

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL020-060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/22/2018
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NAME OF PROVIDER OR SUPPLIER LYNN HYDE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 208 TAYLORS CREEK ROAD ANDREWS, NC 28901
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(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	<p>INITIAL COMMENTS</p> <p>An annual survey was completed on 5/22/18. A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Individuals of all Disability Groups/Alternative Family Living.</p>	V 000	<div style="border: 1px solid black; padding: 5px; width: fit-content; margin-bottom: 10px;"> <p>RECEIVED By MH Lic & Cert Section at 3:34 pm, Jun 07, 2018</p> </div> <p>Attached are the new MARs with orders from the Doctors on administering medications.</p>	
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 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</p>	V 118		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>6-6-18</i>	(X6) DATE
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STATE FORM D999 YVNY11 If continuation sheet 1 of 3

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL020-060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/22/2018
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V 118	<p>Continued From page 2</p> <p>revealed:</p> <ul style="list-style-type: none"> -Phenytoin Sodium was initialed as administered 2 tabs in AM and 1 tab in PM, March 1-May 22 on MARs. -Caltrate was initialed as administered twice daily March 1-May 22 on MARs. -Vitamin D2 was blank for all of April. -Forteo was blank for March-May on MARs. <p>Interview on 5/22/18 with AFL Caregiver revealed:</p> <ul style="list-style-type: none"> -She typed her own MARs each month for her clients. -Client #1's Geodon error was her mistake. -Client #2 got 2 tabs of Phenytoin Sodium in AM because her day program required clients to be independent in administering their own meds and Client #2 could not. The Physician's Assistant (PA) told her giving it that way was ok but did not write it down. -The PA also told the AFL caregiver to give 2 Caltrate chewables but did not write it down. -The Vitamin D2 was given as ordered just not recorded. -The Forteo was denied by Medicaid and Medicare although the nurse in the doctor's office told AFL caregiver they would order something else if insurance continued to refuse. She also reported they had 2 Medicaid numbers for Client #2 which could have been the problem all along. 	V 118	<p>Client #2</p> <p>Staff will get a perscription from the physician indicating how the medication can be administrated. Staff will also be reminded to include the caltrate and the Vitamin D2 on the MAR and to accurately document when administered. Staff will also get a statement from the guardian (Mother) that she refused to pay the \$1,000 for the Forteo injection perscribed daily. This must be documented on the MAR. "Q" will follow up to ensure the correct Medicaid number is on the MAR and in the medical record . All documentation will be reviewed by the PFS Director before submission.</p> <p>Correct Medicaid had been identified.</p>	6/5/18
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4-12-2018

To Whom This May Concern:

I [REDACTED] Co Guardian and [REDACTED] Co Guardian have been notified about the concern for [REDACTED] medication Forte injection that has been not authorized by her Medicare part D to be paid for by the insurance. [REDACTED] will not be receiving this medication unless the insurance will pay for it due to family unable to afford the high cost of the medication.

Sincerely

[REDACTED]

Date: 4-12-18

[REDACTED]

Date 4-12-18



THOMAS V. CLAYTON, MD

FAMILY MEDICINE

P.O. BOX 550 • 2751 HWY. 19 • ANDREWS, NC 28901
PHONE (828) 321-4510 • FAX (828) 321-3973
DEA # BC4197251

PATIENT'S NAME

[REDACTED]

4/3/07

ADDRESS

DATE 5-23-18

DEA# BC4197251

Rt

Mg

Sig

Amt. Disp.

RF#

1. *Dr Forteo 20mg/1 dose pen injector*

2.

3.

4.

3

CR-2553

MD

[Redacted]
[Redacted] (Female)
[Redacted]

