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
	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		

DHSR - Mental Health
AUG 24 2018
Lic. & Cert. Section

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 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	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 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	Label was originally placed on box that the Flonase came in when delivered by pharmacy. The box was accidently discarded. A new label was ordered from the pharmacy and placed on Flonase bottle on 8/15/18. Called pharmacy to request that the label be placed directly on bottle from this day forward to keep this from happening again.	8/15/18

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

August 21, 2018

Ms. Ginger Pope
Cabarrus County Group Homes, Inc.
PO Box 1197
Concord, NC 28026

Re: Annual Survey Completed August 17, 2018
Cabarrus County Group Home, 65 Creswell Drive, Concord, NC 28025
MHL# 013-083
E-mail Address: margiew@ctc.net

Dear Ms. Pope:

Thank you for the cooperation and courtesy extended during the annual survey completed August 17, 2018.

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

- The tag cited is a standard level deficiency.

Time Frames for Compliance

- The standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is October 16, 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 Lynn Grier, Team Leader at 704-596-4072.

Sincerely,

Eileen Sanchez, MA
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
File