| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL090-169 | A. BUILDING: _____ B. WING _____ | R 03/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MONROE CRISIS RECOVERY CENTER | 1408 EAST FRANKLIN STREET MONROE, NC 28112 |

| (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 |
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| V 000 | INITIAL COMMENTS<br><br>An annual, complaint and follow up survey was completed on 3/6/25. The complaints were unsubstantiated (intake #NC00227682 and NC00227590). A deficiency was cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .5000 Facility Based Crisis Service for Individuals of All Disability Groups.<br><br>This facility is licensed for 16 and has a current census of 16. The survey sample consisted of audits of 2 current clients, 4 former clients, 1 deceased client. | V 000 | | |
| V 118 | 27G .0209 (C) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(c) Medication administration:<br>(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.<br>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.<br>(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.<br>(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:<br>(A) client's name;<br>(B) name, strength, and quantity of the drug; | V 118 | | |

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| V 118 | Continued From page 1<br>(C) instructions for administering the drug;<br>(D) date and time the drug is administered; and<br>(E) name or initials of person administering the drug.<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview, the facility failed to ensure medications were administered on the written order of a physician affecting 3 (FC #4, FC #6, and FC #7) of 7 audited clients.<br><br>Review on 3/6/25 of former client (FC) #4's record revealed:<br>-Admission date of 1/28/25.<br>-Discharge date of 2/3/25.<br>-Diagnoses of Cocaine Use Disorder, Severe; Cannabis Use Disorder. Severe; Opioid Use Disorder, Severe; Tobacco Use Disorder, Moderate.<br>-Physician's Order 1/29/25 Seroquel (sleep) 100-200mg (milligrams) by mouth at bedtime prn (as needed); 1/30/25 Seroquel (anxiety) 25mg by mouth three times daily as needed.<br><br>Review on 3/6/25 of FC #6's record revealed:<br>-Admission date of 12/24/24.<br>-Discharge date of 1/2/25.<br>-Diagnoses of Cocaine Use Disorder, Severe; Borderline Personality Disorder; Post-Traumatic Stress Disorder; Unspecified Intellectual | V 118 | | |

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| V 118 | Continued From page 2 | V 118 | | |

Disability.
-Physician's Order 12/27/24 Topiramate (bipolar) 25mg by mouth 2 times daily.

Review on 3/6/25 of FC #7's record revealed:
-Admission date of 12/20/24.
-Discharge date of 12/27/24.
-Diagnoses of Cocaine Use Disorder, Severe; Opioid Abuse, Uncomplicated; Amphetamine-type Substance Use Disorder, Severe; Borderline Personality Disorder; Post-traumatic Stress Disorder.
-Physician's Order 12/20/24 Lamotrigine (depression) 25mg 1 tablet twice a day.

Review on 2/27/24 of the facility's incident reports from 12/1/24 to 2/27/24 revealed:
-2/1/25 FC #4 "complained to staff that she was given her bedtime Seroquel instead of her daytime prn Seroquel which is a lower dose compared to the night time dose."
-12/27/24 FC #6's "medication was picked up by staff on day shift on 12/27/24. The night shift med tech (medication technician) marked that the medication was not available in the MAR without looking in the med cart for it."
-12/28/24 FC #6's "medication was picked up by staff on day shift on 12/27/24. The night shift med tech marked that the medication was not available in the MAR without looking in the med cart for it."
-12/22/24 FC #7 "Two pages of MAR of the same medications but different times. Medication of Lamotrigine 25 mg bid was given 3 times on 12/21/24 and on 12/22/24 the second dose was given at the wrong time (2 hours after first dose - [facility doctor] was notified and the evening does was held."

Review on 3/7/25 of FC #4's MARs from 1/28/25

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| V 118 | Continued From page 3<br>to 2/3/25 revealed:<br>-2/1/25 Seroquel 100mg administered at 1509 (3:09pm)<br>-2/1/25 Seroquel 25mg not administered.<br><br>Review on 3/7/25 of FC #6's MARs from 12/24/24 to 1/2/25 revealed:<br>-Topiramate was not administered on 12/2724 and 12/28/24.<br><br>Review on 3/7/25 of FC #7's MARs from 12/20/24 to 12/27/24 revealed:<br>-12/21/25 Lamotrigine was administered at 7am, 9am, and 7pm.<br><br>Interview on 3/3//25 with the Medication Technician revealed:<br>-Discovered "lots" of medication errors.<br>-Completed incident reports for all medication errors identified.<br><br>Interview on 3/7/25 with the Licensed Practical Nurse (LPN) revealed:<br>-On 2/1/25 FC #4 should have received 25 mg of Seroquel at 3pm if needed rather than 100mg.<br>-On 12/27/24 and 12/28/24 FC #6's Topiramate should have been administered.<br>-On 12/21/24 FC #7 should not have received Lamotrigine at 7am, 9am, and 7pm since the order said two times daily. The 9am dose should not have been administered.<br><br>Interview on 3/7/25 with the Center Director Revealed:<br>-All medication errors are reported to the doctor or nurse.<br>-Had completed coaching and corrective action with responsible staff after each medication error. | V 118 | | |