STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G212	A. BUILDING _____ B. WING _____	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOFFMAN GROUP HOME	104 TEAL STREET HOFFMAN, NC 28347

(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W 390	DRUG LABELING CFR(s): 483.460(m)(2)(i) The facility must remove from use outdated drugs. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to remove outdated drugs from use. This affected 1 of 3 audit clients (#6). The finding is: Review on 7/8/19 of client #6's record revealed an individual program plan dated 2/21/19. She has a diagnoses of moderate intellectual disability, depressive disorder, conduct disorder and allergy to bee, ant stings, and apples which can cause an anaphylactic reaction. Further review on 7/9/19 of client #6's physician orders dated 5/1/19 revealed a prescription for Epinephrine 0.3mg. Injectable. Use as needed for bee and Ant stings. During observations on 7/8/19 client #6 accompanied 4 direct care staff, the Residential Manager (RM) and 5 other clients to a local park at 4:00pm. She was assisted to swing on the swingset and slide down the sliding board. She and the other clients in the facility were outside for about 45 minutes before they left the park and were assisted back into the van to return to the facility. Upon returning back to the facility on 7/8/919 the surveyor asked to see client #6's Epi Pen in the facility van. Direct Care Staff opened up a locked box and a Epi Pen with a drug label with client #6's name on the label was taken out which was inside a plastic bag. The drug label was for	W 390	W390: Nursing will review client#6 medication as well as all other client's medication in the home to ensure there is no expired medications. Monitoring will occur by nursing completing a Medication Storing Assessment focusing on expired medication of client #6 as well as all other clients in the home. Target Date: July 19, 2019 DHSR - Mental Health JUL 24 2019 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7-18-19

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G212	A. BUILDING _____ B. WING _____	07/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOFFMAN GROUP HOME	104 TEAL STREET HOFFMAN, NC 28347

(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 390	Continued From page 1 Epinephrine 0.3 mg. injectable; Use as needed for Anaphylactic reactions for bee or ant stings. The Epinephrine was prescribed on 4/28/17 with an expiration date of 4/27/18. Interview on 7/8/19 with direct care staff revealed they were unaware that the Epi pen prescription had expired. They stated they periodically review all medications to ensure they are not outdated.	W 390		

RHA
HEALTH SERVICES, LLC

☐ Safety Committee Chair
☐ Administrator
☐ QP
☐ QA Notebook

MEDICATION STORAGE ASSESSMENT

Location: Hoffman Date: 7/18/19

Name of Inspector: Dorene Chavis

Section I. Medication Storage (Closet, Cabinet, Med Cart, etc.)

		Yes	No	Corrected
1.	Are medications stored in a locked cabinet, medication cart, or closet?	☒	☐	☐
2.	Is lighting adequate?	☒	☐	☐
3.	Is medication storage area clean, orderly, and between 59-86 degrees F?	☒	☐	☐
4.	Are prescription medications are dispensed in tamper resistant packaging	☒	☐	☐
5.	Have discontinued medications been removed?	☒	☐	☐
6.	Are there expiration dates on all medications?	☒	☐	☐
7.	Have expired medications been removed?	☒	☐	☐
8.	Are all oral and topical medications stored separately?	☒	☐	☐
9.	Is each medication labeled?	☒	☐	☐
10.	Does each label contain the person's name, prescribing physician's name, current dispensing date, and directions for administration? Does the label contain name, address, and phone number of pharmacy and the name of the dispensing practitioner?	☒ ☒	☐ ☐	☐ ☐
11.	Are nose, eye & ear drops each in separate bins on the topical shelf and the bin labeled by the name of the person supported?	☒	☐	☐
12.	Is there a photograph of each person for ID?	☒	☐	☐
13.	Are shelves, carts, clean, floor clean and trash can empty?	☒	☐	☐
14.	Have used syringes and needles been disposed of properly?	☒	☐	☐
15.	Are refrigerated medications in a locked box and in a locked closet?	☒	☐	☐
16.	Is a sharps container in the medicine closet?	☒	☐	☐
17.	Is the sharps container clearly marked with a biohazard label?	☒	☐	☐
18.	Is the sharps container less than ¾ full?	☒	☐	☐
19.	Is the sharps container clearly labeled?	☒	☐	☐

Section II. Medication Administration Records

		Yes	No	Corrected
1.	Is there a current MAR for each person receiving medications?	☒	☐	☐
2.	Does the MAR correspond with the doctors orders?	☒	☐	☐

3.	If there has been a change in dosage or times, is the label flagged on the medicine card/bottle and also on the MAR?	☒	☐	☐
4.	Are all medications and treatment procedures documented correctly on the MAR?	☒	☐	☐
5.	Are PRNs documented according to policy? Is a response to a PRN medication documented?	☒	☐	☐
6.	Are controlled drugs signed out and the count correct?	☒	☐	☐
7.	Is black ink only being used?	☒	☐	☐
8.	Are special shampoos and soaps for individuals who need them documented on the MAR/TAR?	☒	☐	☐
9.	Review of current MAR reveals no medication errors	☒	☐	☐
10.	Is there a current medication reference available (i.e. Medication Handbook, Medication Profile Sheets, etc.)?	☒	☐	☐

Section III: Medication Disposal (Large Centers & Vocational Centers Only)

