


PRINTED: 07/17/2019  
FORM APPROVED

## Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL063-087</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>07/11/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>YADKIN PLACE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>360 YADKIN ROAD SOUTHERN PINES, NC 28387</b>		
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V 000	INITIAL COMMENTS  An annual and complaint survey was completed on 7/11/19. The complaints were substantiated (intake #NC00152870, NC00153189 and NC00153511). Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals  10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision	V 110		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

HZKM11

If continuation sheet 1 of 16



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V 110	<p>Continued From page 2</p> <p>pharmacy." [Staff #1] reported that the medication was put in the D/C (discontinuation) box to be returned to the pharmacy on 5/30/19. The pharmacy deliveryman arrived to drop off the new batch of medications for the group home on 5/30/19 at around 11:00 p.m. [Staff #1] attempted to have the deliveryman take the Xanax; however, the deliveryman would not accept the discontinued medication because a return controlled form was not available.....[Staff #1] said she put the medication back in D/C (discontinued) return box. On the night of 6/1/19 the deliveryman came with the D/C return form. [Staff #1] went back into the locked closet to retrieve the medication and fill out the form. The medication was gone. When [Staff #1] was questioned why she did not notify the Director of the missing medication she stated, "I thought someone just flushed the medication." [Staff #3] was a fill in staff on 6/1/19. [Staff #3-] was questioned and stated he had not one into the D/C (discontinued) closet and was not aware that a medication was in the box to be returned. After questioning the staff that worked shifts during the time the medication went missing and after questioning [The Group Home Director], the medication was missing and not reported to [The Group Home Director] and he was unaware of the missing medication until MCO (Managed Care Organization) visited on 6/18/19.</p> <p>Interview with staff #1 on 7/10/19 revealed:</p> <ul style="list-style-type: none"> <li>-Client #1 had an incident with missing Xanax medication in June 2019.</li> <li>-Client #1 had a change with her Xanax medication.</li> <li>-She had to send the packet of Xanax back to the pharmacy.</li> <li>-They were required to put discontinued medication in a locked box and keep it in the</li> </ul>	V 110		

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V 110	<p>Continued From page 3</p> <p>hallway closet.</p> <p>-A pharmacy person came to the home to get the medication.</p> <p>-The pharmacy person refused to take the Xanax and told her she needed a controlled medication form.</p> <p>-She put the medication back in the locked box, however she did not put it in the locked hallway closet.</p> <p>-She put the medication box on the top of the refrigerator in staff office area.</p> <p>-The pharmacy person came out the next night to pick up the Xanax.</p> <p>-When she looked in the locked box the Xanax was missing.</p> <p>-She was not sure what happened to the medication.</p> <p>-She thought other staff possibly stole the medication.</p> <p>Interview with the Group Home Director on 7/10/19 and 7/11/19 revealed:</p> <p>-On 6/18/19 they had a visit from the local Managed Care Organization (MCO).</p> <p>-The staff from the MCO informed them there was a complaint related to some missing medication.</p> <p>-He was informed there was a complaint in reference to client #1 missing some Xanax tablets.</p> <p>-Client #1 was prescribed Xanax tablets at the beginning of June 2019.</p> <p>-Staff felt like the milligrams of Xanax was possibly too much for client #1.</p> <p>-The Xanax was making client #1 "loopy and sleepy."</p> <p>-The physician was contacted and agreed to decrease the dosage.</p> <p>-The Xanax pills were supposed to be returned to the pharmacy that same night.</p>	V 110		

