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
	MHL097-068	A. BUILDING: _____ B. WING _____	R 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD 60 HOME	258 OLD HIGHWAY 60 WILKESBORO, NC 28697

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{V 000}	INITIAL COMMENTS A follow up survey was completed on 7/17/24. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 3 and has a current census of 2. The survey sample consisted of audits of 2 current clients.	{V 000}	RECEIVED AUG 06 2024 DHSR-MH Licensure Sect	
{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 drug.	{V 118}	V118 The Administrator will in-service all clinical and management staff at the Vocational Center to when nurses are not in the building to notify nurses on call phone when medications are delivery at the Vocational Center. The RN, Administrator, and Qualified Professional will in-service certified medication technicians on how to appropriately document exceptions within the electronic medication administration record. The Corporate Director of Nursing will in-service the nurses on the EMAR system to ensure that the start dates of medications are documented correctly to prevent documentation errors. The Corporate Director of Nursing will in-service nursing on the EMAR system to ensure parameters such as vital signs are added to ensure that staff are logging the data.	

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{V 118}	Continued From page 1 (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 observation, record review, and interview, the facility failed to ensure medications were administered on the written order of a physician and that MARs were kept current affecting 1 of 2 clients (Client #1). The findings are: Review on 7/11/24 of Client #1's record revealed: -admission date 12/21/13. -diagnoses of Mild Intellectual Developmental Disability (IDD), Attention Deficit Hyperactivity Disorder, Schizoaffective Disorder Depressive Type, Hypertension, Atrial Fibrillation, Congestive Heart Failure (CHF), Respiratory Failure with Hypoxia and Hypercapnia, and Severe Obstructive Sleep Apnea. Review on 7/11/24 of an "Appointments" note dated 5/22/24 written by the facility's Registered Nurse (RN) for Client #1 revealed: -"Chest X-Ray reveals worsening bilateral lower lobe pneumonia...received new orders for Doxycycline (antibiotic) 100 mg (milligrams) BID (twice daily) X (times) 10 days..." Review on 7/11/24 of Client #1's "RBVO (read back verbal order)" dated 5/23/24 from the facility's Physician Assistant (PA) #2 written by the	{V 118}	The RN, Administrator, and Qualified Professional will in-service certified medication technicians on notification to nursing when a medication is not available to administer as ordered in the EMAR system. The Corporate Director of Nursing will in-service the nurses on the pharmacy portal to ensure that they are aware of how to know when a medication is planned to arrive. The RN will contact Tarrytown Pharmacy to request different shipping options to include an earlier receiving time each day. The Corporate Director of Nursing will in-service the nurses on proper medication reconciliation following a hospital admission. The Administrator will in-service nursing, Qualified Professional, Direct Support Supervisor, and Direct Support Staff on making sure medication is delivered to the group home for administration within an expectable timeframe after medications are delivered.	

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{V 118}	Continued From page 2 facility's Licensed Practical Nurse (LPN) revealed: -"Doxycycline 100 mg BID X's 10 days." -the verbal order had not been signed by a physician or by the PA #2. Review on 7/11/24 of Client #1's discharge summary dated 5/29/24 from the local hospital revealed: -admission date 5/23/24 with a "Principal Problem (Resolved): Paroxysmal atrial fibrillation with rapid ventricular response (irregular heartbeat)..." -"...Presented to the emergency department with complaints of shortness of breath...On evaluation was found to be new atrial fibrillation and new congestive heart failure...In the emergency department patient's (Client #1's) heart rate was 160..." -"Resolved Problems: Atypical chest pain, Hypomagnesemia, Aspiration pneumonia, Peripheral vascular disease, Dysphagia." -5/29/24 - hospital physician's order - Metoprolol Tartrate (CHF) 25 mg - 1 tablet 2 times a day - "Hold for SBP (systolic blood pressure) < (less than) 105 or HR (heart rate) < 60." -"Admin (Administration) Instructions: Hold for SBP < 105 or HR < 60." Review on 7/11/24 of Client #1's physician's order written by the facility PA #1 revealed: -6/28/24 - Aspirin (heart attack prevention) 81 mg - 1 tablet every morning. Observation on 7/10/24 at 3:43 p.m. of Client #1's medications revealed: -Metoprolol Tartrate 25 mg - 1 tablet 2 times a day - "Hold for SBP < 105 or HR < 60 for CHF" last dispensed 7/2/24. -Aspirin 81 mg - 1 tablet every morning - dispensed 7/1/24. -Doxycycline was not present.	{V 118}	The Administrator will notify the Direct Support Supervisor and Direct Support Staff that Medication Error forms will be generated for all medications errors to include those with incorrect documentation. The Corporate Director of Nursing and the Chief Nursing Officer are shadowing the nurses on medication order approval and EMAR monitoring medications omissions and documentation errors this occurs Monday – Friday daily for the next 14 days and then will assess the need to continue. The clinical team is completing Medication Observation Assessments three times a week for 14 days and then routinely. In the future the Administrator will ensure all nurses follow RHA Policy and Procedure regarding medication dispensing and that MARS are kept current. Completed by August 7th, 2024	