ANDREWS INTERNAL MEDICINE PA
2751 Business 19
Andrews, NC 28901-8097
8283214510

Page Notes

The patient has no known allergies

Medications

Edit Dt / Last Rx	Projected Renewal	Medication	Sig	#	Refill	Status	Options
05/22/2018 04/09/2018	11/18/2018	phenytoin sodium extended 100 mg capsule	1 capsule(s) by mouth three times a day; take 2 in am 1 in evening	90	5	Active	
05/22/2018		Caltrate 600+D Plus Minerals 600 mg calcium-800 unit-40 mg chew tablet	1 tablet(s) by mouth twice a day	60	11	Active	
05/22/2018 05/22/2018	11/18/2018	Xanax 1 mg tablet	1 tablet(s) by mouth twice a day	60	5	Active	
05/22/2018 05/22/2018	11/18/2018	Xanax 0.5 mg tablet	1 tablet(s) by mouth twice a day	60	5	Active	
04/09/2018 04/09/2018	04/04/2018	Depakote 250 mg tablet, delayed release	4 tablet(s) by mouth twice a day	240	11	Active	
04/09/2018 04/09/2018		Forteo 20 mcg/dose (600 mcg/2.4 mL) subcutaneous pen injector	1 application(s) inject below the skin daily; 20 mcg dose daily	30	11	Active	
04/09/2018 04/09/2018	07/08/2018	ergocalciferol (vitamin D2) 50,000 unit capsule	1 capsule(s) by mouth 2 times weekly	26	4	Active	
04/09/2018 04/09/2018	04/04/2018	Synthroid 75 mcg tablet	1 tablet(s) by mouth daily	30	11	Active	
04/09/2018 04/09/2018	10/06/2018	Xanax 1 mg tablet	1 tablet(s) by mouth twice a day	60	5	Active	

5/22/18 working on kid Auth on Forteo patient found to have to medicard number, replacement will be given in 72° if not approved.

M. Maxon 5/22/18
12:00

Sharon V. Clayton

Tuesday, May 22, 2018

JANE B BARWICK, FNP
 License: NC 200185 DEA: MB0574752 NPI: 1316126808
 Clayton, Thomas
 License: NC 30895 DEA: BC4197251 NPI: 1326081571

ANDREWS INTERNAL MEDICINE PA
 2751 Business 19, Andrews, NC 28901-8097
 Phone: (828)321-4510 Fax: (888)491-3514

Patient [REDACTED] Gender Female DOB [REDACTED] Phone [REDACTED] MRN [REDACTED]

Drug	Sig	Dispense	Refills	DAW	Quantity	
Xanax 0.5 mg tablet	1 tablet(s) by mouth twice a day	60 (sixty) Tablet	5 (five)		1-24 25-49 50-74	75-100 101-151 151 & over
Notes						

Drugs Prescribed: 1 (one)

Signature _____

Dispense as Written

Signature  _____

Substitution Permitted

Prescription is void if the number of drugs prescribed is not noted
 Interchange is mandated unless the practitioner indicates "no substitution" in accordance with the law.

Tuesday, May 22, 2018

JANE B BARWICK, FNP
 License: NC 200185 DEA: MB0574752 NPI: 1316126808
 Clayton, Thomas
 License: NC 30895 DEA: BC4197251 NPI: 1326081571

ANDREWS INTERNAL MEDICINE PA
 2751 Business 19, Andrews, NC 28901-8097
 Phone: (828)321-4510 Fax: (888)491-3514

Patient [REDACTED] Gender Female DOB [REDACTED] Phone [REDACTED] MRN [REDACTED]

Drug	Sig	Dispense	Refills	DAW	Quantity	
Xanax 1 mg tablet	1 tablet(s) by mouth twice a day	60 (sixty) Tablet	5 (five)		1-24 25-49 50-74	75-100 101-151 151 & over
Notes:						

Drugs Prescribed: 1 (one)

Signature _____

Dispense as Written

Signature 

Substitution Permitted

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Tuesday, May 22, 2018

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 Clayton, Thomas
 License: NC 30895 DEA: BC4197251 NPI: 1326081571

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 2751 Business 19, Andrews, NC 28901-8097
 Phone: (828)321-4510 Fax: (888)491-3514

Patient [REDACTED] Gender Female DOB [REDACTED] Phone [REDACTED] MRN [REDACTED]

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Notes

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Signature _____

Signature  _____

Dispense as Written

Substitution Permitted

Prescription is void if the number of drugs prescribed is not noted.
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Tuesday, May 22, 2018

JANE B BARWICK, FNP
 License: NC 200185 DEA: MB0574762 NPI: 1316126808
Clayton, Thomas
 License: NC 30895 DEA: BC4197251 NPI: 1326081571

ANDREWS INTERNAL MEDICINE PA
 2751 Business 19, Andrews, NC 28901-8097
 Phone: (828)321-4510 Fax: (888)491-3514