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V 110	<p>Continued From page 4</p> <ul style="list-style-type: none"> <li>-He thought staff had returned the medication towards the beginning on June 2019.</li> <li>-He did not know there was an issue until the MCO staff brought it to his attention.</li> <li>-Therapeutic Alternatives did an investigation once the issue was brought to their attention.</li> <li>-Staff #1 informed them she was in the process of returning the Xanax to the pharmacy.</li> <li>-Staff #1 said a pharmacy person came to the home, however the person would not take the Xanax.</li> <li>-Staff #1 told them the pharmacy person refused to take the medication because she did not have the correct form.</li> <li>-Staff #1 was told she was supposed to have a controlled drug form for the Xanax.</li> <li>-Staff #1 told them she put the medication back into discontinued box and in the locked hallway closet.</li> <li>-Staff #1 told them a pharmacy person came out the next night.</li> <li>-The pharmacy person brought the controlled drug form for the Xanax.</li> <li>-Staff #1 told them she went into the discontinued box to get the Xanax.</li> <li>-Staff #1 told them the Xanax was no longer in the discontinued box.</li> <li>-She told them she did not bring it to anyone's attention because she thought other staff sent medication back.</li> <li>-The Pharmacy confirmed the Xanax for client #1 was never returned to the pharmacy.</li> <li>-Staff #1 never informed them that she left the discontinued box with Xanax on the top of the refrigerator in staff office area.</li> </ul> <p>Interview with the Chief Operations Officer on 7/11/19 revealed:</p> <ul style="list-style-type: none"> <li>-She was aware of the incident with the missing Xanax for client #1.</li> </ul>	V 110			

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V 110	Continued From page 5  -She received a call from the local MCO about the medication issue in June 2019. -Prior to the local MCO coming out, they were not aware the Xanax medication was missing for client #1. -Staff #1 informed them she attempted to return the Xanax medication. -Staff #1 told them the pharmacy person refused to take the medication. -Staff #1 told them she was supposed to have a controlled medication form attached to the medication. -Staff #1 informed them she put the locked medication box which contained the Xanax into the locked hallway closet. -Staff #1 informed them the pharmacy person returned to the home the next night to get the medication. -Staff #1 informed them she went into the locked medication box, however the Xanax was missing. -Staff #1 informed them she never said anything about the medication missing because she thought someone threw it away. -Staff #1 never informed them that she left the discontinued box with Xanax on the top of the refrigerator in staff office area.	V 110		
V 114	27G .0207 Emergency Plans and Supplies  10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility	V 114		

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V 114	<p>Continued From page 6</p> <p>shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to conduct fire and disaster drills under conditions that simulate emergencies. The findings are:</p> <p>Review on 7/11/19 of the facility's fire drill log revealed the following: -7/1/19-2nd shift -6/11/19-1st shift -5/8/19-1st shift -4/11/19-2nd shift -3/25/19-3rd shift -2/3/19-2nd shift -1/22/19-1st shift -12/31/18-3rd shift -There were no fire drills conducted during 3rd shift for the 2nd quarter of 2019.</p> <p>Review on 7/11/19 of the facility's disaster drill log revealed the following: -7/3/19-2nd shift -6/19/19-1st shift -5/21/19-2nd shift -4/30/19-2nd shift -3/26/19-1st shift -2/11/19-1st shift -1/28/19-3rd shift -12/22/18-2nd shift -There were no disaster drills conducted during 3rd shift for the 2nd quarter of 2019.</p>	<p>V 114</p> <p>V 114</p>	<p>Freda Kletsch, COO assisted Eric Taylor, Director with completing dates/shifts time for fire and disaster drills for the remainder of the year for Yadkin Place (see attached schedule). Eric Taylor, Director will review fire and disaster drills monthly to make sure all drills are completed as scheduled.</p>	<p>7/11/19</p>

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V 114	Continued From page 7  -There were no disaster drills conducted during 2nd shift for the 1st quarter of 2019.  Interview with client #2 on 7/10/19 revealed: -Staff conducted fire and disaster drills with them. -She was not sure how often the drills were being conducted.  Interview with client #3 on 7/10/19 revealed: -Staff did fire and disaster drills with them -She thought the fire and disaster drills were done monthly.  Interview with the Group Home Director on 7/11/19 revealed: -The group home had three separate shifts. -He was a little confused about the way the drills were supposed to be conducted. -He confirmed staff failed to conduct fire and disaster drills under conditions that simulate emergencies.  Interview with the Chief Operating Officer on 7/11/19 confirmed: -Staff failed to conduct fire and disaster drills under conditions that simulate emergencies.	V 114		
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.	V 118		



