

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

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11F-E

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/04/2019
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NAME OF PROVIDER OR SUPPLIER BLANCHE DRIVE	STREET ADDRESS, CITY, STATE, ZIP CODE 6208 BLANCHE DRIVE RALEIGH, NC 27607
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(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
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E 020	<p>Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.475(b)(3)</p> <p>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:]</p> <p>Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.</p> <p>*[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance.</p> <p>* [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical</p>	E 020	<p>This deficiency will be corrected by the following actions:</p> <p>A. The Home Manager will coordinate with at least one local hotel/motel to come to an agreement to assist with sheltering the clients from the group home in case of an emergency evacuation situation. B. The Home Manager will complete the necessary documentation with the hotel/motel that agrees to aid in an emergency evacuation situation. C. The Home Manager will file this signed agreement in the homes Emergency Preparedness Plan where information on relocation is kept. D. The Clinical Supervisor and the Home Manager will train all Direct Support Professionals (DSP) on the relocation procedures with specific attention being paid to where the clients should be evacuated to. This training will be documented on form F9.8 Inservice/Training Signature Sheet which will be filed in the training binder at the group home. E. The Home Manager will review the Emergency Preparedness Plan at a minimum of 1x/year to ensure that the plan is accurate and up to date. F. The Clinical Supervisor will review the Emergency Preparedness Plan at a minimum of 1x/year to ensure that the plan is accurate and up to date</p> <p>DHSR - Mental Health</p> <p>SEP 24 2019</p> <p>Lic. & Cert. Section</p>	11/4/2019
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Program Manager	(X6) DATE 9/18/19
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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.

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E 020	<p>Continued From page 1</p> <p>Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients.</p> <p>* [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop specific policies and procedures to address emergency preparedness, which included specific plans where to relocate the clients in the facility in case of an emergency evacuation. The finding is:</p> <p>Management staff did not formulate an agreement with an outside entity regarding sheltering individuals and staff in the event evacuation of the facility became necessary.</p> <p>Review on 9/3/19 of the facility's emergency preparedness plan dated 6/2019 did not include an agreement with alternate lodging specific to where the clients would evacuate in the event of an emergency</p> <p>Interviews on 9/3/19 with the qualified intellectual disabilities professional (QIDP) revealed the emergency preparedness plan (EP) was a template to be used as a guide in developing the facility's EP. When asked where clients would be relocated, the qualified intellectual disabilities professional (QIDP) stated a local entity would be used. He stated there was no written agreement or contact person.</p> <p>During an interview on 9/3/19, the QIDP acknowledged the plan does not include all of the</p>	E 020	Please see Page 1.		

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E 020	Continued From page 2 components outlined in the emergency preparedness plan including an agreement with a local entity that may be used for lodging should the clients need to evacuate from the facility.	E 020	Please see Page 1.		
W 192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to assure direct care staff demonstrated the skills and techniques to address the health needs of 1 of 3 audit clients (#3) in the facility. The finding is: Staff failed to demonstrate the skills needed to monitor blood pressures. During observations of the medication administration pass on 9/4/19 at 7:04am, staff began by taking client #3's blood pressure. After reading the blood pressure staff told the surveyor the systolic pressure was 92 and the diastolic pressure was 68. When staff was asked what parameters the Nurse had instructed staff to be aware of and when she wanted to be notified, staff stated, "Yes." When asked again, staff could not articulate the parameters of low and high blood pressures when they were to contact the Nurse. Review on 9/4/19 of client #3's record revealed she is prescribed Levothyroxine .5mcg by mouth every am. Review of the medication	W 192	This deficiency will be corrected by the following actions: A. The Clinical Supervisor and the Home Manager will train all Direct Support Professionals (DSP) on proper guidelines/procedures for checking the blood pressure of client #3. Specific attention will be paid to what circumstances would require a DSP to contact the RN. This training will be documented on form F9.8 Inservice/Training Signature Sheet which will be filed in the training binder at the group home. B. Direct Support Professionals will document this training on form F10.10 Client Specific Competencies. That form will then be filed in the training binder at the group home. C. The Home Manager will monitor Direct Support Professionals 2x/week to ensure that they are completing documentation and making notifications as required when checking client #3's blood pressure. D. The Clinical Supervisor will monitor Direct Support Professionals 2x/week to ensure that they are completing documentation and making notifications as required when checking client #3's blood pressure.	11/4/2019	

