STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL058-003	A. BUILDING: Lic. & Cert. Section B. WING	R 11/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCLAWHORNE HOME	1044 MCLAWHORNE ROAD ROBERSONVILLE, NC 27871

(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 follow up survey was completed on 11/28/18. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 291	27G .5603 Supervised Living - Operations 10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.	V 291	Plan of Correction V291 27G.5603 Upon review of this deficiency we realized that there was obviously some type of a communication mix up. All of the notes on the deficiency is stated that client #4 did not follow up on a pneumococcal pneumonia vaccine, however, client #4 had this vaccine on October 10, 2018. The vaccine that was suppose to be in question and was on wait list was a shingle vaccine. This was not a prevnar vaccine as listed in deficiency. This vaccine was short throughout the state of North Carolina. It was also a mix up that the physicians office scheduled this vaccine on 11/29/18, they did not, the shingle vaccine is not given at the physician office only the pharmacy.	

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V 291	Continued From page 1 This Rule is not met as evidenced by: Based on record review and interview the facility failed to maintain coordination with other qualified professionals who are responsible for the treatment/habilitation of one of three audited clients (#4). The findings are: Review on 11/27/18 of client #4's record revealed: - admitted to the facility on 7/17/93 - diagnoses of Diabetes; Hypertension; Hyperlipidemia; Intellectual Developmental Disorder and Blindness - a prescription dated 9/25/18 "Prevnar 13 .5ml intramuscularly one time...at pharmacy"...for the prevention of pneumococcal pneumonia... - a written note on the prescription from the pharmacy dated 9/25/18 "we currently have a waiting list for this vaccine. I placed [client #4] on the waiting list and will call caregiver in a few weeks when we get to his name...Prevnar 13-administered at most pharmacy..." Review on 11/28/18 of a letter from the pharmacy that revealed: - "..the vaccine has been on manufacturer backorder since June...we have not been able to get any in stock from our manufacturer and are currently keeping a running waiting list to administer to those patients in need...[client #4] is still on the waiting list with 31 patients awaiting the vaccine in front of him..." During interview on 11/27/18 staff #1 reported: - all staff take the clients to their appointments - she has not followed up on the Prevnar 13 vaccine to see where his name was on the list...or if another pharmacy had the vaccine	V 291	We were however able to get part of the vaccine done on 12 /7 /18. The pharmacist will call us back when part 2 is available, however we have developed a call log to check every other day to ensure we do not miss part 2 of this vaccine. Staff will report the outcome of the calls to manager and manager will follow up weekly with pharmacy. This will be the ongoing process when vaccines are schedule with the pharmacy. Attached are the appointment notes for the shingle vaccine part 1 that was done on 12/7/2018.	

Louis

CLIENT APPOINTMENT FORM

Please fill out all sections and blanks after each and every appointment.

[redacted]

12-7-18
Date of Appointment

[redacted]
Phone Number

Prescriptions Written

Call between Feb & June, 2019 for 2nd shot
Next Appointment date and time

Other Doctor's comments

Received Shingrix vaccine in right deltoid
Ashley Leggett, PharmD, RPh

Please list any other activities client participated in while out:

Jacklee B. Shaver Pre-Apt
Staff Signature and Title

Left M.E. - 9:06 Am
Arrive at Mast Pharmacy - 9:15 Am
Left Mast Pharmacy 9:38 Am

VACCINE ADMINISTRATION RECORD

Name [redacted]

Address

Phone:

Allergies NONE Primary Care Physician and Phone Number: _____

Ethnicity (optional): Caucasian (African-American) Hispanic Asian American Indian Other- _____

