Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL043047	B. WI	NG	ĵ	09/06/2019
NAME	OF PROVIDER OR SUPPLIE		ET ADDRES	SS, CITY, STATE, ZIP CODE		
PROFE	SSIONAL FAMILY CARE	HOME #4	RCHARD C	REST CIRCLE		
	SUMMARY STA	TEMENT OF DEFICIENCIES	ORD, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPRODEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMEN	TS				
	An annual and follow September 06, 2019.	-up survey was completed on Deficiencies were cited.				
	This facility is license category 10A NCAC for Adults with Devel	d for the following service 27G. 5600C Supervised Living opmental disabilities.				
V112	27G .0205 (C-D) Asse Plan	essment/Treatment/Habilitation	V112	The most recent treatment pla Client #1 is at the residential:	n for	Implementation Date: 09/07/2019
	TREATMENT/HABIL PLAN (c) The plan shall be assessment, and in	05 ASSESSMENT AND LITATION OR SERVICE developed based on the partnership with the client or erson or both, within 30				
	of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally			PFCS's Residential Manager will ensure that a copy of the most current updated, revised, or new PCP or ISP of each consumer will be kept at the group home with the original (or printed copy) remaining at the corporate office.		Projected Completion Date: Ongoing
	responsible person of (5) basis for evaluation outcome achievement (6) written consent or responsible party, or a	r both; on or assessment of				
					5	

(X3) DATE SURVEY

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL043047	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MILLOUS	B. WING _		09/0	06/2019
	PROVIDER OR SUPPLI	122 ORC	ADDRESS, C	TY, STATE, ZIP CODE T CIRCLE		
PROFESS	IONAL FAMILY CARE	HOME #4 SANFOR	D, NC 27330			
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
V 112	Continued From p	page 1	V 112			
	Based on record t	net as evidenced by: reviews and interviews, the ent failed to assure a current as completed for 1 of 3 audited ags are:				
	- Admission date - Diagnoses of Hy Gastroesophagea Dependence - Treatment plan dated 6/1/18, pric Interview on 8/30 revealed: - He confirmed the was not in his received Client treatmen would be provided however, the upon	ypertriolyceridemia; al Disease; Tobacco found in the client's record was or to the client's admission. 1/19 with the Facility Director the client's current treatment plan				
V 118	10A NCAC 27G REQUIREMENT (c) Medication at (1) Prescription of only be administ order of a persor drugs. (2) Medications clients only whe client's physician (3) Medications.	dministration: or non-prescription drugs shall ered to a client on the written n authorized by law to prescribe shall be self-administered by n authorized in writing by the	V 118			

(X2) MULTIPLE CONSTRUCTION

STATE FORM

Division of Health Service Regulation

	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL043047	A. BUILD			ATE SURVEY MPLETED
		=	B. WING		09/	/06/2019
	F PROVIDER OR SUPPLIES	122 ORG	ADDRESS, C	CITY, STATE, ZIP CODE ST CIRCLE		
	STORTE L'AMILI CARE		RD, NC 27330)		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 118	Continued From page	2	V 118			
	pharmacist or other privileged to prepare (4) A Medication Ad all drugs administer current. Medications recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for a (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be reco	trained by a registered nurse, legally qualified person and e and administer medications. Iministration Record (MAR) of ed to each client must be kept administered shall be ely after administration. The efollowing: and quantity of the drug; administering the drug; e drug is administered; and of person administering the error medication changes or or orded and kept with the MAR oppointment or consultation				
	interviews, the facility medications were adiphysician's orders for The findings are: Review on 8/30/19 of Admission date of 3-Diagnoses of Hyper Gastroesophageal Di Dependence Physician's orders in 1/9/19 and 5/28/19 for administered: Paliperi	ews, observation and realized to assure ministered according to a 1 of 3 audited clients (#1.) Client #1's record revealed: /22/19 triolyceridemia; sease; Tobacco				
sion of Hos	alth Service Regulation	Chefit #15 July 2019 and				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
MHL043047		B. WING		09/06/2019		
	PROVIDER OR SUPPLI	122 OR HOME #4	Γ ADDRESS CHARD CR ORD, NC 273	, CITY, STATE, ZIP CODE EST CIRCLE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	(X5) COMPLETE DATE	
V 118	August 2019 MAF - Staff documenta administered: Pal morning. Observation on 8 medications-on-h - Paliperidone ER medications with to be administere	bservation on 8/30/19 of Client #1's edications-on-hand at 5:30pm revealed: Paliperidone ER 9mg was among the client's edications with instructions for the medication be administered once daily. Pharmacy dispense date on the medication as			Implementation Date: 09/07/19	
	revealed: - He confirmed the order and the medication Client #1 did not - He said he would be revealed:	n/19 with the Facility Director ne most recent physician's on dose being administered to match. Ild clarify the order with the n and the pharmacy.		PFCS Residential Manage Nurse will ensure that the medications on the physic order, FL-2, and MAR all with each medication char each consumer.	ian's match nge for	Projected Completion Date: Ongoing
Division	of Health Service Regulat	ion		Lic. & Cert. S		ntinuation sheet 5 or

Signature: _

Leon Robinson, QP Residential Manager

Date: 10/09/2019