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
	MHL032-601	A. BUILDING: _____ B. WING _____	08/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE CARE OF RTP	107 ELMSFORD STREET DURHAM, NC 27703

(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 August 28, 2019. Deficiency cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600F Supervised Living/Alternative Family Living	V 000		
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		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	MHL032-601	A. BUILDING: _____ B. WING _____	08/28/2019

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INNOVATIVE CARE OF RTP	107 ELMSFORD STREET DURHAM, NC 27703

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V 118	Continued From page 1 This Rule is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure the medication administration record (MAR) was available and current for one of three audited clients (#3). The findings are . Review on 8/28/19 of Client #3's record revealed: - Admission date of 8/3/19. - Diagnoses of Autism Spectrum Disorder and Severe Intellectual Disability. Review on 8/28/19 of Client #3's Physicians order dated 8/1/19 revealed: -Topamax 50mg tablet - take one table by mouth two times daily. -Abilify 20mg tablet - take one tablet by mouth every evening. Observation on 8/28/19 at 9:00 a.m. of Client #3's medication revealed the following was available: -Topamax 50mg tablet. -Abilify 20mg tablet. Review on 8/28/19 of Client #3's record revealed there was no MAR from August 4 - 28, 2019 for the following medication: -Topamax 50mg tablet - 8 p.m. -Abilify 20mg tablet - 8:00 a.m. and 8:00 p.m. Interview on 8/28/19 with the Owner revealed: -Client #3 was new to the home. -He was changing the pharmacy where client #3's medication was dispensed.	V 118	Please see attached email transmission (Att. A) the Qualified Professional submitted the MARS to the auditor at 9:57am on the date of the audit – 8/28/2019. Please see attached Medication Orders (Att B): -Topamax 50mg tablet - take one table by mouth two times daily. -Abilify 2mg tablet - take one tablet by mouth every evening. This was accurately documented on the individual's MAR (Att C). The MAR was not at the home at the time of the review due to ESUCP's internal process of Shadow files being maintained in the AFL's provider's home. Moving forward, Shadow Files will also have the copy of the MARs. The Qualified Professional will provide these to the AFL Provider during the monthly supervision. MAR's are reviewed by ESUCP's RN weekly. In reviewing the requested POC, the staff did not have that specific weeks MAR's to document on. The Qualified Professional will email the AFL Provider notifying him of the	10/10/19 9/10/19

			requirement to request documents 48 hours prior to running out of required forms. (Att D).	

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 2 -Client #3 did not have an August 2019 MAR with him upon admission. -Requested MAR form from his Qualified Professional and never received.	V 118		

MARs for Kareem.

From: Abby Vaughn
Sent: Wednesday, August 28, 2019 9:57 AM
To: innovative.care.rtp@gmail.com
Subject: FW: Message from KM_368e

Please see the attached MARs for the month of August for KB. Also, the admission date for KM was 03/01/15 and the admission date for AF was 10/01/16.

Thank you.

Abby Vaughn, BAQP
ICS Program Manager
Easter Seals UCP North Carolina & Virginia, Inc.
4000 Wake Forest Road, Suite 200
Raleigh, NC 27609
Phone: (919) 698-1417

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Visit http://www.eastersealsucp.com to learn more about how Easter Seals UCP North Carolina & Virginia helps children and adults with disabilities or mental illness and their families.

From: Raleigh101-420i@wecare.local [mailto:Raleigh101-420i@wecare.local]
Sent: Wednesday, August 28, 2019 9:58 AM
To: Abby Vaughn <abby.vaughn@eastersealsucp.com>
Subject: Message from KM_368e

Leslie,

Here is the e-mail that I sent [redacted] I will also be ensuring that the other AFL providers receive the same information about requesting documentation with at least 48 hours notice in advance. Thanks for your help!

Abby Vaughn, BAQP
ICS Program Manager
Easter Seals UCP North Carolina & Virginia, Inc.
4000 Wake Forest Road, Suite 200
Raleigh, NC 27609
Phone: (919) 698-1417

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Visit http://www.eastersealsucp.com to learn more about how Easter Seals UCP North Carolina & Virginia helps children and adults with disabilities or mental illness and their families.

