FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: COMPLETED C B. WING MHL053-082 09/16/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2621 ANDREWS DRIVE ANDREWS DRIVE FAMILY CARE FACILITY SANFORD, NC 27332 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY V 000 INITIAL COMMENTS V 000 A complaint survey was completed on September 16, 2020. The complaint was substantiated (intake #NC00167901)Deficiency cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600C Supervised Living for Adults with Developmental Disabilities V 118 27G .0209 (C) Medication Requirements V 118 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: DHSR-Mental Health (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug: SEP 2 9 2020 (D) date and time the drug is administered; and (E) name or initials of person administering Lic. & Cert. Section

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(5) Client requests for medication changes or checks shall be recorded and kept with the MAR

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Division of Health Service Regulation

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V 118 Continued From page 1		V 118	The facility will ensure that all		11/15/20
file followed up by appoin with a physician.	ntment or consultation		ordered. For 1 of 1 client (#1) home, there is no order to self	in the	
on record review and interalled to have a physician administer medication affi audited client (#1). The file of the reviewed: -Admission dation -Diagnoses of Bipolar Dispersonality Disorder, Personality Anemia, NIDDM.  -Physician order dated 7/2 Standard OTC order following medication:  -Hydrocortisone 1% -2x daily.  -There was no order for climedicate.  Review 9/16/20 of the dated 7/29/20 revealed:  - "[Qualified Professional] and noticed [client #1] let ovan and took out hydrocord asked [client #1] where did from. [Client #1] while apply she got it from [staff #2]. [Client #1] while apply she got it from [staff #2].	file followed up by appointment or consultation with a physician.  This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to have a physician order to self-administer medication affecting one of one audited client (#1). The findings are:  Review on 9/14/20 of Client #1's record reviewed: -Admission date of 8/1/17Diagnoses of Bipolar Disorder with Dependent Personality Disorder, Personality disorder, NOS, Mild IDD, Hyperlipidemia. Asthma, Anemia, NIDDMPhysician order dated 7/21/20 on FL-2 for Standard OTC order revealed the following medication: -Hydrocortisone 1% - apply to affected area 2x dailyThere was no order for client #1 to self-medicate.  Review 9/16/20 of the Incident Report dated 7/29/20 revealed: - "[Qualified Professional] was driving on highway and noticed [client #1] let down mirror inside the van and took out hydrocortisone medication. [QP] asked [client #1] while applying to rash said that she got it from [staff #2]. [QP] informed [client #1] that [client #1] isn't supposed to have that		medications are administered as ordered. For 1 of 1 client (#1) in home, there is no order to self-administer her medications.  The AFL manager (QP), will proin-service training to Staff #2 and other staff assigned to the home the direct supervision of all medications during administration and on securing all medications before and after administration. Under no circumstances should Client #1 have any medication (sher person.  The QP will monitor the medicat pass in the home weekly to ensure continued compliance.  The Director of Quality Managem will monitor the medication pass the home monthly to ensure continued compliance.		

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION NG:	(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER				09/16/2020	_	
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V 118	Continued From page	2	V 118				
V 118	[client #1's] rash. [Clie cream on her scab. [Q #1] that medication wa [QP] then asked for me [QP] told [client #1], [client would need [client they got to the day pro [QP] the medication in glanced at the medicat #1] what it was used for the control of the con	nt #1] then started putting iP] then informed [client isn't used for her scab. edication from [client #1] lient #1] could not keep it if if it is it is it is if it is	V 118				
(	order.	o was an ever the counter					
	-The order was a stand						
	-He generated a label						
	for group home staff.						
	-Pharmacist could put a	prescription label					
	on OTC product.						
	Interview on 9/15/20 & 9 QP revealed: -Worked at the facility at-Responsible for superviousShe also transported.	s QP for six months.					
	<ul> <li>Staff administered me</li> </ul>	edication to clients					
	She observed and mag	de sure staff were					
	completing medication	administration record.					
	-Client #1 was current at the home.	ly the only client living					

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		
			A. BUILDING:		СОМ	PLETED
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NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STAT	ΓE, ZIP CODE		
ANDREW	S DRIVE FAMILY CARE	FACILITY 2621 AN	DREWS DRIVE			
			RD, NC 27332			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL 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	Continued From page	3	V 118			
	-Client #1 had a rash with over the counter -Client #1 had medical was transporting client Client #1 pulled out the -She was on the phone at the time and the guar client #1 that she shou -She asked client #1 he medication, client #1 re herShe spoke with staff # issue but confirmed sh The rash was gone; it thereClient #1's guardian w #1 having medication of -Client #1 was not allow herClient #1's medication be administered to client-She had a staff meetir	on her neck, treated ointment.  ition in her hand when she #1 to an appointment e cointment while in the car e with client #1's guardian heard when she told lid not have the medication. ow did she get the eported staff #2 gave it to #2 the same day about the redid not document it cleared up and no longer was concerned about client on her.  wed to self-medicate red to have medication on including topical had to not #1.  ng on 9/9/20 with all nedication administration.				
1	Management revealed: -Confirmed the QP spo the incident.	th the Director of Quality ke with Staff #2 regarding I not have a self-medicate				
- t ( c k	Client #1 would be able opical medicine but can Confirmed and provided discussed with the QP to the confirmed with	administrationAll				

Division of Health Service Regulation

PRINTED: 09/17/2020 Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED C B. WING MHL053-082 09/16/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2621 ANDREWS DRIVE ANDREWS DRIVE FAMILY CARE FACILITY SANFORD, NC 27332 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)



## