STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL023-170	A. BUILDING: _____ B. WING _____	07/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE ON ONE CARE - CARING WAY	115 CARING WAY SHELBY, NC 28150

(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 7/12/18. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Individuals of all Disablility Groups.	V 000	DHSR - Mental Health JUL 23 2018 Lic. & Cert. Section	
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing practitioner.	V 117		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 117	Continued From page 1 This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure each prescription drug dispensed included a label with the name, prescribers name, dispensing date, strength, quantity, and expiration date for 1 of 3 sampled clients (#3). The findings are: Observation on 7/12/18 at 3:45pm of the medications for Client #3 included: -Levemir Flextouch 100u - 2 pens without a label. Review on 7/12/18 of the record for Client #3 revealed: -Admission date of 1/8/03 with diagnoses of Hypertension, Diabetes, Unspecified Affective Psychosis and Moderate Intellectual Developmental Disability. -Physician order dated 4/10/18 for Levemir Flextouch 100units/inject 28u daily. Interview on 7/12/18 with Client #3 revealed: -He received his medications as directed by physician. -He had not missed any medications. Interview on 7/12/18 with the Residential Manager revealed: -The label for the insulin was on the box. -The medication had been called in for a refill. -When the refill was reordered, the box with the label and instructions was discarded. -She will ensure the facility keeps the box with the label for the Levimir going forward.	V 117		

115 Caring Way

Shelby, NC 28150

MHL023-170

V-117 Medication Requirement

Measures in place to correct and prevent the deficient area of practice:

The Levimir Insulin has been reordered and is in the lock box at the home. The box with the label will remain in the lock box with all of the medication. Staff will be instructed to not discard the box. When refills are needed, Home Manager will reorder without removing the box from the home.

The medication will be added to the weekly medication audit list to prevent this error from occurring in all locations in which clients receive insulin.

Who will monitor and how often:
at all times.

Direct care staff will inform Home Manager when a refill is needed. Manager, along with medication auditor, will also monitor on a weekly basis to ensure that both the medication and labeled box are in the lockbox.

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

July 17, 2018

DHSR - Mental Health
JUL 23 2018
Lic. & Cert. Section

Eddie Scruggs, Director of Operations
One on One Care Inc.
PMB 109, 1137 East Marion Street
Shelby, NC 28150

Re: Annual Survey completed 7/12/18
One on One Care – Caring Way, 115 Caring Way, Shelby, NC 28150
MHL # 023-170
E-mail Address: escruggs@oneononecare.net

Dear Mr. Scruggs:

Thank you for the cooperation and courtesy extended during the annual survey completed 7/12/18.

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

- Standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is 9/10/18.

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.

July 17, 2018
Eddie Scruggs
One on One Care Inc.

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 Robin Sulfridge, Branch Manager at 336-861-7342.

Sincerely,

Sherry Waters

Sherry Waters
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
File