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V 118	<p>Continued From page 8</p> <p>(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:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p> <p>(D) date and time the drug is administered; and</p> <p>(E) name or initials of person administering the drug.</p> <p>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to follow the physician's orders and failed to keep the MAR current for one of three clients (#1). The findings are:</p> <p>1. The following is evidence the facility failed to follow the physician's orders.</p> <p>Review on 7/10/19 of client #1's record revealed:</p> <ul style="list-style-type: none"> <li>-Admission date of 3/4/19.</li> <li>-Diagnoses of Schizoaffective Disorder, Anemia, High Cholesterol, Incontinence, Fatigue, Tobacco Use and Overweight.</li> <li>-Physician's order dated 12/31/18 for Fluoxetine</li> </ul>	V 118	<p>For all D/C medications, Eric Taylor, Group Home Director will call Freda Kletsch, COO the day of D/C order to make her aware. Director will D/C medication from MAR and remove medication from medication box and complete Southern Pharmacy return form and place the D/C medication and form in the D/C box for pharmacy to pick up. The Director will take a picture of D/C medication, form and D/C box and send to Freda Kletsch, COO, to confirm that medication D/C process has been completed and will notify Freda Kletsch, COO when pharmacy has picked up the medication.</p> <p>Medication Administration Refresher training was given by Vicki Rhodes, RN on 7/12/19. Staff present was Fred Hughes, Eric Taylor, Janice Smith, La'Quasia Burch and Deana Chamberlain. See attached training record and certificates.</p> <p>Staffing scheduled with all staff with Freda Kletsch, COO on 8/2/19 at 10:00 am.</p>	7/12/19	Ongoing
		V118		7/12/19	

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V 118	<p>Continued From page 9</p> <p>20 mg, one capsule daily and Quetiapine 100 mg, one tablet at bedtime.</p> <p>-There was a discontinuation of medication order dated 5/30/19 for Fluoxetine 20 mg and Quetiapine 100 mg.</p> <p>Review of facility records on 7/10/19 revealed:</p> <p>-Incident reports for client #1 revealed the following: (1). 6/18/19-"[Staff #3] administered 1 tab (tablet) Prozac 20mg during 8am med (medication) pass on 6/18/19. This medication was discontinued on 5/30/19." (2). 6/17/19-[Former staff #7] administered 1 tab (tablet) Seoquel 100mg during 8pm med (medication) pass on 6/17/19. This medication was discontinued on 5/30/19. [Former staff #7] initials were written on back of med (medication) pack with date of 6/17/19 and the tablet was missing from pack."</p> <p>Interview with the Chief Operations Officer on 7/11/19 revealed:</p> <p>-She was aware of the medication errors made by staff #3 and FS #7.</p> <p>-The Group Home Director was responsible for reviewing the MAR's, orders and medications.</p> <p>-The Group Home Director should review the MAR's, orders and medications to ensure there were no errors.</p> <p>-A discontinued medication must immediately be placed in the discontinued box and returned to the pharmacy.</p> <p>-She confirmed staff #3 and FS #7 failed to follow the physician's orders for client #1.</p> <p>2. The following is evidence the facility failed to keep the MAR current.</p> <p>Review on 7/10/19 of client #1's record revealed:</p> <p>-Physician's order dated 3/18/19 for Benztropine</p>	V 118		

