STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL013-086	A. BUILDING: ______ B. WING ______	R 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CABARRUS COUNTY GROUP HOME #4	**169 SPRING STREET CONCORD, NC 28025**

(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 5/15/19. 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 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	V 118	DHSR - Mental Health JUN 07 2019 Lic. & Cert. Section	

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	MHL013-086	A. BUILDING: ______ B. WING ______	R 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CABARRUS COUNTY GROUP HOME #4	169 SPRING STREET CONCORD, NC 28025

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V 289	Continued From page 4	V 289		

This Rule is not met as evidenced by:
Based on records review, observation and interviews, the facility failed to operate 24 hours affecting 2 of 3 clients (#1, #2). The findings are:

Review on 5/15/19 of client #1's record revealed:
-admission date of 8/22/07 with diagnosis of OCD, IDD-Moderate, Allergies, Sleep Apnea, Hypokalemia, Vitamin D Deficiency, Chronic Kidney Disease, Seizure Disorder, Hypertension, Hyperlipidemia and Hemochromatosis;
-3/18/19 client #1 went to Urgent Care with left knee pain, X-ray completed, diagnosed with a sprain;
-3/22/19 client #1 saw his primary care physician who checked his left knee, no issues found;
-3/29/19 client #1 went to the Emergency Room for pain in the left knee, X-rays completed, diagnoses with a sprain, referred to Orthopedics;
-4/4/19 seen by Orthopedics, had a MRI on left knee on 4/15/19 revealing a stress fracture and a torn meniscus.

Observation on 5/15/19 at 10:30am revealed client #1 in a wheelchair at the facility's parent agency office.

Review on 5/15/19 of client #2's record revealed:
-admission date of 2/16/19;
-diagnosis of IDD-Moderate, Schizophrenia, High Blood Pressure and Gallstones.

Observation on 5/15/19 of client #1 and client #2 revealed the following:
-10:00am client #1 and client #2 sitting on couches at the facility's parent agency office;
-12:30pm client #1 and client #2 continue to be at the facility's parent agency office;

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
	MHL013-086	A. BUILDING: ______ B. WING ______	R 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CABARRUS COUNTY GROUP HOME #4	169 SPRING STREET CONCORD, NC 28025

(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 118	Continued From page 1 file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on records review, observations and interviews, the facility failed to ensure MARS were kept current and medications administered were recorded immediately after administration affecting 1 of 3 clients (#3). The findings are: Review on 5/15/19 of client #3's record revealed: -admission date of 6/3/13 with diagnoses of Major Depressive Disorder and Generalized Anxiety Disorder; -physician's order dated 2/6/19 for Head and Shoulders Shampoo use daily at 7pm. Observation on 5/15/19 at 3:10pm of client #3's medications on site revealed Head and Shoulders Shampoo present at the facility. Review on 5/15/19 of client #3's MARS from 3/1/19 until 5/15/19 revealed the dosing dates of 4/1-4/30 left blank for Head and Shoulders Shampoo use daily at 7pm with no explanation on the form. Interview on 5/15/19 with client #3 revealed: -used her shampoo daily; -never had to go without it; -always have it. Interview on 5/15/19 with staff #1 revealed: -client #3 never been without her shampoo; -uses it daily.	V 118	Medication Documentation traing was completed by Group Home Manager #1 on 5/22/19 and Group Home Manager #2 on 5/23/19 (See attached training Sheets). Administrator will check to ensure documentation is being completed properly when doing her regular unannounced Visits to this home	5/22/19 + 5/23/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL013-086	A. BUILDING: ______ B. WING ______	R 05/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CABARRUS COUNTY GROUP HOME #4	169 SPRING STREET CONCORD, NC 28025

(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 118	Continued From page 2 Interview on 5/15/19 with Administrative Staff revealed: -she reviewed all the MARS after staff completed them; -she did not catch the blank dosing dates for the shampoo; -documentation error.	V 118		
V 289	27G .5601 Supervised Living - Scope 10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which	V 289		

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
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CABARRUS COUNTY GROUP HOME #4	169 SPRING STREET CONCORD, NC 28025