From: Abby Vaughn
Sent: Monday, September 09, 2019 9:55 AM
To: innovative.care.rtp@gmail.com
Subject: Requesting of Documentation

Horace,

I hope you are doing well and had a good weekend. I wanted to reach out in regards to the DHHS site review that occurred at the home on 08/28/19. One of the deficiencies that we received was not having a current MAR for one of the individuals that resides in the home. Moving forward, please provide a minimum of 48 hours notice when you are in need of any service documentation (service grids, invoices, MARs, etc.) so this way we can ensure that you in your possession all of the necessary and required documentation when providing services. I appreciate all that you do for the individuals that you support and please let me know if there is anything that I can do to be of assistance. Thanks so much and have a wonderful day.

Sincerely,

Abby Vaughn, BAQP
ICS Program Manager

Easter Seals UCP North Carolina & Virginia, Inc.
4000 Wake Forest Road, Suite 200
Raleigh, NC 27609
Phone: (919) 698-1417

Visit http://www.eastersealsucp.com to learn more about how Easter Seals UCP North Carolina & Virginia helps children and adults with disabilities or mental illness and their families.

To: CVS/pharmacy #7513
4309 NEW BERN AVE (NWC) (NEW HOPE ROAD), RALEIGH, NC 27610 Tel: (919) 231-2858 Fax: (919) 231-2898 NCPDP ID: 3421435

Deborah Granick, NP
1001 Navaho Dr, Suite 100, Raleigh, NC 27609-7318
Tel: (919) 856-4703 **Fax:** (919) 856-3795
NPI: 1790059103 **NC Lic. #:** 5009850

[redacted]

Rx
This is a reprinted prescription.
Abilify 2 mg tablet
Dispense **30**(thirty) tablet
Sig: Take **1** (one) tablet by mouth every evening
Days Supply: 30 days
Refills: **3**(three)

Security Features:
1. Quantities are bordered with asterisks and spelled out.
2. Microprinted line between practice information and patient name, visible at 5X magnification: "THIS IS AN ORIGINAL PRESCRIPTION".
3. Description of security features is printed on prescription.

Amie Sharrits, MD

AUG 01 2019

SHARRITS for DG

Product Selection Permitted Dispense As Written

Serial No. BB-22569846290 Issued at 08:48 AM on Monday, July 15, 2019 EDT
Patient Allergies: No Known Drug Allergies (NKDA)

To: CVS/pharmacy #7513
4309 NEW BERN AVE (NWC) (NEW HOPE ROAD), RALEIGH, NC 27610 Tel: (919) 231-2858 Fax: (919) 231-2898 NCPDP ID: 3421435

Deborah Granick, NP
1001 Navaho Dr, Suite 100, Raleigh, NC 27609-7318
Tel: (919) 856-4703 Fax: (919) 856-3795
NPI: 1790059103 NC Lic. #: 5009850

[redacted]

This is a reprinted prescription.

Topamax 50 mg tablet
Dispense **60**(sixty) tablet
Sig: Take **1** (one) tablet by mouth twice a day
Days Supply: 30 days
Refills: **3**(three)

Security Features:
1. Quantities are bordered with asterisks and spelled out.
2. Microprinted line between practice information and patient name, visible at 5X magnification: "THIS IS AN ORIGINAL PRESCRIPTION".
3. Description of security features is printed on prescription.