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{V 118}	Continued From page 3 Review on 7/11/24 of "On-Call" nurses notes from 5/27/24 to 7/10/24 provided by the facility's RN revealed: -5/29/24 - 5:07 p.m. - Client #1 returned to the facility from the hospital. -5/29/24 - 7:42 p.m. - staff (Former Staff #4) asked if Client #1 was supposed to take his Doxycycline. "On call nurse advised that since Doxycycline was prescribed the day before [Client #1] was hospitalized and he only received 1 to 2 doses before going to the ER (emergency room), to hold the antibiotic tonight and document exception as 'Withheld per RN/MD (Medical Doctor) Order' and nurse will get clarification from PCP (Primary Care Physician) tomorrow (5/30/24)." -no additional notes regarding whether to continue Client #1's Doxycycline or not. -5/31/24 at 4:09 p.m. - "...advised [Staff #3] that [Client #1's] Metoprolol was ready and should be picked up at [local pharmacy] at no charge as soon as possible, so med (medication) can be given (administered) this evening..." -7/10/24 at 5:40 p.m. - "[Staff #1]...reports [electronic MAR] has correct parameters in place for [Client #1's] BP (blood pressure) and pulse for his Metoprolol but the documentation requirement is missing. On call nurse checked [electronic MAR] and made corrections so that BP reading must be documented before med pass can continue." Review on 7/11/24 at approximately 12:30 p.m. of Client #1's MARs from 5/27/24 through 7/11/24 revealed: -Metoprolol Tartrate 25 mg - 1 tablet 2 times a day - "Hold for SBP < 105 or HR < 60 for CHF." -listed times to administer Metoprolol were 8:00 a.m. and 8:00 p.m. - initialed as	{V 118}		

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{V 118}	Continued From page 4 administered/started 5/31/24, administered twice daily through 7/10/24, and administered at 8:00 a.m. on 7/11/24. -no SBP or HR vitals were documented prior to administration from 5/31/24 through 7/10/24 at 8:00 a.m. -the first BP documented as taken prior to administration of Metoprolol was 7/10/24 at 8:00 p.m. (after Division of Health Service Regulation surveyor inquired). -Metoprolol was circled with initials of the facility's RN or LPN or blank from 7/2/24 at 8:00 a.m. through 7/7/24 at 8:00 p.m. with exceptions documented as "Medication Unavailable/Nurse Aware" or "Withheld Per DR (doctor)/RN Orders" to equal 12 doses (from 7/3/24 - 7/7/24) that were not administered; 7/8/24 at 8:00 a.m. was blank and had no explanation for 1 missed dose. -Doxycycline - initialed and circled on 5/29/24 at 8:00 p.m., 5/30/24 at 8:00 a.m. and 8:00 p.m., 6/1/24 at 8:00 p.m. and 6/2/24 at 8:00 a.m. with exceptions documented as "Withheld per DR/RN Orders." -Doxycycline was initialed as administered on 5/31/24 at 8:00 a.m. and 8:00 p.m., 6/1/24 at 8:00 a.m. and 6/2/24 at 8:00 p.m. for a total of 4 doses, then "DC'd (discontinued)" and no further initials were documented. -Aspirin 81 mg - 1 tablet every morning - ordered 6/28/24 was not listed on the June MAR; 7/1/24 and 7/3/24 had no initials to indicate it was administered and no exceptions to indicate why the medication was not administered on the July MAR. Interview on 7/11/24 with Client #1 revealed: -he was not sure what medications he took. -"Last night (7/10/24) was the first time they (staff) ever took my blood pressure...and then this morning (7/11/24)."	{V 118}		