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W 192	Continued From page 3 administration record (MAR) revealed staff are to take client #3's blood pressure every am before administering her medication. Further review of the MAR revealed staff were to notify the Nurse if client #3's systolic pressure is below 80. Interview on 9/4/19 with the qualified intellectual disabilities professional (QIDP) confirmed staff should be familiar with blood pressure parameters and when the Facility Nurse is to be contacted.	W 192	Please see Page 3.		
W 257	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(iii) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on record reviews and interview, the facility failed to ensure the individual program plan (IPP) was reviewed and revised as necessary. This affected 1 of 3 audit clients (#1). The finding is: Client #1's team failed to revise her behavior support program (BSP). Review on 9/4/19 of client #1's individual program plan (IPP) dated 6/18/19 revealed she has target behaviors of self-injurious behaviors, inappropriate verbalizations and physical aggression. Further review of client #1's individual program plan (IPP) dated 6/18/19	W 257	This deficiency will be corrected by the following actions: A. The Clinical Supervisor will coordinate with the psychological consultant to revise the BSP of client #1. This revision will remove physical aggression as a targeted behavior. B. The Clinical Supervisor will coordinate with the psychological consultant to ensure all required signatures are present on the revised BSP. C. The Clinical Supervisor will coordinate with the psychological consultant to ensure that the human rights committee reviews the BSP for client #1. D. The Clinical Supervisor will train all Direct Support Professionals (DSP) on the revised BSP for client #1. This training will be documented on form E9 Direct Support Training Signatures. Direct Support Professionals will be trained on the form in the client's group home. E. The Clinical Supervisor will ensure that the training binder at the group home. F. The Home Manager will monitor Direct Support Professionals 2x/week for adherence to the BSP guidelines of client #1. G. The Clinical Supervisor will monitor Direct Support Professionals 1x/week for adherence to the BSP guidelines of client #1.	11/4/2019	

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W 257	Continued From page 4 revealed a BSP dated 6/13/18 to address these target behaviors. Review of her behavioral data for the past 6 months indicated that client #1 had not exhibited any episodes of physical aggression. Review on 9/4/19 of a note by the qualified intellectual disabilities professional (QIDP) for client #1's progress summaries dated 7/2019 revealed a note indicating that client #1's BSP needed to be revised. Interview on 9/4/19 with the QIDP confirmed there has been no episodes of physical aggression by client #1 in several months. Further interview revealed he has contacted the Psychologist several times to request revisions to client #1's BSP, however this has not been completed.	W 257	Please see Page 4.		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the restrictive behavior support plan (BSP) for 1 of 3 audit clients (#5) was reviewed and monitored by the human rights committee (HRC). The finding is: Management staff failed to have the human rights committee review a restrictive behavior plan for	W 262	This deficiency will be corrected by the following actions: A. The Clinical Supervisor will coordinate with the psychological consultant to ensure that the human rights committee reviews the BSP for client #5. B. The Clinical Supervisor will train all Direct Support Professionals (DSP) on the revised BSP for client #5. This training will be documented on form F9.8 Inservice/Training Signature Sheet which will be filed in the training binder at the group home. C. Direct Support Professionals will document this training on form F10.10 Client Specific Competencies. That form will then be filed in the training binder at the group home. D. The Home Manager will monitor Direct Support Professionals 2x/week for adherence to the BSP guidelines of client #5. E. The Clinical Supervisor will monitor Direct Support Professionals 1x/week for adherence to the BSP guidelines of client #5.	11/4/2019	

