

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036150	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING:	(X3) DATE SURVEY COMPLETED 05/21/2018
NAME OF PROVIDER OR SUPPLIER HOFFMAN		STREET ADDRESS, CITY, STATE, ZIP CODE 1482 HOFFMAN ROAD GASTONIA, NC 28054		
(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 000	INITIAL COMMENTS An annual survey was completed on 5-21-18. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G 5600 Supervised Living for Adults Whose primary Diagnosis is a Developmental Disability.	V 000	DHSR - Mental Health JUN 04 2018 Lic. & Cert. Section	
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. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation	V 118	27G .0209 (C) Medication Requirements Residential Manager compares each medication bottle/pack with the MAR weekly to ensure accuracy; Given this medication is administered as a PRN it was stored in the lock box and its expiration was overlooked. The following has been put into place to correct the deficient area of practice: Residential Manager to schedule appointment with Physician in order to obtain refill. Residential Manager to continue documenting weekly medication audit and ensure all medications are within the expiration date. Residential Manager and Direct Support Staff will receive refresher training regarding proper medication audit procedures. To prevent this from happening again: Residential Manager to complete weekly medication audits; Qualified Professional will provide oversight and check MARs on a monthly basis.	7/21/2018

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature] *Quality Management* *5/30/18*

STATE FORM

6899

BY2011

If continuation sheet 1 of 3

1870

1871

1872 1873 1874 1875 1876 1877 1878 1879 1880 1881 1882 1883 1884 1885 1886 1887 1888 1889 1890 1891 1892 1893 1894 1895 1896 1897 1898 1899 1900

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036150	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED 05/21/2018
		B. WING		
NAME OF PROVIDER OR SUPPLIER HOFFMAN		STREET ADDRESS, CITY, STATE, ZIP CODE 1482 HOFFMAN ROAD GASTONIA, NC 28054		
(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	<p>Continued From page 1 with a physician.</p> <p>This Rule is not met as evidenced by: Based on interviews and observations the facility failed to ensure that medications were administered properly, effecting one of three client (client #1). The findings are:</p> <p>Review on 5-21-18 of client #3's medication orders signed 3-29-18 revealed: -Diazepam 5 mg. One tablet by mouth twice daily as needed for anxiety.</p> <p>Review on 5-21-18 of client #3's medication revealed: -Diazepam 5 mg, dispensed 6-29-16 -Expiration date 6-29-17.</p> <p>Review on 5-21-18 of client #3's MAR for may 2018 revealed: -Client #3 reviewed Diazepam 5 mg on May 11 and May 13.</p> <p>Interview on 5-21-18 with facility manager revealed: -She didn't know why the expired medication was being given to client #3 -"I'm guessing it was just an oversight." -"It just fell through the cracks" -They do go through the medications weekly to make sure they are correct.</p> <p>Interview on 5-21-18 with the Qualified Professional revealed: -She didn't know how fact the the medication was expired could have ben overlooked.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036150	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED 05/21/2018
		B. WING		
NAME OF PROVIDER OR SUPPLIER HOFFMAN		STREET ADDRESS, CITY, STATE, ZIP CODE 1482 HOFFMAN ROAD GASTONIA, NC 28054		
(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 2 -She does know that the facility manager checks the medications regularly.	V 118		



DHSR - Mental Health

JUN 04 2018

Lic. & Cert. Section

May 30, 2018

Re: UMAR Services, Inc. Plan of Correction

To Whom It May Concern:

Please accept this Plan of Correction in response to the Annual Survey on 5/21/18 at the Hoffman Group Home. Please review the attached Plan of Correction at your convenience and let me know if you have any questions.

Respectfully,

Kim Jonas
Quality Management and Training Coordinator





NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

ROY COOPER • Governor

MANDY COHEN, MD, MPH • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

May 23, 2018

Ms. Marilyn Garner, CEO
UMAR-WNC, Inc.
5350 77 Center Dr. Suite 201
Charlotte, NC 28217

Re: Annual Survey completed 5-21-18
Hoffman, 1482 Hoffman Road, Gastonia, NC 28054
MHL # 036-150
E-mail Address: marilyng@umarinfo.com

Dear Ms. Garner:

Thank you for the cooperation and courtesy extended during the annual survey completed 5-21-18.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- All tags cited are standard level deficiencies.

Time Frames for Compliance

- A Standard level deficiency must be **corrected** within 60 days from the exit of the survey, which is 7-21-18.

What to include in the Plan of Correction

- Indicate what measures will be put in place to **correct** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to **prevent** the problem from occurring again.
- Indicate **who will monitor** the situation to ensure it will not occur again.
- Indicate **how often** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records.
Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 809 Ruggles Drive, Edgerton Building, Raleigh, NC 27603
MAILING ADDRESS: 809 Ruggles Drive, 2701 Mail Service Center, Raleigh, NC 27699-2701
www.ncdhhs.gov/dhsr • TEL: 919-855-3750 • FAX: 919-733-2757

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

May 23, 2018
Ms. Marilyn Garner

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Lynn Grier at 704-596-4072.

Sincerely,



Patricia Work
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: W. Rhett Melton, Director, Partners Behavioral Healthcare LME/MCO
Selenna Moss, Quality Management Director, Partners Behavioral Healthcare LME/MCO
Rob Robinson, Director, Alliance Behavioral Health LME/MCO
Wes Knepper, Quality Management Director, Alliance Behavioral Health LME/MCO
Trey Suttan, Interim Director, Cardinal Innovations LME/MCO
Onika Wilson, Quality Management Director, Cardinal Innovations LME/MCO
Leza Wainwright, Director, Trillium Health Resources LME/MCO
Kim Keehn, Quality Management Director, Trillium Health Resources LME/MCO
Sarah Stroud, Director, Eastpointe LME/MCO
Jeanette Jordan-Huffam, Quality Management Director, Eastpointe LME/MCO
Victoria Whitt, Director, Sandhills Center LME/MCO
Carol Robertson, Quality Management Director, Sandhills Center LME/MCO
Brian Ingraham, Director, Vaya Health LME/MCO
Patty Wilson, Quality Management Director, Vaya Health LME/MCO

File