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{V 118}	Continued From page 5 -"Staff said they were going to be taking it (blood pressure) every day..." moving forward. Interview and observation on 7/10/24 at 4:29 p.m. with Staff #1 revealed: -would take blood pressure or pulse prior to administering a medication if the "med has parameters." -the electronic MAR "pops up a box of choices" when vitals were to be taken, did not recall if this was the case for Client #1. -viewed Client #1's electronic MAR for Metoprolol and there were no boxes to document the client's vitals. -took Client #1's blood pressure every day before administering his Metoprolol and "only document it if it was out of normal range...and report it to the nurse." -did not have any documentation of Client #1's blood pressure readings due to the client's vitals being "good (within range)." Interview on 7/15/24 with Staff #2 revealed: -"Hadn't been taking his (Client #1's) blood pressure prior to administration (of Metoprolol) because it wasn't on the MAR...it wasn't popping up on the MAR...was told some time last week (by Staff #1) that I needed to take it (blood pressure)...so I have been since...they (nurses) finally fixed it (electronic MAR) so now I do it (take blood pressure) before giving med (Metoprolol)." Interview and record review on 7/12/24 and a second interview on 7/15/24 with Staff #3 revealed: -did not ever administer Client #1's Metoprolol. -took Client #1's blood pressure every day since 5/29/24 and documented it in her "personal notebook."	{V 118}		

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{V 118}	Continued From page 6 -all blood pressures were taken "before med pass...all were done at 3:00 p.m. (7 hours after 8:00 a.m. administration and 5 hours prior to 8:00 p.m. administration)." -notebook paper with Client #1's name handwritten at the top with blood pressure readings from 5/29/24 through 7/12/24. -none of the SBP readings were <105. -"Saw on [electronic MAR] the (Client #1's) blood pressure was to be taken...Not too many people (staff) are able to take manual blood pressures..." and this was why she took it. Interviews on 7/11/24, 7/12/24, 7/15/24 and 7/16/24 with the facility's RN and LPN at the same time revealed: -RN: "...realized last night (7/10/24) when [Staff #1] called that the parameters (blood pressure) were not in there (electronic MAR)." -RN: on 7/2/24 notified PA #2 that Client #1's Metoprolol needed to be refilled, it was at that time she first "noticed the parameters were not put in [electronic MAR]." -RN: attempted to input the blood pressure parameters on 7/2/24, "...guess it didn't save, but I know I put it in there (electronic MAR)...but it didn't take so it didn't prompt staff to take the vital signs." -RN: this was "...my fault for not double checking it (changes to MAR) was saved..." -RN: "Assumed staff were taking the vitals since it (order for Metoprolol) says to hold depending on what they (vitals) are. But as far as knowing for sure if staff were doing this, no, I don't know." -RN: Client #1's Metoprolol was not available from 7/2/24 through 7/7/24 because she "didn't think it (Metoprolol) needed to be re-ordered, thought (Metoprolol) would be on normal cycle refill, but because he (Client #1) came from the hospital it needed to be re-ordered to fill it...the	{V 118}		