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STATE FORM

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V 118	Continued From page 10  Mesylate 1 mg, one tablet two times daily; Clozapine 100 mg, four tablets at bedtime; Atorvastatin 20 mg, one tablet at bedtime and Divalproex 500 mg, three tablets at bedtime. -The July 2019 MAR had a blank box on 7/8/19 for Clozapine 100 mg. -The May 2019 MAR had blank boxes on 5/31 for Benztropine Mesylate 1 mg, Clozapine 100 mg, Atorvastatin 20 mg and Divalproex 500 mg.  Interview with the Group Home Director on 7/10/19 revealed: -He thought staff possibly forgot to sign the May and July MAR's to indicate medication was administered. -There were no issues with clients getting their prescribed medications. -He confirmed staff failed to keep the MAR current for client #1.  Interview with the Chief Operations Officer on 7/11/19 confirmed: -Staff failed to keep the MAR current for client #1.	V 118			
V 120	27G .0209 (E) Medication Requirements  10A NCAC 27G .0209 MEDICATION REQUIREMENTS (e) Medication Storage: (1) All medication shall be stored: (A) in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 degrees and 86 degrees Fahrenheit; (B) in a refrigerator, if required, between 36 degrees and 46 degrees Fahrenheit. If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container; (C) separately for each client;	V 120			

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V 120	<p>Continued From page 11</p> <p>(D) separately for external and internal use; (E) in a secure manner if approved by a physician for a client to self-medicate. (2) Each facility that maintains stocks of controlled substances shall be currently registered under the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure medications were in a securely locked cabinet affecting one of three current clients (#1). The findings are:</p> <p>Review on 7/10/19 of client #1's record revealed: -Admission date of 3/4/19. -Diagnoses of Schizoaffective Disorder, Anemia, High Cholesterol, Incontinence, Fatigue, Tobacco Use and Overweight. -Physician's order dated 5/30/19 for Xanax 1 mg, one tablet three times daily. -There was an order change on 6/5/19 for the Xanax 1 mg. The order changed to Xanax 0.25 mg, one tablet by mouth twice a day.</p> <p>Review of facility records on 7/10/19 revealed: -An internal investigation dated 6/18/19 had the following information-Staff were questioned about a missing medication for client #1. "[Staff #2] reported she knew nothing about a missing medication or the medication not being returned to the pharmacy. [Staff #2] stated she was not working when the medication was returned to the pharmacy." [Staff #1] reported that the medication was put in the D/C (discontinuation) box to be returned to the pharmacy on 5/30/19. The pharmacy deliveryman arrived to drop off the new</p>	<p>V 120</p> <p>V120</p>	<p>For all D/C medications, Eric Taylor, Group Home Director will call Freda Kletsch, COO the day of D/C order to make her aware. Director will D/C medication from MAR and remove medication from medication box and complete Southern Pharmacy return form and place the D/C medication and form in the D/C box for pharmacy to pick up. The Director will take a picture of D/C medication, form and D/C box and send to Freda Kletsch, COO, to confirm that medication D/C process has been completed and will notify Freda Kletsch, COO when pharmacy has picked up the medication.</p> <p>Medication Administration Refresher training was given by Vicki Rhodes, RN on 7/12/19. Staff present was Fred Hughes, Eric Taylor, Janice Smith, La'Quasia Burch and Deana Chamberlain. See attached record and certificates.</p>	<p>7/12/19</p> <p>Ongoing</p> <p>7/12/19</p>	

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## Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL063-087</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>07/11/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>YADKIN PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>360 YADKIN ROAD SOUTHERN PINES, NC 28387</b>		
(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 120	<p>Continued From page 12</p> <p>batch of medications for the group home on 5/30/19 at around 11:00 p.m. [Staff #1] attempted to have the deliveryman take the Xanax; however, the deliveryman would not accept the discontinued medication because a return controlled form was not available.....[Staff #1] said she put the medication back in D/C (discontinued) return box. On the night of 6/1/19 the deliveryman came with the D/C return form. [Staff #1] went back into the locked closet to retrieve the medication and fill out the form. The medication was gone. When [Staff #1] was questioned why she did not notify the Director of the missing medication she stated, "I thought someone just flushed the medication." [Staff #3] was a fill in staff on 6/1/19. [Staff #3-] was questioned and stated he had not one into the D/C (discontinued) closet and was not aware that a medication was in the box to be returned. After questioning the staff that worked shifts during the time the medication went missing and after questioning [The Group Home Director], the medication was missing and not reported to [The Group Home Director] and he was unaware of the missing medication until MCO (Managed Care Organization) visited on 6/18/19.</p> <p>Interview with staff #1 on 7/10/19 revealed:</p> <ul style="list-style-type: none"> <li>-Client #1 had an incident with missing Xanax medication in June 2019.</li> <li>-Client #1 had a change with her Xanax medication.</li> <li>-She had to send the packet of Xanax back to the pharmacy.</li> <li>-They were required to put discontinued medication in a locked box and keep it in the hallway closet.</li> <li>-A pharmacy person came to the home to get the medication.</li> <li>-The pharmacy person refused to take the Xanax</li> </ul>	V 120			

