PRINTED: 08/02/2018
FORM APPROVED

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
	MHL064-113	A. BUILDING: _____ B. WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD MILL RD - BETTER CONNECTIONS	1808 OLD MILL ROAD ROCKY MOUNT, NC 27803

(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 and Complaint survey was completed on 7/26/18. The complaint was unsubstantiated Intake #NC00140273. A deficiency was cited. The facility is licensed for the following service categories 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities and 10A NCAC 27G. 5100 Community Respite Services.	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	V 118		

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	MHL064-113	C.BUILDING: _____ D.WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD MILL RD - BETTER CONNECTIONS	1606 OLD MILL ROAD ROCKY MOUNT, NC 27803

(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 1 checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure one of three audited clients (#1) medication was administered on the written order of a physician. The findings are: Review on 7/24/18 of client #1's record revealed: - admitted on 9/16/10 - diagnoses of Unspecified Bipolar; Intellectual Disability; Severe Seizure Disorder and Cerebral Palsy - a FL2 dated 2/15/18..."Keppra 500mg three times a day" (can treat seizures) Review on 7/24/18 of client #1's May, June & July 2018 MAR revealed: - Keppra 500mg three by mouth twice a day Observation on 7/24/18 at 1:33pm of client #1's medication label revealed: - Keppra 500mg three by mouth twice a day During interview on 7/26/18 the Residential Director reported: - the 2/15/18 FL2 was written by the Qualified Professional - the FL2 was written incorrectly - client #1 has been on the same dosage of Keppra for awhile - he has not had a seizure in over 5 years - however, the physician will not reduce or take him off the Keppra medication	V 118	**V118** QP met with MD to make correction on FL2. Signature obtained from doctor to note correct transcription. See attached copy. Staff will continue to administer correct dosage as noted on latest order which is the FL2 that was obtained on 8-7-18 originally dated 2/15/18. QP or RD will attach all orders to all FL2s when presenting to doctor for his/her signature. The doctor can review orders against what has been transcribed onto FL2 prior to signing. QP will transfer scripts from doctors' orders versus MARs in the future.	9/24/18

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	MHL064-113	B. BUILDING: _____ F. WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD MILL RD - BETTER CONNECTIONS	1808 OLD MILL ROAD ROCKY MOUNT, NC 27803

(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 reviewed the MARs once a month - she had not noticed the discrepancy with the FL2, medication label and MARs During interview on 7/26/18 the Qualified Professional reported: - she was at the facility once a month - she reviewed the MARs during this time - she transcribed the FL2 based on the MARs - normally the clients' physicians caught any errors on the FL2 prior to signature	V 118		

Print Form

Adult Care Home FL2 Form

PRIOR APPROVAL | UTILIZATION REVIEW | ON-SITE REVIEW

IDENTIFICATION

1. PATIENT'S LAST NAME	FIRST	MIDDLE	2. BIRTHDATE (M/D/Y)	3. SEX	4. ADMISSION DATE (CURRENT LOCATION)
[redacted]			[redacted]	M	03/07/17

5. COUNTY AND MEDICAID NUMBER	6. FACILITY ADDRESS	7. PROVIDER NUMBER
[redacted]	Old Mill Road - Rmt, NC 27604	[redacted]

8. ATTENDING PHYSICIAN NAME AND ADDRESS	9. RELATIVE NAME AND ADDRESS
Dr. Daniel Crocker - 4041 Noell Lane, STE 105 Rocky Mt. NC. 27804	[redacted]

10. CURRENT LEVEL OF CARE	11. RECOMMENDED LEVEL OF CARE	12. PRIOR APPROVAL NO.	14. DISCHARGE PLAN
___ HOME ___ SNF ___ ICF ___ HOSPITAL X DOMICILIARY (REST HOME) ___ OTHER	___ HOME ___ SNF ___ ICF ___ HOSPITAL X DOMICILIARY (REST HOME) ___ OTHER	[redacted] 13. DATE APPROVED/DENIED [redacted]	___ HOME ___ SNF ___ ICF ___ HOSPITAL X DOMICILIARY (REST HOME) ___ OTHER

