

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL012-142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>12/09/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LAKE JAMES ALTERNATIVE FAMILY LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5741 FISH HATCHERY ROAD</b> <b>MORGANTON, NC 28655</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 12-9-19. Deficiencies were cited.</p> <p>This facility is licensed for the following service category 10A NCAC 27G .5600F Supervised Living for Individuals of all Disability Groups/Alternative Family Living.</p>	V 000		
V 118	<p><b>27G .0209 (C) Medication Requirements</b></p> <p><b>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</b></p> <p>(c) Medication administration:</p> <p>(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.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(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.</p> <p>(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:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p> <p>(D) date and time the drug is administered; and</p> <p>(E) name or initials of person administering the drug.</p> <p>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation</p>	V 118		

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>MHL012-142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>12/09/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LAKE JAMES ALTERNATIVE FAMILY LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5741 FISH HATCHERY ROAD</b> <b>MORGANTON, NC 28655</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 118	<p>Continued From page 1 with a physician.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure MAR's were kept current for 1 of 3 clients (Client #3). The findings are:</p> <p>Review of Client #3's record on 12-9-19 revealed: -Date of admission: 1-21-19; -Diagnoses: Borderline Intellectual Functioning, Language Disorder, Schizoaffective Disorder, Chronic Kidney disease, Hyperlipidemia and Hypothyroidism; -Physician's orders for the following medications: -lamotrigine 100 milligram (mg) 1 tablet by mouth each evening and fluoxetine hydrochloride 20 mg 1 capsule by mouth daily dated 2-1-19; -omeprazole 20 mg 1 capsule by mouth daily dated 3-28-19; -buspirone hydrochloride 5 mg 1 tablet by mouth three times daily as needed for anxiety dated 7-19-19; -lisinopril 10 mg 1 tablet by mouth daily dated 8-22-19; -aripiprazole 30 mg 1 tablet by mouth at bedtime and divalproex sodium extended release 500 mg 1 tablet by each morning and 2 tablets by mouth each evening dated 10-8-19; -Physician's order allowing client to self-administer his medications dated 2-1-19; -No MAR was on file in the client's record from the date of admission.</p> <p>Interview with Client #3 on 12-9-19 revealed: -He self-administered his medications; -Staff #1 ensured he was compliant with taking</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL012-142</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>12/09/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LAKE JAMES ALTERNATIVE FAMILY LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5741 FISH HATCHERY ROAD</b> <b>MORGANTON, NC 28655</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 118	<p>Continued From page 2</p> <p>his medications as prescribed.</p> <p>Interview with Staff #1 on 12-6-19 revealed: -Client #3 did not have a MAR; -She was told by the Qualified Professional (QP) that Client #3 did not require a MAR since he had an order to self-administer his medications.</p> <p>Interview with the QP on 12-9-19 revealed: -She was unaware that a MAR was needed for clients who self-administered their medications; -A MAR would be prepared this week for Client #3; -The use of the MAR for Client #3 would be implemented immediately.</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 118		