Division of Health Service Regulation

STATE FORM

6899

HZKM11

If continuation sheet 13 of 16

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## Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL063-087</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>07/11/2019</b>
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V 120	<p>Continued From page 13</p> <p>and told her she needed a controlled medication form.</p> <p>-She put the medication back in the locked box, however she did not put it in the locked hallway closet.</p> <p>-She put the medication box on the top of the refrigerator in staff office area.</p> <p>-The pharmacy person came out the next night to pick up the Xanax.</p> <p>-When she looked in the locked box the Xanax was missing.</p> <p>-She was not sure what happened to the medication.</p> <p>-She thought other staff possibly stole the medication.</p> <p>-She confirmed facility staff failed to ensure medications were securely locked in a cabinet.</p> <p>Interview with the Group Home Director on 7/10/19 and 7/11/19 revealed:</p> <p>-On 6/18/19 they had a visit from the local Managed Care Organization (MCO).</p> <p>-The staff from the MCO informed them there was a complaint related to some missing medication.</p> <p>-He was informed there was a complaint in reference to client #1 missing some Xanax tablets.</p> <p>-Client #1 was prescribed Xanax tablets at the beginning of June 2019.</p> <p>-Staff felt like the milligrams of Xanax was possibly too much for client #1.</p> <p>-The Xanax was making client #1 "loopy and sleepy."</p> <p>-The physician was contacted and agreed to decrease the dosage.</p> <p>-The Xanax pills were supposed to be returned to the pharmacy that same night.</p> <p>-He thought staff had returned the medication towards the beginning on June 2019.</p>	V 120		

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## Division of Health Service Regulation

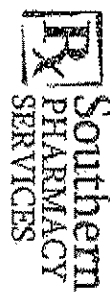
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V 120	<p>Continued From page 14</p> <ul style="list-style-type: none"> <li>-He did not know there was an issue until the MCO staff brought it to his attention.</li> <li>-Therapeutic Alternatives did an investigation once the issue was brought to their attention.</li> <li>-Staff #1 informed them she was in the process of returning the Xanax to the pharmacy.</li> <li>-Staff #1 said a pharmacy person came to the home, however the person would not take the Xanax.</li> <li>-Staff #1 told them the pharmacy person refused to take the medication because she did not have the correct form.</li> <li>-Staff #1 was told she was supposed to have a controlled drug form for the Xanax.</li> <li>-Staff #1 told them she put the medication back into discontinued box and in the locked hallway closet.</li> <li>-Staff #1 told them a pharmacy person came out the next night.</li> <li>-The pharmacy person brought the controlled drug form for the Xanax.</li> <li>-Staff #1 told them she went into the discontinued box to get the Xanax.</li> <li>-Staff #1 told them the Xanax was no longer in the discontinued box.</li> <li>-She told them she did not bring it to anyone's attention because she thought other staff sent medication back.</li> <li>-The Pharmacy confirmed the Xanax for client #1 was never returned to the pharmacy.</li> <li>-Staff #1 never informed them that she left the discontinued box with Xanax on the top of the refrigerator in staff office area.</li> <li>-He confirmed the facility staff failed to ensure medications were securely locked in a cabinet.</li> </ul> <p>Interview with the Chief Operations Officer on 7/11/19 revealed:</p> <ul style="list-style-type: none"> <li>-She was aware of the incident with the missing Xanax for client #1.</li> </ul>	V 120		