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{V 118}	Continued From page 7 hospital wouldn't refill it...as soon as found out (on 7/2/24) I called [PA #2] and he reordered it...it took until 7/7 (2024) to get the med..." -RN: Metoprolol was not administered on the morning of 7/8/24 as she didn't "...know if they (staff) had the med yet...they should have, they are usually good about picking up the meds right away." -LPN: only had a verbal order for the client's Doxycycline, and no signature, due to PA #1 being on medical leave. -RN: there was no follow-up regarding the 5/29/24 nurse's on-call note "because it (Doxycycline) was a 10-day order and it had an end date...it actually doesn't need a discontinue order because it ran out in 10 days, and he (Client #1) was in the hospital some of those days..." -RN: "...don't think staff gave (administered) 4 doses (as MAR indicates)...but I don't have proof of that..." -RN: on 7/16/24, found Client #1's Doxycycline in the main office for destruction and all 20 pills remained in the bottle. -no information was provided regarding the blank dates with no staff initials to indicate administration of Aspirin on Client #1's MARs. Interview on 7/12/24 with the RN for Client #1's Cardiologist revealed: -Client #1 was seen by the Cardiologist on 7/8/24. -Client #1 was "not on a large dose (of Metoprolol)." -"If give (administer) Metoprolol and his (Client #1's) blood pressure or heart rate are below parameters it would cause his heart rate or blood pressure to be really low..." -could cause Client #1 to "start feeling bad or complaining of dizziness..."	{V 118}		

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{V 118}	Continued From page 8 Interviews on 7/12/24 and 7/16/24 with PA #2 revealed: -Metoprolol "...basically helps control the heart rate...can lower the heart rate and lower blood pressure...used for CHF...wouldn't want to give that (Metoprolol) if someone's blood pressure is already low....that low dose of Metoprolol is a safety measure the help him (Client #1) make sure we're not dealing with an out of control blood pressure." -was not aware staff were not taking Client #1's vitals before administering his Metoprolol. -he was on "...such a low dose (of Metoprolol)...when I saw (6/11/24 and 6/28/24) him (Client #1) he looked great...I had a set of vitals and he was normal...something we (staff) should be doing. Is it going to have a huge impact on the patient at the end of the day? Probably not." -was not aware Client #1 missed doses of Metoprolol due to the medication not being available. -"...have had a lot of issues since switched to (pharmacy)...2, 3, 4 or more days to get the med there (facility)...meds are falling through the cracks...delays even more if staff are not there to receive the med when they (meds) arrive (delivered)." -"Don't recall" being called by facility nurse whether to continue Client #1's Doxycycline. -"It's (Doxycycline) a duration order and would have expired in 10 days...Usually when someone (client) gets out of the hospital a review or reconciliation of meds takes place...sounds like a lapse of communication there... -"...because he (Client #1) was so sick it (Doxycycline) may have helped him...(if staff called) would have said to leave him on it (Doxycycline) because he was so sick..." -Client #1 was on a low dose of Aspirin as "he	{V 118}		

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{V 118}	Continued From page 9 was on a blood thinner while in the hospital and his family wanted him on something...I agreed to add Aspirin, because it can prevent DVT (Deep Vein Thrombosis) and heart attacks per some studies." Due to the failure to accurately document medication administration, it could not be determined if the client received his medications as ordered by the physician. Review on 7/17/24 of the Plan of Protection dated 7/17/24 written by the IDD Administrator revealed: -"What immediate action will the facility take to ensure the safety of the consumers in your care? Staff will be in-serviced in reference to the following: -Staff that receive the shipped medication will notify nursing in person or via telephone once a delivery of medications is received and signed for at the vocational center. -Certified medication technicians will be retrained on how to appropriately document exceptions within the electronic medication administration record. (Choose appropriate exception when the medication is not administered vs. (versus) documenting that the medication was provided). -Nursing will be in-serviced on the EMAR (Electronic Medication Administration Record) system to ensure that the start date of medications is documented correctly to prevent documentation errors. -Nursing will be in-serviced on the EMAR system to ensure parameters such as vital signs are added to ensure that staff are logging the data. -Staff will notify nursing when a medication is not available to administer as ordered in the EMAR system. -Nursing will be in-serviced on the pharmacy portal to ensure that they are aware of how to	{V 118}		