Patient [REDACTED] Gender Female DOB [REDACTED] Phone [REDACTED] MRN [REDACTED]

Drug	Sig	Dispense	Refills	DAW	Quantity	
Xanax 1 mg tablet	1 tablet(s) by mouth twice a day	60 (sixty) Tablet	5 (five)		1-24 25-49 50-74	75-100 101-151 151 & over

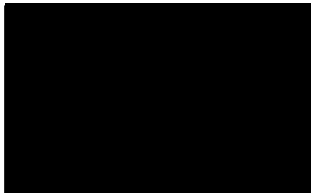
Notes:

Drugs Prescribed: 1 (one)

Signature _____
 Dispense as Written

Signature 
 Substitution Permitted

Prescription is void if the number of drugs prescribed is not noted.
 Interchange is mandated unless the practitioner indicates "no substitution" in accordance with the law



ANDREWS INTERNAL MEDICINE PA
 2751 Business 19
 Andrews, NC 28901-8097
 8283214510

Page Notes

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04/09/2018 04/09/2018	04/04/2019	Depakote 250 mg tablet delayed release	4 tablet(s) by mouth twice a day	240	11	Active	
04/09/2018 04/09/2018	10/06/2018	phenytoin sodium extended 100 mg capsule	1 capsule(s) by mouth three times a day	90	5	Active	
04/09/2018 04/09/2018		Forteo 20 mcg/dose (600 mcg/2.4 mL) subcutaneous pen injector	1 application(s) inject below the skin daily; 20 mcg dose daily	30	11	Active	
04/09/2018 04/09/2018	07/08/2019	ergocalciferol (vitamin D2) 50,000 unit capsule	1 capsule(s) by mouth 2 times weekly	26	4	Active	
04/09/2018 04/09/2018	04/04/2019	Synthroid 75 mcg tablet	1 tablet(s) by mouth daily	30	11	Active	
04/09/2018 04/09/2018	10/06/2018	Xanax 1 mg tablet	1 tablet(s) by mouth twice a day	60	5	Active	

Name: [Redacted]

MR# [Redacted]

Month/Year

5-18

MID [Redacted]

PFS Medication Administration Record

Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Med Name: 7:00a																															
Rate: 8:00																															
Age: 8:00																															
HD3																															
actions: aw/ab BID																															
ison:																															
Med Name: 7AM																															
-DZ																															
Age: [Redacted]																															
MG																															
actions: IP 2 times a day																															
IP 2 times a day																															
IP Tues and																															
son:																															
Med Name: 7AM																															
IAAX																															
Age: 8PM																															
mg																															
actions: [Redacted]																															
R BID																															
son:																															
CITY																															
Med Name:																															
Age:																															
actions:																															
son:																															

If medication is not given, use key code to indicate reason- initial and date. At the end of month, forward copy of MAR to Supervisor

Key Code: Absent-A, Holiday -H, Refusal-R, Workday- W

Staff Signature/Date
Staff Signature/Date

[Redacted Signature/Date]

5-31-18

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		
Med Name: pakote sage: mg actions: bs bid ason: ure																																	
Med Name: antin sage: mg actions: am and 1 at pm ason: ures																																	
Med Name: throid sage: mg actions: b a day in am ison: cid																																	
Med Name: tax sage: mg actions: bid ison: nity																																	

If medication is not given, use key code to indicate reason- initial and date. At the end of month, forward copy of MAR to Supervisor

Key Code: Absent-A, Holiday -H, Refusal-R, Workday-W

Staff Signature/ [Redacted] 5/31/18
Staff Signature/ [Redacted]

Name: [Redacted] MIR# [Redacted] Month/Year 4-18 MID [Redacted] PFS Medication Administration Record

Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Med Name:	[Redacted]																														
Time:	[Redacted]																														
Dose:	[Redacted]																														
Directions:	[Redacted]																														
Reason:	[Redacted]																														
Med Name:	[Redacted]																														
Time:	[Redacted]																														
Dose:	[Redacted]																														
Directions:	[Redacted]																														
Reason:	[Redacted]																														
Med Name:	[Redacted]																														
Time:	[Redacted]																														
Dose:	[Redacted]																														
Directions:	[Redacted]																														
Reason:	[Redacted]																														

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Key Code: Absent-A, Holiday -H, Refusal-R, Workday-W

