Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLI | (7.5) | | 3) DATE SURVEY COMPLETED | |
|--|-------------------------|---|---------------|--|--------------------------|--------------------------|--|
| | | | A. BOILDING | | | | |
| | | MHL053-082 | B. WING | 111111111111111111111111111111111111111 | 01/2 | 28/2019 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY | , STATE, ZIP CODE | | | |
| ANDDEN | | 2621 ANDRE | EWS DRIVE | | | | |
| ANDREWS | DRIVE FAMILY CARE FA | CILITY SANFORD, N | IC 27332 | | | | |
| (X4) ID | SUMMARY STA | | Γ | PROVIDENCE DI ANI DE CORRECTIO | | T | |
| PREFIX TAG | (EACH DEFICIENC | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRI | | BE RIATE | (X5) COMPLETE DATE | | |
| V 000 | INUTIAL COMMENT | | 14.000 | The state of the s | 1611 | | |
| V 000 | INITIAL COMMENTS | 5 | V 000 | FFD A C AAAA | | | |
| | | | | FEB 0 6 2019 | | | |
| | | was completed on January | | | | | |
| | 28, 2019. A deficien | cy was cited. | | Lic. & Cert. Section | 3 | | |
| | T1 | | | | * | | |
| | | sed for the following service | | The facility will ensure that the | , | 3/28/19 | |
| | | C 27G .5600 C Supervised | | Medication Administration Red | | 0/20/10 | |
| | Living for Adults With | n Developmental Disabilities. | | | TOTAL CONTRACT | | |
| | | | | (MAR) is kept current to reflect | t any | | |
| V 118 | 27G .0209 (C) Medic | ation Requirements | V 118 | medication changes. | | | |
| | | | | | | | |
| | 10A NCAC 27G .020 | 9 MEDICATION | | | | | |
| | REQUIREMENTS | | | For Client #1 the MAR was up | dated | | |
| | (c) Medication admi | | | to reflect discontinuation of the | | 3/28/19 | |
| | | n-prescription drugs shall | | | 7 | 3/20/19 | |
| | | to a client on the written | | medication –Haloperidol 5mg. | | | |
| | | horized by law to prescribe | | | | | |
| | drugs. | all be self-administered | | AP (Associate Professional) a | nd/or | | |
| | | en authorized in writing | | QM Director will provide in-ser | vice | | |
| | by the client's physi | | | training to staff assigned in the | | | |
| | | uding injections, shall be | | home on appropriate medication | | | |
| | | licensed persons, or by | | | | | |
| | | trained by a registered nurse, | | pass strategies such that staff | | | |
| | | egally qualified person and | | always cross walking the MAR | | | |
| | | and administer medications. | | the actual pill packets to ensur | е | | |
| | | ministration Record (MAR) | | medications are administered | as | | |
| | of all drugs administ | tered to each client must be | | ordered. Staff will report any | | | |
| | kept current. Medica | tions administered shall be | | discrepancies directly to the Al |) for | | |
| | | ly after administration. The | | | 7 101 | | |
| | MAR is to include the | | | resolution. | | | |
| | (A) client's name; | · · | | | | | |
| | | and quantity of the drug; | | | | | |
| | | administering the drug; | 1 | The AP will monitor in the hom | e | | |
| | | e drug is administered; and | | weekly, review the MAR and pi | | 8/28/19 | |
| | | of person administering | | | | 120118 | |
| | the drug. | | | packets to ensure they are cur | | | |
| | (5) Client requests for | medication changes or | | and reflective of the physician's | 5 | | |
| | | ded and kept with the MAR | | orders. | | | |
| | | pointment or consultation | | | | . 1 | |
| V | with a physician. | | | | | | |
| ision of Hea | alth Service Regulation | | | | | _ | |

TITLE

STATE FORM

9NRL11

If continuation sheet 1 of 3

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/S

| AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2)MULTIPLE CONSTRUCTION A BUILDING | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|--------------------------------------|--|--|---------|--|
| | | MHL053-082 | B. WING | !!!!!!!!!!!!!!!!!!!!!! | 01/2 | 28/2019 | |
| NAME OF | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | |
| ANDREWS DRIVE FAMILY CARE FACILITY SANFORD, NC 27332 | | | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLETE | | |
| V 118 | Continued From page | ge 1 | V 118 | | The same of the sa | | |
| | This Rule is not met on record review, ob the facility failed to k 1 of 1 client (#1.) The Review on 1/25/19 of Admission date of 8 of Diagnoses of Bipolis Personality; Personal Specified; Hyperlipid Anemia; Non-Insulin Mellitus; Spinal Stene Extremity Edema; Chroma Disease; Onychomy of Physician's orders in 9/18/18 for Haloperic three times each day of A January 2019 Madministered Halope from 1/1/19 through in the Client During interview on 1/25/medications-on-hand available in the client During interview on 1/25/medications on 1/25/medication on 1/11/19 through in the Client Professional Confirmed the medicavailable in Client #1/16/19 through in Client #1/16/ | as evidenced by: Based servation and interview, eep the MAR current for e findings are: If Client #1's record revealed: 8/1/17 ar Disorder with Dependent ality Disorder, Not Otherwise emia; Asthma; Allergies; Dependent Diabetes osis; Neurodematitis; Lower pronic Obstructive Pulmonary dosis Bursitis. Included an order dated dol 5mg, one tablet of 1/2. AR documenting staff ridol 5mg to the client 8:00 AM on 1/25/19. If 9 at 3:30 PM of Client #1's I revealed: operidol 5mg was not 's current medications. | | | | | |
| | - contacted the facility | y's pharmacist who said she | | | | | |

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (×2)MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--|---|---------------------------|--|--------|------------------|--|--|
| / | VOI CONTECTION | IDENTIFICATION NOMBER. | A BUILDING | mmmmmmmm | - CON | IPLETED | | |
| | | MHL053-082 | B. WING | 111111111111111111111111111111111111111 | 01/ | 28/2019 | | |
| NAME OF | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | | |
| ANDREWS DRIVE FAMILY CARE FACILITY 2621 ANDREWS DRIVE | | | | | | | | |
| SANFORD, NC 27332 | | | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | JLD BE | COMPLETE DATE | | |
| V 118 | Continued From page 2 | | V 118 | | | | | |
| | would locate and pro 1/3/19 from Client #1 the medication. | ovide a copy of a note dated I's physician to discontinued of a copy of information faxed | | | | | | |
| | Client #1's physician administering Halop times each day to Cl | | | | | | | |
| | AP confirmed: - staff failed to accur | ew on 1/28/19, the facility's ately document medication ent #1 and keep her MAR | | | | | | |
| | | | | | | | | |
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| wision of Ha | | | | | | | | |

Division of Health Service Regulation



Provider of MH/DD/SA Services

February 1, 2019

Ms. Maryland Chenier, MSW, LCSW, MPH Facility Compliance Consultant I Mental Health Licensure and Certification Section N.C. Division of Health Service Regulation 2718 Mail Service Center Raleigh, NC 27699-2718 DHSR - Mental Health

FEB 06 2019

Lic. & Cert. Section

Re: Annual and Complaint Survey completed January 28, 2019 Andrews Drive Family Care Facility 2621 Andrews Drive, Sanford, NC 27330 MHL#053-082

Dear Ms. Chenier:

See attached hard copy of the plan of correction (POC) for the Andrews Drive Family Care Facility visit. We hope that you will find the attached POC acceptable. If you have questions, feel free to contact me directly. Otherwise, we very much look forward to your follow-up visit.

Kindest regards,

James A. Harris

Director, Quality Management