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{V 118}	Continued From page 10 know when a medication is planned to arrive. -Nursing will reach out to [Pharmacy] to request a different shipping option to include an earlier receiving time each day. -Nursing will be trained on proper medication reconciliation following a hospital admission. -Nursing and staff will be trained to ensure that medication is delivered to the group home for administration within an acceptable timeframe after receiving. -Medication error forms will be generated for all medication errors to include those with incorrect documentation. Describe your plans to make sure the above happens. -The Administrator will in-service all clinical and management staff at the Vocational Center to when nurses are not in the building to notify nurses on call phone when medications are delivery at the Vocational Center. By: 7/17/24 -The RN, Administrator, and Qualified Professional will in-service certified medication technicians on how to appropriately document exceptions within the electronic medication administration record. By: 7/17/24 -The Corporate Director of Nursing will in-service the nurses on the EMAR system to ensure that the start dates of medications are documented correctly to prevent documentation errors. By: 7/17/24 -The Corporate Director of Nursing will in-service nursing on the EMAR system to ensure parameters such as vital signs are added to ensure that staff are logging the data. By: 7/17/24 -The RN, Administrator, and Qualified Professional will in-service certified medication technicians on notification to nursing when a medication is not available to administer as ordered in the EMAR system. By: 7/17/24	{V 118}		

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{V 118}	Continued From page 11 -The Corporate Director of Nursing will in-service the nurses on the pharmacy portal to ensure that they are aware of how to know when a medication is planned to arrive. By: 7/17/24 -The RN will contact [Pharmacy] to request different shipping options to include an earlier receiving time each day. By: 7/17/24 -The Corporate Director of Nursing will in-service the nurses on proper medication reconciliation following a hospital admission. By: 7/17/24 -The Administrator will in-service nursing, Qualified Professional, Direct Support Supervisor, and Direct Support Staff on making sure medication is delivered to the group home for administration within an expectable timeframe after medications are delivered. BY: 7/17/24 -The Administrator will notify the Direct Support Supervisor and Direct Support Staff that Medication Error forms will be generated for all medications errors to include those with incorrect documentation. By: 7/17/24" Client #1 was diagnosed with Mild IDD, Attention-Deficit Hyperactivity Disorder, Schizoaffective Disorder Depressive Type, Hypertension, Atrial Fibrillation, CHF, Respiratory Failure with Hypoxia and Hypercapnia, and Severe Obstructive Sleep Apnea. Client #1 was ordered Metoprolol 25 mg twice daily on 5/29/24 upon discharge from the hospital for treatment of CHF. The physician's order was to hold the dose if Client #1's SBP was less than 105 or if his heart rate was less than 60. Facility staff did not monitor and record Client #1's SBP or heart rate prior to administration of Metoprolol from 5/31/24 through 7/10/24 (a total of 82 medication administration dosing times). Client #1 was not administered Metoprolol from 7/2/24 through 7/8/24, missing a total of 13 doses of medication as the facility did not re-order his Metoprolol in a	{V 118}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL097-068	A. BUILDING: _____ B. WING _____	R 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD 60 HOME	258 OLD HIGHWAY 60 WILKESBORO, NC 28697

(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 118}	Continued From page 12 timely manner resulting in none being available for administration. On 5/23/24, Client #1 was ordered Doxycycline to be administered for 10 days. The MAR indicated Client #1 was administered 4 doses of Doxycycline; however, the bottle of Doxycycline which was to be returned to the pharmacy for destruction contained all 20 tablets which had been dispensed by the pharmacy. On 6/28/24, Client #1 was prescribed Aspirin 81mg daily. Client #1's MARs for June and July 2024 were not kept current as the June MAR did not include a listing of Aspirin and the July MAR had blanks with no signatures to identify administration of Aspirin on 7/1/24 and 7/3/24 and no explanation as to why Aspirin was not administered on those dates. This deficiency constitutes a Continuing Type A1 rule violation originally cited for serious neglect for failure to correct within 23 days.	{V 118}		