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## Division of Health Service Regulation

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V 120	<p>Continued From page 15</p> <ul style="list-style-type: none"> <li>-She received a call from the local MCO about the medication issue in June 2019.</li> <li>-Prior to the local MCO coming out, they were not aware the Xanax medication was missing for client #1.</li> <li>-Staff #1 informed them she attempted to return the Xanax medication.</li> <li>-Staff #1 told them the pharmacy person refused to take the medication.</li> <li>-Staff #1 told them she was supposed to have a controlled medication form attached to the medication.</li> <li>-Staff #1 informed them she put the locked medication box which contained the Xanax into the locked hallway closet.</li> <li>-Staff #1 informed them the pharmacy person returned to the home the next night to get the medication.</li> <li>-Staff #1 informed them she went into the locked medication box, however the Xanax was missing.</li> <li>-Staff #1 informed them she never said anything about the medication missing because she thought someone threw it away.</li> <li>-Staff #1 never informed them that she left the discontinued box with Xanax on the top of the refrigerator in staff office area.</li> <li>-She confirmed the facility staff failed to ensure medications were securely locked in a cabinet.</li> </ul>	V 120			





Old-fashioned values: Americans

1-866-768-8479 • Fax: 1-866-928-3983

### Facility:

☐ Regular Items ☐ Refrigerated Items

☐ Refrigerated Items

**DRUGS RETURNED TO PHARMACY  
OR RELEASED TO THE PATIENT**

[illegible]

V110 sheet 2 of 16

### INSTRUCTIONS:

- (1) list controlled substances separately on the form supplied by the State Drug Authority
  - (2) complete applicable information in unrelated areas
  - (3) keep pink copy and
  - (4) return both medication and forms to pharmacy
- or
- (5) have patient or responsible party sign form for medications released upon discharge, then forward forms to pharmacy.

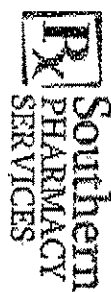
FOR MEDICATIONS RELEASED WITH PATIENT

I certify that the medications listed above are released to me and I understand and request that the medications are not dispersed in child-resistant containers.

સાંપ્રદાયિક

Deixe

## WILLIAMS



Old-fashioned values matter

1-866-768-8479 • Fax: 1-866-928-3983

**For Controlled Items Only**  
**Facility:** \_\_\_\_\_

**DRUGS RETURNED TO PHARMACY  
OR RELEASED TO THE PATIENT**

[illegible]

V110 Sheet 2 of 16

**INSTRUCTIONS:**

- (1) list controlled substances separately on the form supplied by the State Drug Authority;
  - (2) complete applicable information in unshaded areas
  - (3) keep yellow copy and
  - (4) return both medication and form to pharmacy
- or
- (5) have patient or responsible party sign form for medications released upon discharge, then forward form to pharmacy.

FOR MEDICATIONS RELEASED WITH PATIENT

I certify that the medications listed above are released to me and I understand and request that the medications are not dispensed in child-resistant containers.

Signature \_\_\_\_\_

Date:

44

Therapeutic Alternatives, Inc. – P.O. Box 814 – Randleman, NC 27317

(c)  
**MEDICATION ADMINISTRATION**

1. Prescription or non-prescription drugs shall only be administered to a consumer on written order of a person authorized by law to prescribe drugs.
2. Medications shall be self-administered by consumers only when authorized in writing by the consumer'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 credentialed to prepare and administer medications.
4. A Medication Administration Record (MAR) of all drugs administered to each consumer must be kept current. Medications administered shall be recorded immediately after administration. The MAR shall include the following: consumer's name; name, strength, and quantity of the drug; instructions for administering the drug; date and time the drug is administered; name or initials of person administering the drug.
5. Community Support Individual, Community Support Team, CAP-MR/DD, Crisis Respite, Psychosocial Rehabilitation, Mobile Crisis, Intensive In-Home, Day Programs, and Targeted Case Management Services do not administer medications. Under rare circumstances staff providing these services may administer medications on a case by case consideration. Staff must have completed the required medication administration training and the consumer's plan must indicate medication administration. Staff administering medication must comply with all medication policies and procedures.

