitted: 8/9/22 -15 years old -Diagnoses: ADHD, Disruptive Mood Disorder Review on 4/5/23 of client #3's record revealed: -Admitted: 10/17/22 -16 years old -Diagnoses: ADHD, Borderline Intellectual Functioning, Conduct Disorder, PTSD, Cannabis Dependency A. Example of medication not having physician's	{V 118}		

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{V 118}	Continued From page 2 orders Review on 4/5/23 of client #3's MARs dated 1/1/23-4/5/23 revealed: -Trazodone 50 milligram (mg) (depression) 1 tablet PRN (as needed) -Guanfacine 2 mg. (mood) 1 tablet AM (morning) Record review on 4/5/23 of client #3's record did not have physician's orders for Trazodone 50 mg, and Guanfacine 2 mg. Further record review on 4/5/23 of client #3's printed out physician's order revealed the Trazodone 50 mg and the Guanfacine 2 mg were printed on a page with not date nor a physician's signature located on the page. Interview on 4/5/23 the Associate Professional (AP) stated the following, -Had physician's orders printed from the pharmacy to keep in the facility. -Not sure why some of the orders did not have a physician signature or date of order. -Client #3 took those medications daily or as needed for Trazodone. B. Example of MARs not being kept current from 1/1/23-4/5/23 Review on 4/5/23 of client #1's record revealed: -Physician order dated 9/13/22 for Aripiprazole 2 mg, one tablet at night. Review on 4/5/23 of client #1's MAR revealed the following date not initialed: -Aripiprazole (mood) 5 mg- 2/26/23 Review on 4/5/23 of client #2's record revealed: -Physician order dated 12/12/22 for Quetiapine	{V 118}		

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{V 118}	Continued From page 3 150 mg, one tablet at 5:30 PM. Review on 4/5/23 of client #2's MAR revealed the following date not initialed: -Quetiapine (Bipolar Disorder)150 mg- 2/28/23 Review on 4/5/23 of client #3's record revealed: -Physician orders dated 1/5/23 for Flonase 2 sprays AM; Symbicort 2 puffs twice a day and Cetirizine 10 mg 1 AM -Physician order dated 1/11/23 for Resperidone 2 mg twice a day -Physician order dated 2/11/23 for Hydroxyzine 25 mg 1 tablet daily Review on 4/5/23 of client #3's MAR revealed the following dates not initialed: -Flonase- 2/26/23, 3/11/23 and 3/12/23 -Symbicort-2/17/23, 2/20/23, 2/21/23, 2/22/23 and 2/23/23 -Cetirizine 10 mg- 2/27/23 -Risperidone 2 mg- 2/27/23 -Hydroxyzine 25 mg- 2/24/23 and 2/25/23 Further review on 4/5/23 of client #3's MAR revealed: -March 2023 MAR - no Epinephrine .3mg printed on MAR -April 2023 MAR- no Epinephrine .3mg printed on MAR Review on 4/11/23 of the Corporate Compliance Officer's (CCO) "Medication Check Sheet" revealed: -2/10/23, 2/24/23, 3/9/23, 3/22/23 and 4/6/23 checks were completed on client #1, #2, #3. -On the above checked sheets, there was no documentation of medication administration errors found during her reviews. -12/29/22- "Out of work... 12/23/22-2/9/23."	{V 118}		

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{V 118}	Continued From page 4 Interview on 4/5/23 the AP stated: -"I scanned (looked over)" the MARs daily. -"Sometimes get busy, may have missed one." -Was the only one who reviewed the MARs. -After last survey, they were working on getting an electronic MAR system. -The CCO was the one who was over this new system. -The CCO came by every other week to check the medications and conduct trainings. -Had not seen her complete any check list that showed any medication errors. -Had not had any medication errors in the last few months. -Had not heard from the CCO with any issues regarding her review of the MARs. -Printed the MARs due to issues with the current pharmacy getting the MARs to them on time. -"I must have not printed page 2" of client #3's MAR that included the Epinephrine pen 0.3 mg on it. C. Example of client #3 not receiving medication as prescribed by physician: Interview on 4/5/23 client #3 stated: -Had missed his Risperidone two or three days a few weeks ago. -The AP had not ordered the refill in time and he went without his medication for a few days. -The AP was the one who ordered the medication refills. -Did not notice any symptoms from missing his medication. Interview on 4/11/23 the Pharmacist stated: -Client #3's Risperidone was filled on 1/11/23, 2/6/23 and 3/15/23. -The medication was filled for 30 days each time.	{V 118}		

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{V 118}	Continued From page 5 -Refills had to be called in, this medication was not on auto refill. Interview on 4/11/23 the AP stated: -He was responsible for calling in all refills for medications. -No client had missed any medications due to it not being in the facility. -Client #3 did have extra pills from not taking all of his medications while on home visits with his family. -Not aware of client #3 missing any medications in the facility. D. Example of staff not being trained to administer the Epinephrine Pen for client #3 Review on 4/5/23 of February MAR for client #3, a written note at the bottom revealed: -"Mention to CCO staff need training on Epinephrine, she stated we will get nurse to train staff how to use." Review on 4/5/23 of client #3's record revealed he was prescribed Epinephrine .3 mg on 1/5/23. Review on 4/5/23 of staff "Sign in sheet" revealed all staff were trained by the Registered Nurse on 3/2/23 for administration of the Epinephrine .3 mg. Interview on 4/5/23 and 4/12/23 the AP stated: -They did not get trained on how to administer client #3's Epinephrine 0.3mg until a few weeks ago. -They had been waiting on training due to getting a nurse to come out and do it. -All staff had now been trained to administer the Epinephrine pen. -Did not know what the Epinephrine pen was	{V 118}		