Amie Sharrits, MD

AUG 01 2019

Product Selection Permitted Dispense As Written

Serial No. BB-22569846296 Issued at 08:48 AM on Monday, July 15, 2019 EDT

Patient Allergies: No Known Drug Allergies (NKDA)

[redacted]

919 856 4703 (ext 1922)

Dr. Sherie

Dr. Grant

east seals UCP

Medication Administration Record
Sunday - Saturday

[redacted]

Allergies: No Allergies

Month/Year: August 2019

MCO: Alliance

***Instructions to ESUCP representative**: Place time given and initials in each box under date, turn in this form to ESUCP office when services are completed. If medications are not given for any reason, place initial in box under date, circle initials. Comment on back for any reasons outside of routine administration (PRN Meds, Missed Doses, Outside of timeframe, etc.) Use full signature with credentials following any notes on back.*

Medications		SUN	MON	TUES	WED	THUR	FRI	SAT
	Date							8/3/19
Name: **Topamax** Strength: **50mg tablet** Quantity/Dose: **1 (one) tablet** Time's to be administered: **Twice daily** Route: **by mouth** Instructions:	TIME 8am							H 8AM
	TIME							
	TIME							
	TIME 8Pm							H 8Pm
Name: **Abilify** Strength: **2mg tablet** Quantity/Dose: **1 tablet** Time's to be administered: **every evening** Route: by mouth Instructions:	Time 8Pm							H 8Pm
	Time							
	Time							
	Time							
Name: Strength: Quantity/Dose: Time's to be administered: Route: Instructions:	Time							
	Time							
	Time							
	Time							

Staff Signature: H RP Staff Initials: H Date: 8/3/19

RN Review: Jean Ellis RN Date: 8/13/19

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Medication Administration Record
Sunday - Saturday

[redacted]

Allergies: No Allergies

Month/Year: August 2019

MCO: Alliance

Comment below for any reasons outside of routine administration (PRN Meds, Missed Doses, Outside of timeframe, etc.) Use full signature with credentials following any notes written below.

DATE	COMMENTS

Staff Signature & Credentials: ______________________ Date: __________

Staff Signature & Credentials: Jean Ellis RN Date: 8/13/19

east seals UCP

Medication Administration Record
Sunday - Saturday

[redacted]

rgies: No Allergies

Month/Year: August 2019

MCO: Alliance

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		SUN	MON	TUES	WED	THUR	FRI	SAT
Medications	Date	8/4/19	8/5/19	8/6/19	8/7/19	8/8/19	8/9/19	8/10/19
Name: **Topamax**	TIME 8am	8Am th	8Am th	8Am th	8Am th	7Am th	8Am th	8Am th
Strength: **50mg tablet**	TIME							
Quantity/Dose: **1 (one) tablet**	TIME							
Time's to be administered: **Twice daily**	TIME 8pm	8Pm th	7Pm th	8Pm th	8Pm th	8Pm th	8Pm th	8Pm th
Route: **by mouth**								
Instructions:								
Name: **Abilify**	Time 8am	8Pm th	7Pm th	8Pm	8Pm th	8Pm th	7Pm th	8Pm th
Strength: **2mg tablet**	Time							
Quantity/Dose: **1 tablet**	Time							
Time's to be administered: **every evening**	Time							
Route: by mouth								
Instructions:								
Name:	Time							
Strength:	Time							
Quantity/Dose:	Time							
Time's to be administered:								
Route:								
Instructions:	Time							

Staff Signature: [signature] PP Staff Initials: th Date: 8/10/19

RN Review: Jean Ellis RN Date: 8/13/19

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Medication Administration Record
Sunday - Saturday

[redacted]

Allergies: No Allergies

Month/Year: August 2019

MCO: Alliance

Comment below for any reasons outside of routine administration (PRN Meds, Missed Doses, Outside of timeframe, etc.) Use full signature with credentials following any notes written below.