*Consumer requests for medication changes or checks shall be recorded and kept with the MAR file followed-up by appointment or consultation with a physician.*

10A NCAC 27G .0209 (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 and controlled substances shall be disposed of by transfer to a local pharmacy for destruction.
3. The Program shall maintain a record of the medication disposal.
4. Documentation shall specify the following: consumer's name; medication name, strength, quantity; disposal date; method of disposal; signature of the person disposing of medication; signature of person witnessing destruction.
5. Upon discharge of a consumer, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the consumer 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 the consumer's discharge from services.

(e)  
**MEDICATION STORAGE**

All medication shall be stored:

1. in a securely locked cabinet in a clean, well-lighted, ventilated room between 59 and 86 degrees Fahrenheit;
2. in a refrigerator, if required, between 36 and 46 degrees Fahrenheit. (If the refrigerator is used for food items, medications shall be kept in a separate, locked compartment or container.);
3. separately for each consumer;
4. separately for external and internal use; and
5. in a secure manner if approved by a physician for a consumer to self-medicate.

V110 Sheet 2 of 16

From: Eric Taylor Eric.Taylor@mytahome.com &  
Subject: fire drill  
Date: July 22, 2019 at 4:10 PM  
To: Freda Klitsch freda@mytahome.com  
Cc: Eric.Taylor@mytahome.com



### Drills Aug – Dec 2019

August Drills: Fire 7<sup>th</sup> at 6am (3<sup>rd</sup> Shift)      Disaster 20<sup>th</sup> 1230a (3<sup>rd</sup>)  
Sept Drills: Fire 12<sup>th</sup> at 330p (1<sup>st</sup> Shift)      Disaster 25<sup>th</sup> at 9am (1<sup>st</sup> shift)  
Oct Drills: Fire 7<sup>th</sup> at 10pm (2<sup>nd</sup> Shift)      Disaster 24<sup>th</sup> at 6pm (2<sup>nd</sup> Shift)  
Nov Drills: Disaster 3<sup>rd</sup> 515am (3<sup>rd</sup> Shift)      Fire 16<sup>th</sup> at 3am (3<sup>rd</sup> Shift)  
Dec Drills: Fire 5<sup>th</sup> 315pm (1<sup>st</sup> Shift)      Disaster 23<sup>rd</sup> 320pm (1<sup>st</sup> Shift)

Drills will remain in sequential order of shifts (1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, then back to 1<sup>st</sup>) Eric will monitor drills to ensure staff accuracy of drill knowledge and verify documentation. Eric will initial all fire and disaster drill records to indicate oversight of each drill monthly. Eric will never have another citation on these drills!!!!!!

Eric M. Taylor  
CHC of Moore  
CHC of Hoke  
Se Habla Espanol  
(910)-695-5558 C  
(910)-692-8688 F

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V114 Sheet 7 of 16

### TRAINING RECORD

Time: 10:00 am - 2:00 pm

**Title:**

**Subject:** Medication Administration Refresher Training

**Brief Subject Outline (attach separate sheet if more space needed)**

## ATTENDANCE

[illegible]

V118 Sheet 9 of 16

V120 sheet 12 of 16

Training Record +  
Certificates - 6 pgs.