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{V 118}	Continued From page 6 prescribed for. -Client #3 had allergies and was told if he had trouble breathing or "it stops (breathing)" to use the Epinephrine pen. -Did not know what would trigger client #3's breathing to slow, "Just keep an eye on it (his breathing)." -Client #3 had never needed to use the Epinephrine pen since his admission to the facility. Interview on 4/5/23 and 4/12/23 the CCO stated: -Was at the home every two weeks to do trainings, staff meetings and review medications. -Created a "Medication Check Sheet" to use to monitor the medication system. -Was having issues with the pharmacy and now switching to a new pharmacy and transition to electronic MAR to prevent medication documentation errors. -Had found medication errors in her reviews such as missing signatures and addressed this with the AP and in their trainings with staff. -The AP informed her there were no issues with medication administration and reported no medication errors in the last few months. -This had been very "strenuous and tedious," and a "stressful process." -They are currently working on their third system in the last few months to correct the medication errors. -Had lots of staff turnover in the last few months, so there was ongoing training. -Did not get staff trained on the use of the Epinephrine pen due to needing to get a nurse out to do the training. -All staff have now been trained on the use of an Epinephrine pen. -Not aware of why client #3's MAR sheet was not printed to include the Epinephrine pen .3 mg.	{V 118}		

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{V 118}	Continued From page 7 -Had checked the MARs and did not catch that the second page of client #3's MAR with the Epinephrine pen .3 mg was not present. -The facility was using their own MARs due to the pharmacy not getting them correct. -Had a meeting on 3/29/23 with staff to start implementing a disciplinary process with initialing the MARs. -Hoping the new system with the Electronic MAR will work better and result in error free MARs as she was told by the representative. -Was told that staff could not move to the next screen of the electronic MAR until all medications were initialed. -Had been out with medical complications for a month and did not delegate anyone to do her medication checks while she was out. -"I feel like we were back into compliance to a certain degree." -"I did not request the follow up" for continued Type A1, "we were still working on system issues." -"We were not ready for a follow up and did not think y'all (surveyor) would come unless we called." -"We dropped the ball on these things." Interview on 4/12/23 the Licensee stated: -They had recently switched pharmacies due to the previous pharmacies not filling the medications in a timely manner and issues with the MARs. -Going to Electronic MARs. -Had been relying on the AP and the CCO to check the medications and ensure they were back into compliance. -Had been delegating duties to the CCO, AP and the Qualified Professional (QP) and "assumed they were doing the jobs they were getting paid for."	{V 118}		

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{V 118}	Continued From page 8 -Visited the home two to three times a week and always asked about the medications and was told they were in compliance. -Had not heard of any reports of medication errors in their management meetings. -Sometimes did check the MARs and was not aware of any errors and had reviewed them with the CCO. -"I thought we had them squared away." -"Very upset hearing things are still missing, this is elementary type stuff" that was not being done. -Staff had been giving medications and documenting it for years, not sure why this is such an issue for them now. -Planned to "pull things in line" from this point. -"My wife and I" will now plan to come back and do the monitoring to get the medication issues straight. Review on 4/12/23 of Plan of Protection dated 4/12/23 completed by the CCO and signed by the Licensee revealed the following, "What immediate action will the facility take to ensure the safety of the consumers in your care? - Amani will correct this deficiency of V118 by [Licensee] (the Director) and [Licensee's Wife] overseeing the medication administration process as of today 04/12/23. All staff (AP, QP, and CCO) will check and report to [Licensee]/ [Licensee's Wife] weekly showing signatures on MAR's by all staff to bring organization into compliance. There will be checks and balances system of the medication administration to bring everything back into compliance. Describe your plans to make sure the above happens. - Staff Signatures-If MAR's are not signed by staff, there will be a disciplinary action assigned to the staff that is violating medication rules of 1st	{V 118}		

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{V 118}	Continued From page 9 verbal warning, 2nd is a write-up, and 3rd is termination and/or as determined by the Amani Executive Team. -Physician Orders/After-Visit Summary will be signed and dated by the doctor and Express Care Pharmacy (ECP) will assist us with this process if needed. Amani is transitioning to eMar (electronic MAR) with ECP with the hopes of error-free Medication Administration. The physician order that was out of compliance was fixed on 4/11/23 and a copy given to the state as proof of compliance. -Refills of medications for clients has already become compliant as of 4/11/23 with Express Care Pharmacy assigning agency to "batch" delivery. There will be a system designed for checks and balance-shift check of sheet so that each shift checks behind each other." The facility served clients ages 15 and 16 with diagnoses of PTSD, Conduct Disorder, ADHD, Disruptive Mood Disorder and Borderline Intellectual Functioning. Client #3 did not have physician's orders present for two of nine medications listed on his MAR. Clients #1, #2, & #3's MARs were not initialed thirteen times from January 1, 2023 through April 5, 2023 along with client #3's prescribed Epinephrine pen not printed on two months of MARs. Client #3 had missed two to three days of Risperidone due to staff not getting medications refilled in a timely manner and staff were not trained to administer client #3's Epinephrine pen that was prescribed on 1/5/23 until 3/2/23. The AP and the CCO were delegated by the Licensee to provide oversight and monitoring of the clients medications. Through the AP and CCO's monitoring, these medication errors had not been identified. This deficiency constitutes a continued failure to	{V 118}		

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{V 118}	Continued From page 10 correct the Type A1 for serious neglect. An administrative penalty of $500.00 per day continues to be imposed for failure to correct within 23 days.	{V 118}		