15. ADMITTING DIAGNOSES - PRIMARY, SECONDARY, DATES OF ONSET

1. Mood Disorder NOS	5. Seizure Disorder
2. Moderate Mental Retardation	6.
3. Perinatal Hypoxia	7.
4. Cerebral Palsy	8.

16. PATIENT INFORMATION

DISORIENTED TO: N / A	AMBULATORY STATUS	BLADDER	BOWEL
CONSTANTLY	X AMBULATORY	X CONTINENT	X CONTINENT
INTERMITTENTLY	SEMI-AMBULATORY	INCONTINENT	INCONTINENT
INAPPROPRIATE BEHAVIOR	NON-AMBULATORY	INDWELLING CATHETER	COLOSCOPY
WANDERER	FUNCTIONAL LIMITATIONS	EXTERNAL CATHETER	RESPIRATION
X VERBALLY ABUSIVE	X SIGHT Wears Glasses	COMMUNICATION OF NEEDS	X NORMAL
INJURIOUS TO SELF	HEARING	X VERBALLY	TRACHEOSTOMY
INJURIOUS TO OTHERS	X SPEECH Sometimes Slurred	NON-VERBALLY	OTHER
X INJURIOUS TO PROPERTY	CONTRACTURES	DOES NOT COMMUNICATE	02 PRN CONT
OTHER:	ACTIVITIES/SOCIAL	SKIN	NUTRITION STATUS
PERSONAL CARE ASSISTANCE	PASSIVE	X NORMAL	X DIET Regular
X BATHING	X ACTIVE	OTHER:	SUPPLEMENTAL
FEEDING	GROUP PARTICIPATION	DECUBITI DESCRIBE:	SPOON
X DRESSING	RE-SOCIALIZATION	DRESSINGS:	PARENTERAL
TOTAL CARE	X FAMILY SUPPORTIVE		NASOGASTRIC
PHYSICIAN VISITS	NEUROLOGICAL		GASTROSTOMY
X 30 DAYS	X CONVULSIONS/SEIZURES		INTAKE AND OUTPUT
60 DAYS	GRAND MAL		FORCE FLUIDS
OVER 180 DAYS	PETIT MAL		WEIGHT
	FREQUENCY		HEIGHT

17. SPECIAL CARE FACTORS	FREQUENCY	SPECIAL CARE FACTORS	FREQUENCY
BLOOD PRESSURE		BOWEL AND BLADDER PROGRAM	
DIABETIC URINE TESTING		RESTORATIVE FEEDING PROGRAM	
PT (BY LICENSED PT)		SPEECH THERAPY	
RANGE OF MOTION EXERCISES		RESTRAINTS	

18. MEDICATIONS/NAME & STRENGTH, DOSAGE & ROUTE

1. Klonopin 1mg - 1mg PO BID + ½ tab. daily
2. Abilify 10mg - BID
3. Cogentin 2mg - BID
4. Zyrtec 10mg Daily
5. Thorazine 100mg QID
6. Celexa 20mg Daily
7. Clonidine 0.1mg BID
8. Colace 100mg BID
9. Keppra 500mg ~~TID~~ 3 tablets bid (twice a day)
10. Trileptal 600mg TID
11. Miralax 17g daily PRN
12. Trazodone 50mg QHS
13. Nizoral 2% topical Shampoo PRN

19. X-RAY AND LABORATORY FINDINGS/DATE:

20. ADDITIONAL INFORMATION

21. PHYSICIAN'S SIGNATURE [signature] DATE 2/15/18

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

August 3, 2018

Page 30

John Williams, CFO, Operations Director
Better Connections, Inc.
PO Box 3381
Greenville, NC 27836

Re: Annual & Complaint Survey completed July 26, 2018
1808 Old Mill Road, Rocky Mount, NC 27803
MHL #064-113
E-mail Address: jwilliams@betterconnectionsinc.com
Intake #NC00140273

Dear Mr. Williams:

Thank you for the cooperation and courtesy extended during the Annual & Complaint survey completed July 26, 2018. The complaint was unsubstantiated.

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 other 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 September 24, 2018.

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 Renee Ames at (919) 552-6847.

Sincerely,

Rhonda Smith
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: Trey Sutten, 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
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