D. sion of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL032-411	A. BUILDING: ______ B. WING ______	07/23/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARVEST OF HOPE	2509 LANE STREET DURHAM, NC 27707

(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 July 23, 2019. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600A Supervised Living for Adults with Mental Illness.	V 000	the pharmacy to rectify the problem. In addition, Administrator will conduct monthly medication training to assure each staff is knowledgeable of any changes or updates. Administer will also provide individual medication training as needed and upon request.	7/24/19
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 with a physician.	V 118		

RECEIVED
By DHSR - Mental Health Lic. & Cert. Section at 4:15 pm, Aug 08, 2019

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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V 118	Continued From page 1 This Rule is not met as evidenced by: Based on record reviews and interview, the facility failed to record administered medications immediately affecting one of three clients (#3). The findings are: Review on 7/23/19 of Client #3's record revealed: -Admission date of 12/1/10. -Diagnoses of Major Depressive Disorder; Borderline Personality Disorder; Post Traumatic Stress Disorder; Type 2 Diabetes; Chronic Low Back Pain; Coronary Artery Disease; Hyperlipidemia; Hypertension. -Physician's order dated 5/30/19 for Ferrous Sulfate 384 mg, one tablet in the morning with food. -There was no evidence of a July 2019 MAR for the above medication. Interview with the Co-Administrator on 7/23/19 revealed: -The pharmacy did not print Ferrous Sulfate on the July 2019 MAR for Client #3. -She was under the impression that the medication had been printed on the MAR. -Staff had not realized that the medication had not been printed. -Pharmacy had delivered the medication to the home. -Orders for the medication was still active. -Ferrous Sulfate was administered for Client #3 for the month of July. -Staff did not document the medication because it was not printed on the July 2019 MAR for client #3.	V 118	Harvest of Hope administrator will ensure that all medications are legibly noted on each MAR correctly. Administrator will ensure that upon pharmacy delivery each order for medication will be thoroughly checked in the present of the person providing the delivery, verification is a must! Should there be a discrepancy, the administrator will immediately contact	7/24/19

DHSR - Mental Health
AUG 08 2019
Lic. & Cert. Section

D. sion of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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V 118	Continued From page 2 -She confirmed staff failed to record administered medication immediately for client #3.	V 118		

NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES

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

July 29, 2019

Hattie Carrington, Co-Administrator
Hazel Clinkscales/Hattie Carrington
2509 Lane Street
Durham, NC 27707

DHSR - Mental Health
AUG 08 2019
Lic. & Cert. Section

Re: Annual Survey completed July 23, 2019
Harvest of Hope, 2509 Lane Street, Durham, NC 27707
MHL # 032-411
E-mail Address: hcc1947@yahoo.com

Dear Ms. Carrington:

Thank you for the cooperation and courtesy extended during the annual survey completed July 23, 2019.

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

- All other tags cited are standard level deficiencies.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is 9/21/19.

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.

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718
www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

Hattie Carrington 7-28-19

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 the South Piedmont Team Leader, Mr. Bryson Brown at (919) 855-3822.

Sincerely,

Edgar Garrido, MSW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: DHSR@Alliancebhc.org
File