1.	Record of returned medications contains: a. Person's name b. Medication name c. Strength d. Quantity e. Return date	☒	☐	☐
2	No medications are held longer than 30 calendar days later than the date of discharge or expiration	☒	☐	☐

Section IV. Toiletries

		Yes	No	Corrected
1.	Does each person possess his/her own toiletry items? (i.e. brush, comb, nail clippers, etc.)	☒	☐	☐
2.	Are combs/brushes stored separately from other articles?	☒	☐	☐
3.	Are toothbrushes dry, clean, in good condition and maintained in a manner as to avoid contamination.	☒	☐	☐
4.	Are toiletries locked (when applicable to identified individuals)?	☒	☐	☐
5.	Are electric razors clean and working?	☒	☐	☐
6.	Are special shampoos and soaps available for individuals who need them? (Nizoral shampoo, basis soap, etc.)	☒	☐	☐

Section V. Environmental/Equipment (Group Homes)

		Yes	No	Corrected
1.	Is the First Aid Kit in place and stocked appropriately?	☒	☐	☐
2.	Is the PPE kit in place and stocked appropriately?	☒	☐	☐
3.	Is the Medaphene Plus in place and labeled? (should be located with PPE kit) If Medaphene Plus is not available, is there a supply of bleach?	☒	☐	☐
4.	A. Is there an appropriate bottle available for bleach/water solution?	☒	☐	☐

	B. Is the bottle clearly labeled, dated, and bleach/water solution discarded after 24 hours?	☒	☐	☐
5.	Are appropriate gloves accessible for staff use?	☒	☐	☐
6.	Do all bathrooms have liquid soap and paper towels?	☒	☐	☐
7.	Is dirty linen stored separately and covered?	☒	☐	☐
8.	A. Is all diagnostic equipment and supplies, i.e, blood pressure machine, blood glucose monitor, thermometer, stethoscope, scales, etc. available per individual's needs?	☒	☐	☐
	B. Is it working properly?	☒	☐	☐
	C. Is it clean and in good condition?	☒	☐	☐
9.	A. Is Adaptive equipment present per physician orders?	☒	☐	☐
	B. Is Adaptive equipment clean and in good working condition, i.e., wheelchairs, scooters, lifting devices, gait belts, walkers, etc.?	☒	☐	☐
10.	Oxygen tanks secured appropriately. Oxygen tubing coiled and not touching the floor. Extra oxygen tanks stored securely in the nursing department. Oxygen tubing changed every 72 hours for continuous oxygen therapy. Oxygen tubing labeled and dated.	☒	☐	☐

Section VI. Equipment (Van)

		Yes	No	Corrected
1.	Is there a PPE kit and First Aid Kit on the van?	☒	☐	☐
2.	Are these adequately stocked with approved items only?	☒	☐	☐

(3) Meds in the locked tackle box cleared all expired meds removed. Allowed

Packing Slip

Deliver To:

[redacted]

TOT952563

[redacted]

01&PAK846267

[redacted]

RxNo	Qty	Medication Label Name	Comments
[redacted]			

PACKER'S INITIALS: _____

BY SIGNING BELOW YOU ACKNOWLEDGE THE ITEMS ABOVE HAVE BEEN RECEIVED:

Dorene Chavers	Dorene Chavers	7/18/14
SUPERVISING FACILITY REP PRINT NAME	SIGNATURE	DATE
FACILITY REP PRINT NAME	SIGNATURE	DATE

Packing Slip

Deliver To:

[redacted]

[redacted]

TOT855933

01&PAK823478

[redacted]

RxNo	Qty	Medication Label Name	Comments
[redacted]			

PACKER'S INITIALS: _____

BY SIGNING BELOW YOU ACKNOWLEDGE THE ITEMS ABOVE HAVE BEEN RECEIVED:

SUPERVISING FACILITY REP PRINT NAME	SIGNATURE	DATE 4/11/19
FACILITY REP PRINT NAME	SIGNATURE	DATE

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

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

July 12, 2019

Mr. Jonathon Bostic, Administrator
RHA Health Services NC, LLC
15235 Airport Road
Maxton, North Carolina 28364

Re: Recertification Completed on July 9, 2019
Hoffman Group Home, 104 Teal Street, Hoffman, NC 28347
Provider Number :34G212
MHL: 077-011
E-mail Address: jbostic@rhanet.org

Dear Mr. Bostic:

Thank you for the cooperation and courtesy extended during the recertification survey completed on July 9, 2019. This survey was required for continued participation in the Medicaid program.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form (CMS-2567). The purpose of the Statement of Deficiencies is to provide you with specific details of the practice(s) that does/do not comply with regulations. You must develop one Plan of Correction that addresses each deficiency listed on the CMS-2567 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 and what to include in the Plan of Correction.

Type of Deficiencies Found

- Standard level deficiencies were cited.

Time Frames for Compliance

- Standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, which is **September 9, 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 CMS-2567 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

Please be advised that additional W tags may be cited during the Life Safety Code portion of the recertification survey.

A follow up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call KimberlyMcCaskill at (919)218-9152 or email at: Kim.McCaskill@dhhs.nc.gov.

Sincerely,

Kimberly C. McCaskill

Kimberly C. McCaskill, MSW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

Cc: qmemail@cardinalinnovations.org
DHSRreports@eastpointe.net
_DHSR_Letters@sandhillscenter.org