

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL064-161</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R-C 06/23/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>KOODY HEALTH CARE SERVICES INC II</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>601 COLBY COURT ROCKY MOUNT, NC 27803</b>
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V 000	<p><b>INITIAL COMMENTS</b></p> <p>A complaint and follow up survey was completed on 6/23/23. The complaint was substantiated (intake #NC00202884) Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600A Living for Adults with Mental Illness</p> <p>The facility is licensed for 5 and currently has a census of 5. The survey sample consisted of 3 current clients.</p>	V 000		
V 118	<p><b>27G .0209 (C) Medication Requirements</b></p> <p><b>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</b></p> <p>(c) Medication administration:</p> <p>(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.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(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.</p> <p>(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:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p> <p>(D) date and time the drug is administered; and</p> <p>(E) name or initials of person administering the</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>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 ensure MARs were kept current and a physician order was present for one of three clients (#1). The findings are:</p> <p>Review on 6/22/23 of client #1's record revealed: -Admission date of 2/23/23 -Diagnoses of Schizoaffective Disorder, Type II Diabetes and Hypertension</p> <p>Review on 6/23/23 of client #1's hospital Discharge orders dated 2/25/23 revealed: -Clozapine 200 mg -twice a day -Clozapine 100 mg-once a day -Lithium Carbonate 300 mg- bedtime -Metformin 500 mg- twice a day</p> <p>Interview on 6/22/23 The pharmacy stated: -Client #1's clozapine was last filled on 3/28/23 for thirty days. -Client #1 did not have any more refills. -Client #1 saw physician on 4/23/23 and did not receive clozapine order. -Client #1 had received an order for Lithium Carbonate 450 mg.</p> <p>Further review on 6/22/23 of client #1's record did</p>	V 118		

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V 118	<p>Continued From page 2</p> <p>not reveal order for lithium carbonate 450 mg dated 4/23/23.</p> <p>Review on 6/23/23 of client #1's May 2023 MAR revealed the following medications listed and initialed from 5/1/12-5/21/23.</p> <ul style="list-style-type: none"> <li>-Clozapine 200 mg -twice a day</li> <li>-Clozapine 100 mg-once a day</li> <li>-Lithium Carbonate 300 mg- bedtime</li> </ul> <p>Interview on 6/23/23 the Home Manager stated:</p> <ul style="list-style-type: none"> <li>-Took client #1 to the doctor on 4/23/23 to establish care.</li> <li>-Was told by the physician he could not write new prescriptions until he had blood work completed.</li> <li>-Client #1 had his blood work completed that day.</li> <li>-Was not aware why the physician did not refill the clozapine.</li> <li>-Not aware the physician had increased the lithium carbonate.</li> <li>-Was just giving the medications the pharmacy sent as she assumed the physician continued all the medications.</li> <li>-Had hired someone to check the medications to match the orders and maintain the MARs.</li> <li>-Not sure why the clozapine was still on the May 2023 MAR and staff was initialing it, if the medication was not there.</li> <li>-Was not checking the medications as they arrived and comparing them to the MAR.</li> <li>-"Assumed" the new person she hired was doing that.</li> <li>-Will check them herself from now on.</li> </ul> <p>Interview on 6/23/23 the Licensee/Nurse Practitioner stated:</p> <ul style="list-style-type: none"> <li>-After last survey, hired someone to just do the medications.</li> <li>-The Home manager was to over see this to ensure the orders were present in the home as</li> </ul>	V 118		

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V 118	Continued From page 3  well as the MARs up to date. -Very disappointed her staff had not maintained the medications as they were supposed to. -Not sure what else to do. -Will address this with the home manager.  This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 291	27G .5603 Supervised Living - Operations  10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court	V 291		

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V 291	<p>Continued From page 4</p> <p>or legal system is involved or when health or safety issues become a primary concern.</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to coordinate services for one of three audited clients (#1). The findings are:</p> <p>Review on 6/22/23 of client #1's record revealed: -Admission date of 2/23/23 -Diagnoses of Schizoaffective Disorder, Type II Diabetes and Hypertension</p> <p>Review on 6/23/23 of client #1's hospital Discharge orders dated 2/25/23 revealed: -Clozapine 200 mg -twice a day -Clozapine 100 mg-once a day -Lithium Carbonate 300 mg- bedtime -Metformin 500 mg- twice a day</p> <p>Interview on 6/22/23 The pharmacy stated: -Client #1's clozapine was last filled on 3/28/23 for thirty days. -Client #1 did not have any more refills. -Client #1 saw physician on 4/23/23 and did not receive clozapine order. -Client #1 had received an order for Lithium Carbonate 450 mg.</p> <p>Further review on 6/22/23 of client #1's record did not reveal order for lithium carbonate 450 mg dated 4/23/23.</p> <p>Interview on 6/22/23 client #1's legal guardian stated: -She was not aware staff #1 had not been taking his clozapine.</p>	V 291		

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V 291	<p>Continued From page 5</p> <ul style="list-style-type: none"> <li>-Client #1 was stable on his 600 mg dose of clozapine.</li> <li>-Should have wen to his appointment on 4/23/23 to convey this to the doctor.</li> <li>-Had asked the home manger was there any change in his medications after his doctor appointment and was told no.</li> <li>-Thought he was still taking the medications he had while in the hospital.</li> <li>-Concerned staff did not follow up with her or the physician to make sure there was not a lapse in his clozapine.</li> <li>-Will now attend all his appointments to ensure his medications are correct.</li> </ul> <p>Interview on 6/22/23 the home manager stated:</p> <ul style="list-style-type: none"> <li>-Took client #1 to the doctor on 4/23/23 to establish care.</li> <li>-Was told by the physician he could not write new prescriptions until he had blood work completed.</li> <li>-Client #1 had his blood work completed that day.</li> <li>-Was not aware why the physician did not refill the clozapine.</li> <li>-Not aware the physician had increased the lithium carbonate.</li> <li>-Was just giving the medications the pharmacy sent as she assumed the physician continued all the medications.</li> <li>-"Should have followed up" after client #1's blood work to get the clozapine.</li> <li>-The doctor would usually email orders for medications after he reviewed the blood work.</li> <li>-Thought he would have ordered the medications as needed based on the blood work.</li> <li>-"We dropped the ball" in not following up to see why they physician did not refill the clozapine.</li> </ul>	V 291		