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
	MHL0601323	A. BUILDING: _____ B. WING _____	05/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS HOME	6914 CEDARCREEK DRIVE CHARLOTTE, NC 28215

(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 5/30/18. A deficiency was cited. *This facility is licensed for the following service category:* 10A NCAC 27G .5600F Supervised Living/ Alternative Family Living (AFL)	V 000		
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 with a physician.	V 118		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Natasha Williams BA QDDP — TITLE: Residential Director — (X6) DATE: June 13, 2018

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V 118	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to administer medications based on the written orders of a person authorized to prescribe medications, affecting 1 of 2 clients (Client #2). The findings are: Review on 5/24/18 of Client #2's record revealed: - Admission date of 8/1/16 - Diagnoses of Autism, Mild Intellectual Disability Disorder, Impulse Control Disorder, Mood Affective Disorder, Adjustment Disorder with Anxiety Review on 5/24/18 of March-May 2018 MARs revealed: - Probiotic, 1 capsule PO (by mouth) daily Review on 5/24/18 of Client #2's medication orders revealed: - No medication order written by a physician for Probiotic Interview on 5/24/18 with Staff #1 revealed: - He did not know where the order was but he knows they did have it. He will check for it at the office. Interview on 5/30/18 with The Qualified Professional (QP) revealed: - They had the original order when it was first written, but she doesnt know what happened to it. - The doctor office was held up and failed to get a copy of it to them	V 118	**V 118 27G .0209 (C) Medication Requirements** **10 NCAC 27G .0209 MEDICATION REQUIREMENTS** **Correction:** A Small Miracle LLC (ASM) has received copy of the Physicians Orders for the following Medication sited: (See attached) • Probiotic **Prevention:** ASM will ensure the AFL Contractor obtain and keep all current prescriptions, orders, and discontinue orders for all medications the individual is prescribed. All copies will be maintained in the Home binder located at the residence and the ASM binder located at the Main Office. ASM will take measures to ensure all AFL Staff are trained to maintain and keep all documentation required for compliance. **Who Will Monitor:** The Qualified Professional will monitor documentation at both locations and observe quarterly or as needed to ensure compliance.	

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V 118	Continued From page 2 This deficiciency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		

A SMALL MIRACLE LLC
1509 Idlewild Road North Charlotte NC 28216

CLIENT NAME: [redacted]
MEDICAID NUMBER: [redacted]
RECORD # [redacted]
DATE OF BIRTH: [redacted]

PHYSICIAN'S ORDERS

Instructions: A signed order is required for each visit. Orders for administering medications must include the dosage and schedule for administration. Orders must be renewed every 6 months. A Medication information forms are required for prescription medications. If the resident has a legal guardian, an Authorization to Administer Medication form is required for psychotropic and over the counter medications.

DATE:
Six(6) Month Medication Review Date:
Type of service: **Residential Support**

Diagnosis (optional): disorder autism, hypothyroidism, GERD, behavior
Orders for Treatment:

MEDICATIONS

Medication Name	Strength	Dosage	Frequency	Discontinue date (if applicable)	Initial If PRN	Authorization to self-administer
Desmospressin	0.1 mg	3-4 tab	qHs			
Trazodone	50 mg	1 tab	qHs			
Levothyroxine	125 mg	1 tab	daily			
Albuterol Sulfate	0.5%/2.5mg	0.5mL	q6h			
Omeprazole	40mg	1 tab	daily			

OVER THE COUNTER PRN MEDICATIONS

The medications initiated below may be given as directed:

Digestive Probiotic

Citrcel Fiber Therapy

Vitamin D-3

Immodium

PHYSICIAN'S SIGNATURE: [signature]
DATE: 12/1/17

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

June 12, 2018

Ann Newsome
A Small Miracle, LLC
1890 Tommy's Road
Goldsboro, NC 27534

Re: Annual Survey Completed 5/30/18
Davis Home, 6914 Cedarcreek Drive, Charlotte NC 28215
MHL # 060-1323
E-mail Address: ann.newsome@asmallmiraclellc.com

Dear Ms. Newsome:

Thank you for the cooperation and courtesy extended during the annual survey completed 5/30/18.

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

- Re-cited standard level deficiencies.

Time Frames for Compliance

- Re-cited standard level deficiency must be ***corrected*** within 30 days from the exit of the survey, which is 6/29/18.

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.

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,

Devora R. Neely

Devora Neely, MSW, BSN, RN
Nurse Consultant
Mental Health Licensure & Certification Section

Cc: Trey Sutten, Interim Director, Cardinal Innovations LME/MCO
Onika Wilson, Quality Management Director, Cardinal Innovations LME/MCO
File

- 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.***

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Devora R. Neely

Devora Neely, MSW, BSN, RN
Nurse Consultant
Mental Health Licensure & Certification Section

Cc: Trey Sutten, Interim Director, Cardinal Innovations LME/MCO
Onika Wilson, Quality Management Director, Cardinal Innovations LME/MCO
File

ASM A Small Miracle
Quality Home and Community Based Services for Adults and Children

June 13, 2018

NCDHHS
Division of Health Service Regulation
Mental Health Licensure and Certification Section
Attn: Devora Neely
Nurse Consultant

Re: Annual Survey completed May 30, 2018
Davis Home, 6914 Cedarcreek Drive, Charlotte NC 28215
MHL # 060-1323

Dear Ms. Neely,

Thank you for the services you rendered on 5/30/2018 located at the Davis Home. You noted an area of deficiency that was in need of correction and we have responded expeditiously. Please find enclosed a copy of your letter to ensure correct identification. The summary state of deficiencies and the plan of correction.

We believe that this will conclude all necessary corrections. However, if you find that there is something else that needs our attention, Please do not hesitate to call me at 704-321-1635.

Sincerely,

Natara Williams-Stroup

Natara Williams
Director of Residential Services