

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/31/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G320</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/30/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE, INC OLD ROPER ROAD GROUP HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>206 A OLD ROPER ROAD PLYMOUTH, NC 27962</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) COMPLETION DATE	
W 368	<p><b>DRUG ADMINISTRATION</b> CFR(s): 483.460(k)(1)</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure all medications were administered in accordance with physician's orders. This affected 1 of 5 clients (#1) observed receiving medications. The finding is:</p> <p>Client #1 did not receive her eye drops as prescribed.</p> <p>During observations of medication administration in the home on 7/29/19 at 5:05pm, client #1 received one drop of Travatan .004% eye drops in each eye. Within a few seconds, the client also received one drop of Refresh eye drops in both eyes.</p> <p>Review on 7/29/19 of client #1's physician's orders dated 4/30/19 revealed an order for Travatan .004% , instill 1 drop in each eye every night at 6pm. The orders noted, "Wait 3 - 5 minutes between administering different eye medications".</p> <p>Interview on 7/30/19 with the facility's nurse confirmed staff have been instructed to wait a few minutes before administering client #1's second eye drops as indicated on her physician's orders.</p>	W 368			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.