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# CERTIFICATE of ACHIEVEMENT

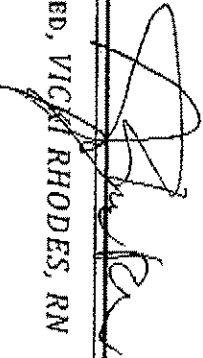
THIS ACKNOWLEDGES THAT

**ERIC TAYLOR**

HAS SUCCESSFULLY COMPLETED THE TRAINING FOR 4.5 HOURS

MEDICATION ADMINISTRATION REFRESHER TRAINING



X  
  
SIGNED, VICKI RHODES, RN



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# CERTIFICATE of ACHIEVEMENT

THIS ACKNOWLEDGES THAT

**FRED HUGHES**

HAS SUCCESSFULLY COMPLETED THE TRAINING FOR 4.5 HOURS

MEDICATION ADMINISTRATION REFRESHER TRAINING



SIGNED, MICKI RHODES, RN



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# CERTIFICATE of ACHIEVEMENT

THIS ACKNOWLEDGES THAT

**DEANA CHAMBERLAIN**

HAS SUCCESSFULLY COMPLETED THE TRAINING FOR 4 1/2 HOURS

MEDICATION ADMINISTRATION REFRESHER TRAINING



SIGNED, *[Signature]*  
VICKI RHODES, RN





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# CERTIFICATE of ACHIEVEMENT

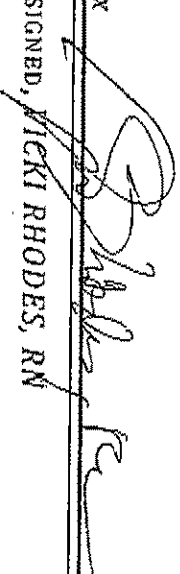
THIS ACKNOWLEDGES THAT

**JANICE SMITH**

HAS SUCCESSFULLY COMPLETED THE TRAINING FOR 4 1/2 HOURS

MEDICATION ADMINISTRATION REFRESHER TRAINING



X  
  
SIGNED, MICKI RHODES, RN



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# CERTIFICATE of ACHIEVEMENT

THIS ACKNOWLEDGES THAT

**LA'QUASIA BURCH**

HAS SUCCESSFULLY COMPLETED THE TRAINING FOR 45 HOURS

MEDICATION ADMINISTRATION REFRESHER TRAINING



SIGNED, Vicki Rhodes, RN

**FAX COVER SHEET**

**Therapeutic Alternatives, Inc.**  
**962 S. Fayetteville Street**  
**Asheboro, NC 27203**  
**(336) 626-1700 Office**  
**(336) 625-2767 Fax**

<b>Send To: Mental Health Licensure and Certification Section - NCDHHS</b>	<b>From: Freda Kletsch, COO</b>
<b>Attention: Kimberly Sauls, Facility Compliance Consultant I</b>	<b>Date: 7/23/19</b>
<b>Office Location: Raleigh, NC</b>	<b>Office Location: Asheboro, NC</b>
<b>FAX Number: 919-715-8078</b>	<b>Phone Number: (336) 626-1700</b>

- ☐ Urgent
- ☐ Reply ASAP
- ☐ Please comment
- ☐ Please review
- ☒ For your information

Total Pages including cover sheet: 28

**Comments:**

Plan of Correction attached in connection with Annual and Complaint Survey completed 7/11/19 – Yadkin Place, 360 Yadkin Road, Southern Pines, NC; MHL #063-087; Itake #NC00152879, NC00153189 and NC00153511.

Original being sent by regular mail.

☐

IF BOX IS MARKED, the individual obtaining this document from the fax machine is requested to sign and return this cover sheet to the fax number indicated above.

Signature: \_\_\_\_\_

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July 23, 2019

**BY REGULAR MAIL &  
TELEFAX (919-715-8078)**

Mental Health Licensure and Certification Section  
North Carolina Department of Health and Human Services  
2718 Main Service Center  
Raleigh, NC 27699-2718

Re: Annual and Complaint Survey completed 7/11/19  
Yadkin Place, 360 Yadkin Road, Southern Pines, NC 28387  
MHL # 063-087  
Intake #NC00152879, NC00153189 and NC00153511

Dear Sir/Madam:

Enclosed please find our Plan of Correction in connection with the Department's Annual and Complaint survey completed on July 11, 2019. The original Plan of Correction is being sent to you by regular mail.

Please contact me if you need further information.

Yours truly,

*Freda Kletsch, COO*  
Freda Kletsch, COO

FK:tf  
Enclosures