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V 289	Continued From page 3 serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses; (4) "D" designation means a facility which serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses; (5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or (6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL).	V 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 289	Continued From page 5 -1:16pm client #1 and client #2 continue to be at the facility's parent agency office; -1:43pm client #1 and client #2 continue to be at the facility's parent agency office. Interview on 5/15/19 with client #1 revealed: -attend a workshop Monday through Friday; -hurt his knee, can't attend his workshop; -go to physical therapy on Tuesday and Thursdays; -at office other days. Attempts to interview client #2 on 5/15/19 with unsuccessful as he did not respond to questions with answers related to the questions asked. Interview on 5/15/19 with the Qualified Professional revealed: -client #2 was waiting on placement at the local workshop; -the Local Management Entity are evaluating the funds for the workshop and the workshop has a freeze on new admissions; -client #2's paperwork was almost completed and then the freeze happened; -client #1 hurt himself and is recovering form his injury. Interview on 5/15/19 with staff #2 revealed: -client #1 not in the workshop yet; -ready to go to the workshop; -talked about it a lot. Interview on 5/15/19 with Administrative Staff revealed: -client #1 comes to the office on days he does not have his PT, he is recovering from his injury; -client #2 comes to the office because he is not enrolled at the workshop because of the	V 289	Client #1 is still recovering but hopes to return to work after seeing his physician on June 10, 2019. He is currently staying at one of our group homes while the others are at work during his recovery. Client #2 is now staying at one of our group homes while others are at work. He will continue to do so until day placement can be found. A form was created to document his main activity/activities during this time to show that he has had a meaningful day and access to the community (continued on next page).	5/16/19

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 289	Continued From page 6 admission freeze; -would have to pay a lot of overtime to staff at the facility if client #2 remained at the facility; -live-in staff get off at 9:30am and return to work at 2:30pm; -will address issues of clients at the office.	V 289	See attached form	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL013-086 (Y1)	A. Building B. Wing (Y2)	5/15/2019 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CABARRUS COUNTY GROUP HOME #4	169 SPRING STREET CONCORD, NC 28025

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0536 Reg. # 27E .0107 LSC	Correction Completed 05/15/2019	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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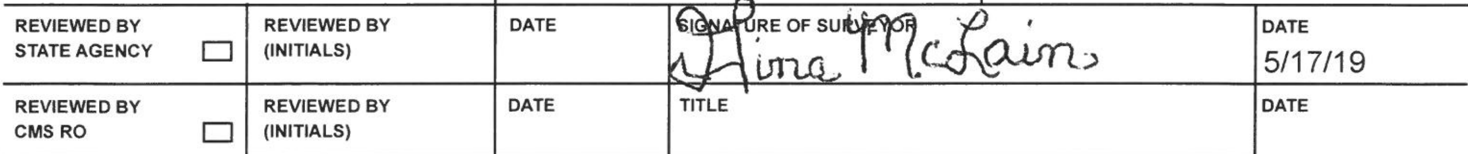


REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR: Tina McLain	DATE 5/17/19
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/30/2018	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: JHX512

STATE FORM: REVISIT REPORT (11/06)

Cabarrus County Group Homes, Inc.

STAFF TRAINING

Date: 5/23/19	Trainer: Margie White, QP

Training Topic

Medication Documentation Training

Total Time:

Attendee Signature

1- Janete Melton	17-
2-	18-
3-	19-
4-	20-
5-	21-
6-	22-
7-	23-
8-	24-
9-	25-
10-	26-
11-	27-
12-	28-
13-	29-
14-	30-
15-	31-
16-	32-

Cabarrus County Group Homes, Inc.

STAFF TRAINING

Date: 5/22/19	Trainer: Margie White, QP

Training Topic

Medication Documentation Training

Total Time:

Attendee Signature

1- Delena Crowell, DC, GHMgr	17-
2-	18-
3-	19-
4-	20-
5-	21-
6-	22-
7-	23-
8-	24-
9-	25-
10-	26-
11-	27-
12-	28-
13-	29-
14-	30-
15-	31-
16-	32-

Name: Tony Jones　　　　Record #: 50632

Day Activities (Mondays – Fridays)

Please document Tony's main activity/activities for the day while other residents are at work to show that he has had a meaningful day and access to the community. Turn in documentation at the end of each month.

____
Month/Year

Date	Activity/Activities	Staff Signature

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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

May 20, 2019

DHSR - Mental Health

JUN 07 2019

Lic. & Cert. Section

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

Re: Annual and Follow up Survey completed 5/15/19
Cabarrus County Group Home #4, 169 Spring Street NW, Concord, NC 28025
MHL # 013-086
E-mail Address: gpopehas4@gmail.com; margiew@ctc.net

Dear Ms. Pope:

Thank you for the cooperation and courtesy extended during the annual and follow up survey completed May 15, 2019. Deficiencies were 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 deficiencies were cited.

Time Frames for Compliance

- The standard level deficiencies must be corrected within 60 days from the exit date of the survey, which is July 14, 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.

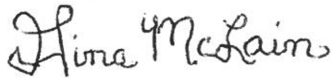
Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

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
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

CC: qmemail@cardinalinnovations.org
File