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
	MHL092-725	A. BUILDING: ______ B. WING ______	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINE VALLEY	**5213 PRONGHORN LANE** **RALEIGH, NC 27610**

(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 May 02, 2019. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C. Supervised Living for Adults with Intellectual and Developmental Disorders.	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation	V 118		

RECEIVED
By DHRS-Mental Health Licensure at 8:34 am, Jun 04, 2019

Division of Health Service Regulation

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V 118	Continued From page 1 with a physician. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure one of three clients (#1)'s medication was administered as prescribed. The findings are: Review on 04/30/19 of client #1's record revealed: -Admitted: September 2008 -Diagnoses which included Mild Mental Retardation, Personality d/o (disorder), Seizure d/o with Vagus Nerve Stimulation, Mood d/o, Epilepsy and Psychosis -Actively engaged in Palliative (Hospice) Services -Physician's orders via email from the hospice nurse dated 01/22/19- Blood Pressure every 8 hours...if above 170 (top number)122 systolic give one tablet Clonidine .1 mg by mouth, call hospice with additional questions. Note: Per MARs Clonidine administered average 4 times a month between February-April 2019. -April 2019 Blood Pressure logs reflected blood pressure checked twice a day During interviews on 5/02/19, three of three staff reported: -Client #1's blood pressure was checked on each shift -These staff worked first and second shift. Staff assigned client #1 documented her blood pressure readings. During interview on 05/01/19, the Home Manager	V 118		

Division of Health Service Regulation

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V 118	Continued From page 2	V 118		

reported:
-It was her understanding the Blood Pressure was only checked three times a day, when Clonidine was given.

During interview on 05/02/19, the Hospice Nurse reported she:
-Verified the 01/22/19 order for blood pressure to be checked every 8 hours was the most recent physician's order.
-Came to the home weekly and monitored the Blood Pressure log readings
-was not aware of the blood pressure documentation was only twice a day opposed to the required three times daily
-Would clarify with group home staff of the orders during her next onsite.

Appendix 1-B: Plan of Correction Form

Plan of Correction

POC for MHL # 092-725
Annual Survey – 5/2/2019 for 5213 Pronghorn Lane, Raleigh NC, 27610

Provider Name:	**ACI Support Specialists**	**Phone:**	**910-763-7458 Ext 256**
Provider Contact Person for follow-up:	**Randall Evans**	**Fax:**	**910-763-8907**
		Email:	**revans@dungarvin.com**
Address:	834 Timber Dr. Garner, NC 27529		

Finding	Corrective Action Steps	Responsible Party	Time Line
Facility failed to assure one of the three clients medication was administered as prescribed.	1. Focused supervision with group home Staff on all shifts to address : a. Utilizing Communication alerts(S-Com) within the Therap system for updates or changes in client medications/prescriptions/instructions b. All shifts will receive in-service training each time there is a medication/prescription change with any resident within the home. 2. Group Home Manager will verify/review all prescription/medication changes with the supervising RN prior to communicating changes with staff. 3. Medication Logs will be reviewed weekly by group home manager and QP to ensure log and administration matches current prescription. 4. QM Dept. will provide ongoing monitoring through audit processes to ensure all processes identified in this POC are followed and will provide feedback to I/DD Team Lead when discrepancies are discovered.	1. Group Home Manager 2. Group Home Manager Supervising RN 3. Group Home Manager QP 4. QM Dept.	Implementation Date: 6/3/2019 Projected Completion Date: 1. Focused Supervision:6/15/19 2. Ongoing 3. Ongoing 4. Ongoing

RECEIVED
By DHRS-Mental Health Licensure at 8:37 am, Jun 04, 2019

☐ Home Care ☐ Home Health Care ☐ Hospice Services ☐ Infusion Services

☐ **SPECIAL INSTRUCTIONS**

☐ **CONFERENCE-COMMUNICATION DOCUMENTATION**

☐ **NARRATIVE NOTE**

Pine Valley Group Home

Patient Name: (Last, First, M [redacted] **Client #1** MR#

DATE	TIME	COMMENTS	SIGNATURE / TITLE after each entry
5/2/19		New Orders: Clarification	
		Check [redacted] BP at 8am + 4pm each day (document reading)	
		If systolic reading 170 or greater (Top number)	
		please give Clonidine 0.1mg PO	
		Recheck BP 1 hour later. If BP reading 170 or greater please contact Hospice	
		Clonidine may be given every 8 hours if BP 170 or greater or as directed by Hospice physician	
		TO: Dr James / Maya Jackson RN	
		919	

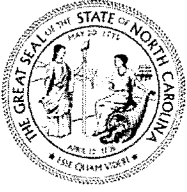
PARTICIPANTS

☐ Copy in the Home *(Special Instructions)* ☐ Copy Sent to Physician Date: ____________

Person Instructed Signature	Date

Signature	Title	Date

Reorder From: DSSI / MED-PASS



NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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

May 23, 2019

Rita Barnes,
ACI Support Specialist, LLC
834 Timber Drive
Garner, NC 27529

Re: Annual Survey completed May 02, 2019
Pine Valley, 5213 Pronghorn Lane, Raleigh, NC 27610
MHL # 092-725
E-mail Address: Rbarnes@dungarvin.com

Dear Rita Barnes:

Thank you for the cooperation and courtesy extended during the Annual Survey completed May 02, 2019. 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

- 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 July 02, 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***

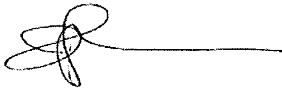
please remember never to send confidential information (protected health information) via email.

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 Kowalski-Ames at 919-552-6847.

Sincerely,



India Vaughn-Rhodes
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: DHSR@Alliancebhc.org
Pam Pridgen, Administrative Assistant