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W 262	Continued From page 5 client #5. Review on 9/4/19 of client #5's behavior support program (BSP) dated 9/26/17 revealed this program addresses the following target behaviors: non-compliance, physical aggression and inappropriate verbalizations. Further review revealed this program incorporates the use of Paroxetine 20 mg., Alprazolam 2 mg. (for physician appointments) and Abilify 2 mg daily and the use of a crisis dose of Abilify 2 mg. for agitation. Additional review of this program revealed the guardian signed written informed consent on 10/8/18. There was no written consent from the HRC for the BSP in client#5's BSP. Interview on 9/4/19 with the qualified intellectual disabilities professional (QIDP) confirmed the HRC is mandated to review any programs that contain restrictions, including the use of psychotropic medications. Further interview confirmed there was not consent from the HRC for client #5's BSP dated 9/26/17.	W 262	Please see Page 5.		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and verified by interview, the facility failed to assure the behavior support plan (BSP) for 1 of 3 sampled clients (#1) was conducted only with the written informed consent	W 263	This deficiency will be corrected by the following actions: A. The Clinical Supervisor will audit all medical charts to determine if any consent forms, especially those pertaining to a clients BSP, are up to date. B. The Clinical Supervisor will get signatures from Parents/Guardians for any consents which are missing or expired. C. The Clinical Supervisor will file the signed consents in the appropriate section of the client's medical chart. D. The Clinical Supervisor will monitor consent forms, as part of the ISP process, at a minimum of 1x/year or more often as they are needed.	11/4/2019	

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W 263	Continued From page 6 of the guardian. The finding is: Client #1's interdisciplinary team failed to obtain written informed consent for her BSP. Review on 9/4/19 of client #1's record revealed she has been adjudicated incompetent and appointed a Guardian of the Person to act on her behalf. Review of the IPP revealed client #1 has target behaviors of self-injurious behaviors, inappropriate verbalizations and physical aggression. Further review of client #1's individual program plan (IPP) dated 6/18/19 revealed a BSP dated 6/13/18 to address these target behaviors. Further review of the BSP revealed no written informed consent from client #1's legal guardian. Interview on 9/4/19 with the qualified intellectual disabilities professional (QIDP) confirmed that all behavior support programs (BSP)'s that incorporate restrictions which include the use of psychotropic medications must have written informed consent from the legal guardian for the person they support. Additional interview confirmed he had obtained verbal consent for client #1's BSP dated 6/13/18 but that he had not followed up with the legal guardian to obtain written informed consent.	W 263	Please see Page 6.	
W 316	DRUG USAGE CFR(s): 483.450(e)(4)(ii) Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually. This STANDARD is not met as evidenced by: The facility failed to show evidence medication to	W 316	Please see Page 8.	

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W 316	<p>Continued From page 7</p> <p>control inappropriate behaviors for 1 of 3 sampled clients (#5) had attempted to be reduced within the year or documentation showing the client is on the lowest effective dosage as evidenced by interview and review of records. The finding is:</p> <p>Client #5's team failed to review the use of her crisis medication to determine if it was still needed.</p> <p>Review on 9/4/19 of client #5's behavior support program (BSP) dated 9/26/17 revealed this program was to target the inappropriate behaviors of Non-Compliance, Physical Aggression and Inappropriate verbalizations. The program included the use of psychotropic medications to include Abilify 2 mg. daily, Paroxetine 20mg. and Alprazolam 2 mg. The program also included a crisis dose of Abilify 2mg. as needed anxiety and agitation.</p> <p>Review on 9/4/19 of client #5's recent physician orders dated 6/26/19 revealed no recent use of this crisis dose of Abilify 2mg. as needed anxiety and agitation.</p> <p>Interview on 9/4/19 with the qualified intellectual disabilities professional (QIDP) revealed client #5 has not required the use of the crisis dose of Abilify 2mg. in over 6 months. Further interview confirmed the team has not discussed with the Physician the continued need for this crisis dose of Abilify 2mg. for client #5.</p>	W 316	<p>This deficiency will be corrected by the following actions:</p> <p>A. The Clinical Supervisor and the RN will coordinate with the psychological consultant (BSP revision) and the prescribing physician (discontinuation of Abilify 2mg as a PRN) to revise the BSP of client #5. This revision should remove the use of Abilify 2mg as a PRN medication for behaviors.</p> <p>B. The Clinical Supervisor will coordinate with the psychological consultant to ensure all required signatures are present on the revised BSP.</p> <p>C. The Clinical Supervisor will coordinate with the psychological consultant to ensure that the human rights committee reviews the BSP for client #5.</p> <p>D. The Clinical Supervisor and/or the RN will train all Direct Support Professionals (DSP) on the revised BSP for client #5. This training will be documented on form F9.8 Inservice/Training Signature Sheet which will be filed in the training binder at the group home.</p> <p>E. Direct Support Professionals will document this training on form F10.10 Client Specific Competencies. That form will then be filed in the training binder at the group home.</p> <p>F. The Home Manager will monitor Direct Support Professionals 2x/week for adherence to the BSP guidelines of client #5.</p> <p>G. The Clinical Supervisor will monitor Direct Support Professionals 1x/week for adherence to the BSP guidelines of client #5.</p>	11/4/2019	
W 369	<p>DRUG ADMINISTRATION</p> <p>CFR(s): 483.460(k)(2)</p> <p>The system for drug administration must assure that all drugs, including those that are</p>	W 369	Please see Page 9.		

