Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL033-065	B. WING		R 10/26/	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
OPEN A	RMS FAMILY SERVICE	ES INC	RPER STREE MOUNT, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	rs .	V 000			
	on 10/26/18. Deficient The facility is licens category 10A NCAC	w up survey was completed encies were cited. ed for the following service C 27G 5600C Supervised nentally Disabled Adults.				
V 114	10A NCAC 27G .02 AND SUPPLIES (a) A written fire pla area-wide disaster shall be approved be authority. (b) The plan shall be and evacuation proposted in the facility (c) Fire and disaster shall be held at least repeated for each sunder conditions the	ncy Plans and Supplies 207 EMERGENCY PLANS In for each facility and plan shall be developed and by the appropriate local e made available to all staff cedures and routes shall be conducted at simulate fire emergencies. Ill have basic first aid supplies	V 114			
	failed to ensure drill The findings are: Review on 10/18/18 log revealed: it was difficult to the time the drill wall for example on	view and interview the facility is were completed quarterly. 3 of the facility's disaster/fire of determine what type of drill &				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		MHL033-065	B. WING			R 26/2018	
OPEN ARMS FAMILY SERVICES, INC. 1649 HAR			DRESS, CITY, S PER STREE OUNT, NC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
V 114	4:10pm and 7:30pn determine which dr times - the drills were reach drill was not d During interview on Licensee/Qualified - she had 3 shifts - she completed same time - she will separate and specify which see the drills will be [This deficiency corand must be correct.]	n, however it was difficult to ill was completed at the above not separated and the time for ocumented 10/26/18 the Professional reported: s a fire and disaster drill at the te the fire and disaster drills hift it was completed on completed quarterly	V 114				
	10A NCAC 27G .02 REQUIREMENTS (c) Medication adm (1) Prescription or r only be administere order of a person a drugs. (2) Medications sha clients only when a client's physician. (3) Medications, inc administered only b unlicensed persons pharmacist or other privileged to prepar (4) A Medication Ad all drugs administer current. Medication	09 MEDICATION					

Division of Health Service Regulation STATE FORM

SKIT11 If continuation sheet 2 of 5

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE		` '	E CONSTRUCTION		SURVEY PLETED
7.1.12 . 2.1.1	0. 00.1.1.20.1.0.1			A. BUILDING:			
		MHL033-065		B. WING			R 26/2018
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
OPEN ARMS FAMILY SERVICES, INC			RPER STREE IOUNT, NC				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 118	MAR is to include t (A) client's name; (B) name, strength (C) instructions for (D) date and time t (E) name or initials drug. (5) Client requests checks shall be rec		g; ed; and ing the es or the MAR	V 118			
	This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure 3 of 3 clients (#1, #2 & #3) medications were administered and recorded immediately after administration. The findings are: A. Record review on 10/18/18 of client #1's record revealed:						
	 diagnoses of S Intellectual Develop a FL2 dated 1/day; Topamax 50m 20mg everyday and bedtime 	e facility on 8/26/16 chizophrenia Disorde comental Disability; Ob 11/18: Cogentin 1mg og twice a day; Omepi d Clozaril 300mg 3 ta ler dated 7/25/18: Zol bedtime	esity twice rozale bs at				
	the following: - September 20° initialed between 9/	8 of client #1s MARs 18 medications were 1/28/18-9/30/18 itialed some medicati	not				

Division of Health Service Regulation

STATE FORM SKIT11 If continuation sheet 3 of 5

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE COMP		SURVEY LETED		
AND I LAN OF CONNECTION IDENTIFICATION NOWIDEN.		A. BUILDING:		F		
		MHL033-065	B. WING			6/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
OPEN A	RMS FAMILY SERVICI	FS. INC	PER STREE OUNT, NC :			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 3	V 118			
	10/17/18 during the	day and at bedtime				
	B. Record review of revealed: - admitted to the diagnoses of Score Poevelopmental Disardyperlipidemia and a FI2 dated 3/15 times a day (TID); human 10/18/18 MARs revealed the there was no standiated to the diagnoses of Schypertension; Mild Developmental Disardy a FL2 dated: 2/everyday; Losartan everyday; metformi three times a day; Eseroquel 40mg even bedtime Clonazepa DDAVP .1mg twice Review on 10/18/18 MAR revealed the formula of the staff had not inital 10/17/18 during the During interview on Licensee/Qualified	facility on 9/9/09 chizophrenia; Intellectual ability; Depression; Anxiety 4/18: Depakote 500mg three Haldol 10mg TID; Oxybutynin xybutynin 15mg bedtime 3 of client #2's October 2018 following: aff initials from 10/13/18 - n 10/18/18 of client #3's facility 3/6/17 chizophrenia; Diabetes; Dementia: Intellectual ability 16/18: Atorvastatin 40mg potassium 100-25m n 1000 everyday; Haldol 15mg Benztropine 1mg twice a day; eryday; Trazadone 100mg m .5mg twice a day and a day 3 of client #3's October 2018 following: tialed some medications on a day and at bedtime 10/26/18 the Professional reported: eason why staff should not				

6899

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY LETED
			A. BOILDING	·	F	
		MHL033-065	B. WING			6/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
OPEN A	RMS FAMILY SERVIC	ES INC	RPER STREE MOUNT, NC			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)		COMPLETE DATE
V 118	Continued From pa	age 4	V 118			
		ere administered				
		on a home visit from 10/13/18- buld have initialed "O" for				
	homevisit	he medications twice a				
		ation errors were not found				
		nstitutes a re-cited deficiency cted within 30 days.]				
	and must be correct	sted within 50 days.j				

Division of Health Service Regulation STATE FORM

6899 SKIT11 If continuation sheet 5 of 5