

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-829	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/06/2019
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NAME OF PROVIDER OR SUPPLIER HANNAH FAMILY CARE HOMES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7109 HICKORY NUT DRIVE RALEIGH, NC 27613
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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) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>An annual, follow up and compliant survey was completed on 11/06/19. The compliant was unsubstantiated (intake # NC22156176). Deficiencies were cited.</p> <p>The facility is licensed for a 10A NCAC 27G .5600A Supervised Living for Mentally Ill Adult.</p>	V 000		
V 113	<p>27G .0206 Client Records</p> <p>10A NCAC 27G .0206 CLIENT RECORDS</p> <p>(a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to:</p> <p>(1) an identification face sheet which includes:</p> <ul style="list-style-type: none"> (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; <p>(2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV;</p> <p>(3) documentation of the screening and assessment;</p> <p>(4) treatment/habilitation or service plan;</p> <p>(5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician;</p> <p>(6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician;</p> <p>(7) documentation of services provided;</p> <p>(8) documentation of progress toward outcomes;</p> <p>(9) if applicable:</p>	V 113		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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V 113	<p>Continued From page 1</p> <p>(A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143.</p> <p>This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure consents were maintained for one of three audited clients (#1). The findings are:</p> <p>Review on 11/05/19 of client #1's record revealed: -Admission date of 09/05/2017. -Diagnoses of Schizoaffective Disorder. -No evidence of consents were completed.</p> <p>During interview on 11/06/19 the Qualified Professional/Licensee reported: -Waiting for consents from guardian. -Sent out consents awhile ago. -Have not called guardian to ask for consents. -Guardian visits every month if possible.</p>	V 113		