DATE	COMMENTS

Staff Signature & Credentials: ______________________ Date: __________

Staff Signature & Credentials: Jean Ellis [illegible] Date: 8/13/19

east seals | UCP

Medication Administration Record
Sunday - Saturday

[redacted]

Allergies: No Allergies

Month/Year: August 2019

MCO: Alliance

Instructions to ESUCP representative: *Place time given and initials in each box under date, turn in this form to ESUCP office when services are completed. If medications are not given for any reason, place initial in box under date, circle initials. Comment on back for any reasons outside of routine administration (PRN Meds, Missed Doses, Outside of timeframe, etc.) Use full signature with credentials following any notes on back.*

Medications		SUN	MON	TUES	WED	THUR	FRI	SAT
	Date	8/11/19	8/12/19	8/13/19	8/14/19	8/15/19	8/16/19	8/17/19
Name: **Topamax**	TIME 8am	8Am HL	8Am HL	8Am HL	8Am HL	8Am HL	8Am HL	8Am HL
Strength: **50mg tablet**	TIME							
Quantity/Dose: **1 (one) tablet**	TIME							
Time's to be administered: **Twice daily**	TIME 8pm	8Pm HL	8Pm HL	8Pm HL	8Pm HL	8Pm HL	8Pm HL	8Pm HL
Route: **by mouth**								
Instructions:								
Name: **Abilify**	Time 8pm	8Pm HL	8Pm HL	8Pm HL	8Pm HL	8Pm HL	8Pm HL	8Pm HL
Strength: **2mg tablet**	Time							
Quantity/Dose: **1 tablet**	Time							
Time's to be administered: **every evening**	Time							
Route: by mouth								
Instructions:								
Name:	Time							
Strength:	Time							
Quantity/Dose:	Time							
Time's to be administered:								
Route:								
Instructions:	Time							

Staff Signature: HL Staff Initials: HL Date: 8/17

RN Review: Jean Ellis RN Date: 8/19/19

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Medication Administration Record
Sunday - Saturday

[redacted]

Allergies: No Allergies

Month/Year: August 2019

MCO: Alliance

Comment below for any reasons outside of routine administration (PRN Meds, Missed Doses, Outside of timeframe, etc.) Use full signature with credentials following any notes written below.

DATE	COMMENTS

Staff Signature & Credentials: _____ Date: _____

Staff Signature & Credentials: Jean Ellis RN Date: 8/19/19

easter seals | UCP

Medication Administration Record
Sunday - Saturday

[redacted]
Allergies: No Allergies
Month/Year: August 2019
MCO: Alliance

Instructions to ESUCP representative: ***Place time given and initials in each box under date, turn in this form to ESUCP office when services are completed. If medications are not given for any reason, place initial in box under date, circle initials. Comment on back for any reasons outside of routine administration (PRN Meds, Missed Doses, Outside of timeframe, etc.) Use full signature with credentials following any notes on back.***

Medications		SUN	MON	TUES	WED	THUR	FRI	SAT
Name: **Topamax**	Date	8/18/19	8/19/19	8/20/19	8/21/19	8/22/19	8/23/19	8/24/19
Strength: **50mg tablet**	TIME	8Am LH	8Am LH	8Am LH	8Am LH	8Am LH	8Am LH	8Am LH
Quantity/Dose: **1 (one) tablet**	TIME							
Time's to be administered: **Twice daily**	TIME							
Route: **by mouth**	TIME	8PM LH	8PM LH	8PM LH	8PM LH	8PM LH	8PM LH	8PM LH
Instructions:								
Name: **Abilify**	Time	8PM LH	8PM LH	8PM LH	8PM LH	8PM LH	8PM LH	8PM LH
Strength: **2mg tablet**	Time							
Quantity/Dose: **1 tablet**	Time							
Time's to be administered: **every evening**	Time							
Route: by mouth Instructions:								
Name:	Time							
Strength:	Time							
Quantity/Dose:	Time							
Time's to be administered: Route: Instructions:	Time							

Staff Signature: LH PR Staff Initials: LH Date: 9/24/19

RN Review: Jean Ellis RN Date: 8/26/19

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Medication Administration Record
Sunday - Saturday

[redacted]

Allergies: No Allergies

Month/Year: August 2019

MCO: Alliance

Comment below for any reasons outside of routine administration (PRN Meds, Missed Doses, Outside of timeframe, etc.) Use full signature with credentials following any notes written below.

DATE	COMMENTS

Staff Signature & Credentials: _____ Date: _____

Staff Signature & Credentials: Jean Ellis RN Date: 8/26/19