STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL013-083	A. BUILDING: _____ B. WING _____	08/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CABARRUS COUNTY GROUP HOME	65 CRESWELL DRIVE CONCORD, NC 28025

(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 August 17, 2018. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults Whose Primary Diagnosis is a Developmental Disability.	V 000		
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
	MHL013-083	A. BUILDING: _____ B. WING _____	08/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CABARRUS COUNTY GROUP HOME	65 CRESWELL DRIVE CONCORD, NC 28025

(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 117	Continued From page 1	V 117		

This Rule is not met as evidenced by:
Based on interview, record review, and observation, the facility failed to ensure that each prescription medication had a pharmacy packaging label affecting 1 of 3 audited clients (Client #3). The findings are:

Review on 8/14/18 of Client #3's record revealed:
-Admission date of 11/18/1977;
-Diagnoses of Intellectual Developmental Disability - Severe, Developmental Disorder of Speech and Language, Irritable Bowel Syndrome with Diarrhea, Adjustment disorder with Mixed Disturbance of Emotions and Conduct, Speech Impairment;
-Physician's order dated 2/1/18 for Flonase 50mcg 2 sprays per nostril each morning.

Interview on 8/15/18 with Administrative Assistant revealed:
-There is no pharmacy label on Client #3's Flonase;
-Will call the pharmacy to ensure that Client #3's Flonase is labeled properly.

Interview on 8/17/18 with the Administrator revealed:
-The pharmacy arranged to properly label Client #3's Flonase on 8/15/18;
-Will ensure all medications are labeled properly in the future.

Observation on 8/15/18 at approximately 11:40am of Client #3's medication revealed:
-Bottle of Flonase with no pharmacy label

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL013-083	A. BUILDING: _____ B. WING _____	08/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CABARRUS COUNTY GROUP HOME	65 CRESWELL DRIVE CONCORD, NC 28025

(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 117	Continued From page 2 identifying name of client, prescriber's name, dispensing date, directions for administration, name of the dispensing practitioner, and name, address and phone number of the pharmacy.	V 117		