Screening Questions

1.	Are you sick today?	YES	(NO)
2.	Do you have allergies to medications, food, eggs, yeast, a vaccine component, or latex?	YES	(NO)
3.	Have you ever had a serious reaction after receiving a vaccination?	YES	(NO)
4.	Has any physician or other healthcare professional ever cautioned or warned you about receivingcertain vaccines or receiving vaccines outside of a medical setting?	YES	(NO)
5.	Do you have a long-term health problem such as heart disease, lung disease, liver disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia or other blood disorder?	YES	(NO)
6.	Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem? Have you been diagnosed with rheumatoid arthritis, ankylosing spondylitis, Crohn's disease, herpes, or cold sores?	YES	(NO)
7.	In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	YES	(NO)
8.	Have you had a seizure or a brain or other nervous system problem or Guillain Barre?	YES	(NO)
9.	During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug (including acyclovir, famciclovir, valacyclovir)?	YES	(NO)
10.	**For women**: Are you pregnant or is there a chance you could become pregnant during the next month?	YES	NO
11.	Have you received any vaccinations or TB skin test in the past 4 weeks?	YES	(NO)
12.	Do you have a history of fainting, particularly with vaccines?	YES	(NO)
13.	**For Tdap and adult Td:** Do you have a cut, injury, puncture or open wound that prompted you to get a tetanus shot?	YES	(NO)
14.	**For Zoster:** Have you had a past reaction to gelatin or triple antibiotic ointment?	YES	NO

MEDICARE RECIPIENTS PLEASE COMPLETE THE SECTION BELOW:

Please check one:

☐ *I hereby authorize* _____ *(pharmacy) to bill Medicare Part B/Part D on my behalf. I request that payment of authorized Medicare benefits be made to* _____ *(pharmacy) for the above vaccine and its administration as furnished to me by* _____ *(pharmacy). I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services.* **Medicare Health Insurance Claim Number (HICN):** _____

☐ *I hereby attest that as of the date indicated above, I am <u>not</u> enrolled in Medicare Part B/Part D.*

PRIVATE INSURANCE HOLDERS PLEASE COMPLETE THE SECTION BELOW:

Please check one:

☐ *I hereby authorize* _____ *(pharmacy) to bill* _____ *(insurance) on my behalf. I request that payment of authorized benefits be made to* _____ *(pharmacy) for the above vaccine and its administration as furnished to me by* _____ *(pharmacy). I authorize any holder of medical information about me to release to* _____ *(insurance) and its agents any information needed to determine these benefits payable for related services.*

Subscriber ID #: _____ **Group #:** _____ **BIN #:** _____

I have read, or have had read to me, the written information regarding the vaccine(s) marked above. I have had the opportuni ty to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) being administered and have received a copy of a current Vaccine Information Sheet for each vaccine I am receiving today. I, on behalf of myself, my heirs, execu tors, personal representatives, agents, successors, and assigns hereby agree to release, indemnify, and hold harmless Mutual Drug, its subsidiaries, divisions, affiliates, agents, officers, directors, contractors, and employees from any and all claims arising out of, in connection with, or in any way related to the administration of the vaccine(s) marked above. I certify that I am at least 18 years old and hereby give my consent to the pharmacists of this Mutual Member Drug Store to administer the vaccine(s) marked above. If under 18 years old signature by parent or guardian required. **I AGREE TO WAIT NEAR THE VACCINATION LOCATION FOR APPROXIMATELY 15 MINUTES FOR OBSERVATION BY A MUTUAL DRUG MEMBER PHARMACIST.**

[redacted] 12-7-18
Name (print) Signature Date

Name (print) [redacted] **Date** 12-7-18

Vaccine to be administered: _____ Influenza _____ Pneumococcal Polysaccharide _____ Pneumococcal Conjugate ✓ Herpes Zoster
_____ Hepatitis B _____ Meningococcal Polysaccharide _____ Meningococcal Conjugate _____ Tetanus-Diphtheria
_____ Tetanus and Diphtheria Toxoids and Pertussis _____ Tetanus and Diphtheria Toxoids and Acellular Pertussis _____ Tetanus Toxoid

1. Shingrix D294J 3/22/21 0.5ml IM
Vaccine name & manufacturer Lot# & exp. date Dose

LD or (RD) 12/7/18 Ashley Leggett RPh
Site of Injection Date of VIS Signature of administrator of vaccine

2. _____ _____ _____
Vaccine name & manufacturer Lot# & exp. date Dose

LD or RD _____ _____
Site of Injection Date of VIS Signature of administrator of vaccine

Store Stamp:

Primary Care MD notified: Date:_____
Phone____ Fax____ RPh/Tech:_____

SHINGRIX CALENDAR

Vaccine to prevent Shingles

Receive your 2nd vaccine in 2-6 months

GIVEN		DUE BETWEEN	
JAN		MAR	TO JUL
FEB		APR	TO AUG
MAR		MAY	TO SEPT
APR		JUN	TO OCT
MAY		JUL	TO NOV
JUN		AUG	TO DEC
JUL		SEPT	TO JAN
AUG		OCT	TO FEB
SEPT		NOV	TO MAR
OCT		DEC	TO APR
NOV		JAN	TO MAY
DEC	7	FEB 7	TO JUN 7

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V 291	Continued From page 2 - any staff could have followed up on the Prevnar 13 vaccine - she planned to develop a form that would assist staff on following up with future appointments During interview on 11/27/18 staff #2 reported: - any staff could have followed up on the Prevnar 13 vaccine, however she has not - there was a waiting list at the pharmacy when he was initially taken to get the vaccine - she has not followed up to see where his name was on the list...or attempted to contact another pharmacy - she contacted his physician's office today and client #4 has an appointment for the vaccine on 11/29/18 During interview on 11/28/18 the Residence Service Manager reported: - she made contact with the pharmacy today - client #4 was currently still on the waiting list - she understood other pharmacies could be contacted for the Prevnar 13 vaccine	V 291		
V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit.	V 752		

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V 752	Continued From page 3 This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure water temperatures were maintained between 100-116. The findings are: Observation on 11/27/18 revealed the following water temperatures: - kitchen sink was 92 - clients' bathroom sink was 92 During interview on 11/27/18 staff #1 reported: - she started in February 2018 - 3 months after she started someone came and turned the water temperature up During interview on 11/27/18 the Residential Service Manager reported: - a water heater was purchased in 2017 - a representative from a plumbing company recently had to turn the water down - the water temperatures were ran around 115 however, steam came from the water..."that was too hot" - another water thermometer was purchased today to check the water temperatures - she would also contact someone to come back out and recheck the water temperatures [This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.]	V 752	V752 27G.0304(b)(4) Hot Water Temperatures Corey's Plumbing Company came to the Mclawhorn Rd home on 12/3/2018.The water temperature was checked and adjusted to 110 degrees. The plumber stated that the mixing valve was not heating the water properly and the problem is now repaired. However, he would need to check back in about one week to ensure that the temperature stays the same or within the correct range. Corey's forwarded the invoice to Martin Enterprises on 12/20/18. A copy of the invoice is submitted with the Plan of Correction. Staff will continue to monitor water temps daily until we ensure that setting are correct. The temperatures will be noted in the office and submitted to manager daily. Manager will contact plumber immediately if reading is off.	

Corey Heating, Air Conditioning, &
Plumbing Inc
406 Washington Street
PO Box 787
Williamston, NC 27892

Invoice

Date	Invoice #
12/20/2018	7486

Bill To	Ship To
MARTIN ENTERPRISES PO BOX 1042 WILLIAMSTON NC 27892	

P.O. Number	Terms	Ship
	Due on receipt	12/20/2018

Quantity	Description	Amount
	104 MC LAWHORN STREET CHECK WATER HEATER	
	SERVICE BY MARTY	90.00
	Sales Tax	0.00

Total	$90.00
Payments/Credits	$0.00
Balance Due	$90.00
Customer Total Balance	$90.00

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

December 6, 2018

Becky Bullock, Executive Director
Martin Co. Res. Services., Inc. d/b/a Martin Enterprises
PO Box 1042
Williamston, NC 27892

Re: Annual & Follow up Survey completed November 28, 2018
McLawhorne Home, 1044 McLawhorne Road Roberson, NC 27871
MHL # 058-003
E-mail Address: rebeccabullock@martinenterprises.org

Dear Ms. Bullock:

Thank you for the cooperation and courtesy extended during the Annual & Follow up survey completed November 28, 2018.

As a result of the follow up survey, it was determined that none of the deficiencies are in compliance. Additional deficiencies were cited during the survey.

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

- Re-cited standard level deficiencies.
- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Re-cited standard level deficiency must be ***corrected*** within 30 days from the exit of the survey, which is December 28, 2018.
- Standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is January 27, 2019.

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: Leza Wainwright, Director, Trillium Health Resources LME/MCO
Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources LME/MCO
File