STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-164	A. BUILDING: ______ B. WING ______	12/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CABARRUS COUNTY GROUP HOME 5	**106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023**

(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 12/5/18. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge.	V 119	DHSR - Mental Health JAN 07 2019 Lic. & Cert. Section	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-164	A. BUILDING: _____ B. WING _____	12/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CABARRUS COUNTY GROUP HOME 5	106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023

(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 119	Continued From page 1 This Rule is not met as evidenced by: Based on records review, observations and interviews, the facility failed to ensure all expired medication were disposed of in a manner that guards against diversion or accidental ingestion affecting 3 of 3 clients (#1, #2, #3). The findings are: Finding #1: Review on 12/5/18 of client #1's record revealed: -admission date of 7/1/07 with diagnosis of Intellectual Disability Disorder Mild, Oppositional Defiant Disorder, Autistic Disorder, Hypertension and Seasonal Allergies; -physicians' orders dated 10/30/18 for the following medications: Ibuprofen 200mg one three times a week and Mucinex 1200mg one every 12 hours as needed. Observation on 12/5/18 at 3:22pm of client #1's medications on site revealed: -Ibuprofen 200mg one three times a week had two labels, one on top from pharmacy #1 dispensed 6/6/17 with expiration date 6/6/18, underneath a second label from pharmacy #2 with a dispense date of 5/27/16, a manufacturer's expiration date of 10/2017; -Mucinex 1200mg one every 12 hours as needed had two labels, one on top from pharmacy #1 dispensed 3/3017 with expiration date 3/30/18, underneath a second label from pharmacy #2 with a dispense date of 5/27/16, a manufacturer's expiration date of 10/2017. Review on 12/5/18 of client #1's MARS from 10/2018-12/2018 revealed the following: -Ibuprofen 200mg one three times a week not administered;	V 119	Expired Ibuprofen returned to Pharmacy on 12/6/18. New Ibuprofen ordered and received on 12/6/18 (see attached) Expired Mucinex returned to pharmacy on 12/6/18 for disposal. New Mucinex ordered on 12/6/18 and delivered to group home on 12/7/18 (see attached)	12/6/18 12/6/18 12/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-164	A. BUILDING: _____ B. WING _____	12/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CABARRUS COUNTY GROUP HOME 5	106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023

(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 119	Continued From page 2 -Mucinex 1200mg one every 12 hours as needed not administered. Finding #2: Review on 12/5/18 of client #2's record revealed: -admission date of 7/1/07 with diagnosis of Intellectual Disability Disorder Moderate, Attention Deficit Disorder, Speech Impairment, Hyperlipidemia, Asthma, Vitamin D Deficiency and Allergic Rhinitis; -physician's order dated 2/19/18 for the following medication: Ventolin HFA 90 mcg inhale 2 puffs every 4-6 hours as needed. Observation on 12/5/18 at 3:40pm of client #2's medications on site revealed: -Ventolin HFA 90 mcg inhale 2 puffs every 4-6 hours as needed had two labels, one on top from pharmacy #1 dispensed 1/5/17 with expiration date 1/5/18, underneath a second label from pharmacy #2 unable to read, a manufacturer's expiration date of 9/2017. Review on 12/5/18 of client #2's MARS from 10/2018-12/2018 revealed Ventolin HFA 90 mcg inhale 2 puffs every 4-6 hours as needed not administered. Finding #3: Review on 12/5/18 of client #3's record revealed: -admission date of 6/1/14 with diagnosis of Intellectual Disability Disorder Mild, Major Depression Disorder, Hypercholesterolemia, Hypertension, Leukopenia, Onychonyosis, Vitamin D Deficiency, Kidney Stones and Gastritis Colitis; -physician's order dated 8/22/18 for the following medication: Desitin 13% apply twice daily as needed.	V 119	Expired Ventolin HFA inhaler (Pro-Air) was sent to pharmacy on 12/6/18 for disposal. A new one was ordered and received on 12/6/18 (see attached)	12/6/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL080-164	A. BUILDING: _____ B. WING _____	12/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CABARRUS COUNTY GROUP HOME 5	106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023

(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 119	Continued From page 3 Observation on 12/5/18 at 3:31pm of client #3's medications on site revealed: -Desitin 13% apply twice daily as needed had two labels, one on top from pharmacy #2 with expiration date 6/6/17, underneath a second label also from pharmacy #2 with expiration date of 8/16/17, a manufacturer's expiration date of 4/2017. Review on 12/5/18 of client #3's MARS from 10/2018-12/2018 revealed the following: -Desitin 13% apply twice daily as needed not administered. Interview on 12/5/18 with the Group Home Manager revealed: -not aware of why two labels on the medications; -been on her job about a year; -the as needed medications have not been used; -client #2 has a new inhaler which is current and not expired. Interview on 12/5/18 with the Administrative Assistant revealed: -changed pharmacies from #2 to #1 over a year ago; -pharmacy #1 sent labels for all as needed medications for staff to put over labels from pharmacy #2; -nobody caught the expiration dates on the as needed medications.	V 119	Expired Desitin was returned to pharmacy for disposal on 12/6/18. Ordered a new Desitin on 12/6/18. Pharmacy had to order and due to snow it was delivered to group home on 12/12/18. (See attached) Beginning 12/6/18, when a label expires but the medication is still good. the medication will be sent back to the pharmacy to be relabeled.	

