

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-619	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 05/22/2024
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NAME OF PROVIDER OR SUPPLIER LEARNING SERVICES-RIVER RIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 5301 ROBBINS DRIVE RALEIGH, NC 27610
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V 000	<p>INITIAL COMMENTS</p> <p>An annual and follow up survey was completed on 5/22/24. A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .2100 Specialized Community Residential Centers for Individuals with Developmental Disabilities.</p> <p>This facility is licensed for 12 and has a current census of 10. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 118	<p>27G .0209 (C) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</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		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mary Jo Norfolk</i> 6/18/2024	TITLE	(X6) DATE
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MHL & C 6/18/24

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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 reviews, observations, and interviews the facility failed to administer medications on the written order of a physician for 1 of 3 audited clients (#2). The findings are:</p> <p>Review on 5/14/24 of client #2's record revealed:</p> <ul style="list-style-type: none"> - admitted 5/27/04 - diagnoses: Traumatic Brain Injury - a physician's order dated 3/13/24 for Levetiracetam 500 milligrams (mg) (seizures) taken twice daily - a physician's order dated 4/19/24 for Levetiracetam 500 mg taken twice daily - a physician's order dated 3/13/24 for Epinephrine 0.3mg Injection (severe allergic reaction) injected intramuscularly once as needed - an allergy to Codeine and bee stings <p>Review on 5/14/24 of client #2's April 2024 MAR revealed:</p> <ul style="list-style-type: none"> - no documentation of administration of Levetiracetam from 4/10/24 - 4/22/24 <p>Observation on 5/22/24 at 12:03pm revealed:</p> <ul style="list-style-type: none"> - no Epinephrine with client#2's medications <p>Review on 5/15/24 at 12:37pm of text messages</p>	V 118	<p>The Operations Manager implemented a protocol for Shift Coordinators to run a medication variance report in QuickMar on each shift to check for any missed medication documentation. Documentation will be completed before the end of the shift. The Operations Manager or nursing will also run a medication variance report weekly to check for any missed documentation. Nursing will also review orders and the mar to ensure all orders are entered correctly. Epinephrine was received for the resident. His allergies are clearly noted on the MAR</p>	5/23/24 and ongoing

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V 118	<p>Continued From page 2</p> <p>between the nurse #2 and the physician:</p> <ul style="list-style-type: none"> - messages are dated 4/22/24 - nurse #2 notified physician of discontinued order on 4/10/24 for Levetiracetam for client #2 - she (nurse #2) indicated client #2 had not been receiving Levetiracetam - she asked the physician if a new order could be written - the physician responded "Yes please" <p>During interview on 5/22/24 staff#3 reported:</p> <ul style="list-style-type: none"> - she was not aware of any allergies for client #2 <p>During interviews on 5/14/24 and 5/22/24 with nurse #1 reported:</p> <ul style="list-style-type: none"> - been at the facility since 3/15/24 - she (nurse #1) believed a former nurse accidentally discontinued the Levetiracetam order in their system - she thought staff were still giving the medication on those dates "because they knew he took it every day" - as soon as she discovered it was discontinued in the system, they obtained a new order - she was not sure what client#2's allergies were and why he was prescribed Epinephrine - she disposed of his Epinephrine because it was expired - she did not remember the date she disposed of the Epinephrine - she ordered another today (5/22/24) and it would be at the facility tomorrow (5/23/24) <p>Interview on 5/15/24 with nurse #2 reported:</p> <ul style="list-style-type: none"> - discovered on 4/22/24 that client #2 was not taking Levetiracetam - knew nurse #1 thought it was still being given, but was no way to be sure 	V 118		

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V 118	<p>Continued From page 3</p> <p>- contacted physician and obtained new order for Levetiracetam immediately</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p> <p>Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.</p>	V 118		