

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL053-082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/02/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ANDREWS DRIVE FAMILY CARE FACILITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2621 ANDREWS DRIVE SANFORD, NC 27332</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) COMPLETE DATE
V 000	<p><b>INITIAL COMMENTS</b></p> <p>An annual and follow-up survey was completed on October 2, 2019. A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600 C Supervised Living for Adults with Developmental Disabilities.</p>	V 000		
V 289	<p><b>27G .5601 Supervised Living - Scope</b></p> <p>10A NCAC 27G .5601 SCOPE</p> <p>(a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence.</p> <p>(b) A supervised living facility shall be licensed if the facility serves either:</p> <p>(1) one or more minor clients; or</p> <p>(2) two or more adult clients.</p> <p>Minor and adult clients shall not reside in the same facility.</p> <p>(c) Each supervised living facility shall be licensed to serve a specific population as designated below:</p> <p>(1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses;</p> <p>(2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses;</p> <p>(3) "C" designation means a facility which serves adults whose primary diagnosis is a developmental disability but may also have other diagnoses;</p> <p>(4) "D" designation means a facility which</p>	V 289		

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

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL053-082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/02/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ANDREWS DRIVE FAMILY CARE FACILITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2621 ANDREWS DRIVE SANFORD, NC 27332</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) COMPLETE DATE
V 289	<p>Continued From page 1</p> <p>serves minors whose primary diagnosis is substance abuse dependency but may also have other diagnoses;</p> <p>(5) "E" designation means a facility which serves adults whose primary diagnosis is substance abuse dependency but may also have other diagnoses; or</p> <p>(6) "F" designation means a facility in a private residence, which serves no more than three adult clients whose primary diagnoses is mental illness but may also have other disabilities, or three adult clients or three minor clients whose primary diagnoses is developmental disabilities but may also have other disabilities who live with a family and the family provides the service. This facility shall be exempt from the following rules: 10A NCAC 27G .0201 (a)(1),(2),(3),(4),(5)(A)&amp;(B); (6); (7) (A),(B),(E),(F),(G),(H); (8); (11); (13); (15); (16); (18) and (b); 10A NCAC 27G .0202(a),(d),(g)(1) (i); 10A NCAC 27G .0203; 10A NCAC 27G .0205 (a),(b); 10A NCAC 27G .0207 (b),(c); 10A NCAC 27G .0208 (b),(e); 10A NCAC 27G .0209[(c)(1) - non-prescription medications only] (d)(2),(4); (e) (1)(A),(D),(E);(f);(g); and 10A NCAC 27G .0304 (b)(2),(d)(4). This facility shall also be known as alternative family living or assisted family living (AFL).</p> <p>This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the Licensee failed to meet scope for a 5600A supervised living facility affecting 1 of 2 clients (#1) residing in the facility. The findings are:</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL053-082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/02/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ANDREWS DRIVE FAMILY CARE FACILITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2621 ANDREWS DRIVE SANFORD, NC 27332</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) COMPLETE DATE
V 289	<p>Continued From page 2</p> <p>Review on 10/2/19 of the facility's license revealed:</p> <ul style="list-style-type: none"> <li>- The facility was initially licensed on 7/2/18 as a residential facility for three (3) ambulatory residents.</li> <li>- The construction division surveyed the building and approved occupancy for three (3) ambulatory residents on 5/10/18.</li> <li>- The current license (through 12/31/19) was completed by the licensee on 10/18/18 documented all resident(s) currently in the facility as ambulatory.</li> <li>- Ambulatory is defined by the State (and noted on the license) as "A person who can evacuate the building without physical or verbal assistance during a fire or other emergency."</li> </ul> <p>Review on 10/2/19 of Client #1's record revealed:</p> <ul style="list-style-type: none"> <li>- Admission date of 8/1/17</li> <li>- Diagnosis of Bipolar Disorder with Dependent Personality; Personality Disorder, Not Otherwise Specified; Asthma; Anemia; Non-Insulin Dependent Diabetes Mellitus; Spinal Stenosis; Chronic Obstructive Pulmonary Disease; Myalgia</li> <li>- Treatment Plan dated 4/01/19 included a safety goal for the client to use her walker at all times and to "use walker correctly."</li> <li>- Incident reports documenting the client has experienced two falls while out of the facility.</li> </ul> <p>Observation on 10/2/19 at 4:30 PM of the exterior of the facility revealed:</p> <ul style="list-style-type: none"> <li>- The back and front entrance to the interior of the facility contained brick steps before the entry door.</li> <li>- There was not a ramp located at either entrance.</li> </ul> <p>Additional observation on 10/2/19 at approximately 5:30 PM revealed:</p>	V 289		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL053-082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>10/02/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ANDREWS DRIVE FAMILY CARE FACILITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2621 ANDREWS DRIVE SANFORD, NC 27332</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) COMPLETE DATE
V 289	<p>Continued From page 3</p> <ul style="list-style-type: none"> <li>- Client #1 arrived to the facility from her Day program.</li> <li>- Staff assisted her out of the van.</li> <li>- Client #1 required the physical support and guidance of staff to navigate the stairs and enter the facility. She was unable to safely complete the task alone.</li> </ul> <p>During interview on 10/2/19, staff confirmed:</p> <ul style="list-style-type: none"> <li>- Client #1 is unstable when trying to ambulate without her walker.</li> <li>- Client #1 needs to use her walker at all times.</li> <li>- Client #1 need assistance from staff to enter and exit the facility.</li> </ul>	V 289		