1	[redacted]	ProAir HFA 90mcg	619801	1 Inhaler	DE	[redacted]
2	[redacted]	Fexofenadine 180mg	1405452 R	25	DE	[redacted]
3	[redacted]	Ibuprofen 200mg	4245781 N	1 bottle	DE	[redacted]
4	[redacted]	Mucinex DM	1397168 N	160x	DE	[redacted]
5	[redacted]	Destinin Cream	68086641	1/4 tube	DE	[redacted]

CANNON PHARMACY
"Life is Easy Here"
LONG-TERM CARE
ENHANCED CARE

Medication Return Form

Cannon Pharmacy Enhanced Care
140 Cabarrus Ave West
Fax: 1-866-380-1678
Phone: 704-918-4833

Med Discontinued:	DC
Resident Discharge:	RDC
Resident Expired:	EXP
Overstock:	OS
Resident Absent:	SU
Family Provides:	FP
Resident Refusal:	RR
Pharmacy Error:	ER
Med Expired:	DE

Community: _____ Bag ID Number: _____ Date Pharmacy Picked Up: _____

Patient Name	Medication Name, Strength	RX Number	Number Returned	Reason for Return	Technician Returning Med
[redacted]					
[redacted]					

Instructions:

1. Send controlled substances separately
2. Fill out as much information as possible
3. Have pharmacy driver sign form
4. Keep yellow sheet for records
5. Send white sheet and medication back to pharmacy

Signatures:

_____
Community Representative Signature

_____
Pharmacy Representative Signature

CANNON PHARMACY
"Life is Easy Here"
LONG-TERM CARE
ENHANCED CARE

Medication Return Form

Cannon Pharmacy Enhanced Care
140 Cabarrus Ave West
Fax: 1-866-380-1678
Phone: 704-918-4833

Med Discontinued:	DC
Resident Discharge:	RDC
Resident Expired:	EXP
Overstock:	OS
Resident Absent:	SU
Family Provides:	FP
Resident Refusal:	RR
Pharmacy Error:	ER
Med Expired:	DE

Community: CC.C.H Bag ID Number: [redacted] Date Pharmacy Picked Up: [redacted]

Patient Name	Medication Name, Strength	RX Number	Number Returned	Reason for Return	Technician Initials
[redacted]					

Instructions:

1. Send controlled substances separately
2. Fill out as much information as possible
3. Have pharmacy driver sign form
4. Keep yellow sheet for records
5. Send white sheet and medication back to pharmacy

Signatures:

Community Representative Signature

Pharmacy Representative Signature

CANNON PHCY ENHANCED CARE

L8B215B 19125009 140 CABARUS AVE W CONCORD, NC 28027 PAGE 4

CCGH- CABARRUS GROUP HOMES FC7223009 12/06/18 14:03
288 AVIATION DR
CHINA GROVE, NC 28023-6661
704-855-0004

CCGH181206140300000901

Batch No 1403

CONSOLIDATED DELIVERY SHEETS

RX #	PATIENT	QTY	PRICE	UNIT	DRUG	DOCTOR	ROOM	SIGNED	ORDER A/R
[redacted]		30		TAB	IBUPROFEN 200 MG TABLET	ADAMS, CAROL	CG	.....	.....
[redacted]		18		GM	VENTOLIN HFA 90 MCG INHAL	GOSS, FREDER	CG	.....	.....

CHECKED BY :_____ PRINT NAME :_____ DATE :_____ TIME :_____

RECEIVED BY :_____ PRINT NAME :_____ DATE :_____ TIME :_____

AUTHORIZED SIGNATURES ONLY (stamped signatures & dates are not acceptable)

CANNON PHCY ENHANCED CARE

L8B215B 19125009 140 CABARUS AVE W CONCORD, NC 28027 PAGE 1

CCGH- CABARRUS GROUP HOMES FC7223009 12/07/18 17:52

288 AVIATION DR

CHINA GROVE, NC 28023-6661

704-855-0004

CCGH181207175200000901

Batch No 1752

C O N S O L I D A T E D D E L I V E R Y S H E E T S

RX #	PATIENT	QTY	PRICE	UNIT	DRUG	DOCTOR	ROOM	SIGNED	ORDER A/R
[redacted]		14		TBM	MUCINEX DM ER 1,200-60 MG	ADAMS, CAROL	CG	.....	.....

CHECKED BY :_____ PRINT NAME :_____ DATE :_____ TIME :_____

RECEIVED BY :_____ PRINT NAME :_____ DATE :_____ TIME :_____

AUTHORIZED SIGNATURES ONLY (stamped signatures & dates are not acceptable)

CCGH- CABARRUS GROUP HOMES
288 AVIATION DR
CHINA GROVE, NC 28023-6661
704-855-0004

CCGH181212124400000901

Batch No 1244

CONSOLIDATED DELIVERY SHEETS

RX #	PATIENT	QTY	PRICE	UNIT	DRUG	DOCTOR	ROOM	SIGNED	ORDER A/R
[redacted]		113		GM	DESITIN 13% CREAM	ADAMS, CAROL	CG	.....	.....

CHECKED BY :_____ PRINT NAME :_____ DATE :_____ TIME :_____

RECEIVED BY :_____ PRINT NAME :_____ DATE :_____ TIME :_____

AUTHORIZED SIGNATURES ONLY (stamped signatures & dates are not acceptable)

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

December 12, 2018

Ginger Pope
Cabarrus County Group Homes, Inc.
P.O. Box 1197
Concord, NC 28026

Re: Annual Survey completed 12/5/18
Cabarrus County Group Home #5, 106 S. Franklin Street, China Grove, NC 28023
MHL # 080-164
E-mail Address: jwpope@ctc.net; margiew@ctc.net

Dear Ms. Pope:

Thank you for the cooperation and courtesy extended during the annual survey completed December 5, 2018. A deficiency was cited.

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

- Standard level deficiency was cited.

Time Frames for Compliance

- Standard level deficiencies must be corrected within 60 days from the exit date of the survey, which is February 3, 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 Lynn Grier at (704)596-4072.

Sincerely,

Gina McLain

Gina McLain
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