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W 369	<p>Continued From page 8</p> <p>self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observations and confirmed with record reviews and interviews, the facility failed to assure all medications were given as ordered. This affected 1 of 3 audit clients (#3) residing in the facility. The finding is:</p> <p>Staff failed to ensure audit client #3 received Azelastine Nasal spray as ordered by the physician.</p> <p>During observations on 9/4/19 of the medication administration pass for client #3 at 7:04am, staff administered the following: Desmopressin tablets (4) , Boost HC (1), Lactulose 15ml., Levetiracetam 500 mg. (2), Levothyroxine .5 mcg. (1), Vitamin D3 2,000 units (1) and Azelastine nasal spray 0.1% (1) spray for each nostril.</p> <p>Review on 9/4/19 of the physician order for client #3 dated 6/26/19 revealed the following: Desmopressin tablets (4) , Boost HC (1), Lactulose 15ml., Levetiracetam 500 mg. (2), Levothyroxine .5 mcg.(1), Vitamin D3 2,000 units (1) and Azelastine nasal spray 0.1% (2) sprays for each nostril.</p> <p>Interview on 9/4/19 with the qualified intellectual disabilities professional (QIDP) revealed client #3's physician orders are current and should have been followed to assure that client #3 was given Azelastine nasal spray 0.1% (2) sprays for each nostril.</p>	W 369	<p>This deficiency will be corrected by the following actions:</p> <p>A. The Clinical Supervisor and the RN will train all Direct Support Professionals (DSP) on proper use of client #3's Azelastine Nasal spray as it has been ordered by a physician. This training will be documented on form F9.8 Inservice/Training Signature Sheet which will be filed in the training binder at the group home.</p> <p>B. The Home Manager will monitor Direct Support Professionals 2x/week to ensure that they are administering medications as they are prescribed by a physician to all clients residing in the home.</p> <p>C. The Clinical Supervisor will monitor Direct Support Professionals 1x/week to ensure that they are administering medications as they are prescribed by a physician to all clients residing in the home.</p>	11/4/2019

DHSR - Mental Health

SEP 24 2019

Lic. & Cert. Section

September 17, 2019

Kimberly C. McCaskill, MSW
Facility Compliance Consultant I
Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

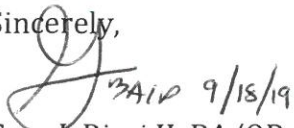
Re: Plan of Correction for Recertification Survey
Blanche Drive, 6208 Blanche Drive, Raleigh, NC 27607
Provider Number: 34G083
MHL Number: MHL-092-057

Dear Mrs. McCaskill,

Thank you for your time and the feedback given during the survey you completed on September 4, 2019. We appreciate your diligence in assisting us in providing the best care possible to the consumers we serve. We look forward to making the recommended changes that will improve the services we provide.

Enclosed you will the Plan of Correction. If you have any questions, please call me at (919) 387-1011 ext. 217. Again, thank you for your time and patience.

Sincerely,


Gary J. Ricci II, BA/QP
Program Manager, CANC

Enclosures