Staff Signature/Date [Redacted] 4-30-18
 Staff Signature/Date [Redacted]

Time 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Med Name:
epakote
Usage: 8:00 am
50mg
Directions: bid

Med Name:
glant
Usage: 8:00 pm
0mg
Directions: bid

Med Name:
levothyroid
Usage: 6:30 am
mg
Directions: bid

Med Name:
max
Usage: 8:00 pm
5 mg
Directions: bid

If medication is not given, use key code to indicate reason- initial and date. At the end of month, forward copy of MAR to Supervisor

Key Code: Absent-A, Holiday-H, Refusal-R, Workday-W

4-30-18

Staff Signature/Date
Staff Signature/Date

Appalachian Community Services
91 Timberlane Road
Waynesville NC 28786-7927
Tel: 8284547220 Fax: 8773461089

Laura Hudson
License #: 5007029 DEA
#: MH3268352 NPI:1407073109

Barry Moore
License #: 19520 DEA
#: BM7582364

Name: [REDACTED] DOB: [REDACTED]
[REDACTED]

Rx: Geodon 80 MG Oral CAPSULE
Directions: take 2 tabs at HS with food

Comments: PA criteria met

Dispense #: *** 60 *** Refills: *** 2 ***

Date: 5/24/2018

By: *Laura U. Hudson PMHNP-BC*

Product Substitution Permitted

Name: [Redacted] MR# [Redacted] Month/Year 4-18 MID [Redacted] PFS Medication Administration Record

Med Name:	Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Med Name: [Redacted]	7am	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]
Med Name: [Redacted]	8pm	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Med Name: [Redacted]	7am	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]	[Redacted]

If medication is not given, use key code to indicate reason- initial and date. At the end of month, forward copy of MAR to Supervisor
Key Code: Absent-A, Holiday-H, Refusal-R, Workday-W

Staff Signature/Date: [Signature] 4-30-18
Staff Signature/Date: [Signature]

919 715 0070 Vonage

Name: [Redacted] MR#: [Redacted] Month/Year 4-18 MID: [Redacted] PFS Medication Administration Record

Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
5 Med Name: Geedone	[Redacted]																														
Dosage: 80mg cap	[Redacted]																														
Directions: 2 @ bedtime	[Redacted]																														
Reason: behaviors	[Redacted]																														
6 Med Name: Luviox	[Redacted]																														
Dosage: 50mg tab	[Redacted]																														
Directions: 3 tabs in the AM	[Redacted]																														
Reason: behaviors	[Redacted]																														
7 Med Name: FORPAMATE	[Redacted]																														
Dosage: 100MG	[Redacted]																														
Directions: 1 TAB BID	[Redacted]																														
Reason: Poor Appetite	[Redacted]																														
3 Med Name:	[Redacted]																														
Dosage:	[Redacted]																														
Directions:	[Redacted]																														
Reason:	[Redacted]																														

Home as of 4-4

If medication is not given, use key code to indicate reason- initial and date. At the end of month, forward copy of MAR to Supervisor

Key Code: Absent-A, Holiday-H, Refusal-R, Workday-W

Staff Signature/Date
Staff Signature/Date

[Handwritten Signature]
4-30-18

FAX COVER SHEET

To: **From:** PFS Fax
<pfsfax@disabilitypartners.org>

Company: **Date:** 06/07/18 12:12:44 PM

Fax Number: 19197158078 **Pages (Including cover):** 20

Re: Hyde Home POC

Notes:

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Person First Services

(A program of Pathways for the Future)

Office: 1-828-354-0296

Fax: 1-828-412-4421

CONFIDENTIALITY NOTICE: This fax, including attachments if for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, or disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender immediately and destroy all copies of the original message.





Person First Services

2775 US 74 East, Sylva NC 28779

Phone : 828-354-0296 Fax: 828-412-4421

FAX COVER SHEET

To /Company: Cathy Sandford Date: 6/7/18

Fax Number: 919-733-2757

Number of pages: 19 (including cover page)

From: Lynda Cowan

- Urgent
 For your review
 Reply ASAP
 Please Comment

Hyde home POC 6/7/18

Will put original in mail today.

CONFIDENTIALITY NOTICE: This fax, including attachments if for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, or disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender immediately and destroy all copies of the original message.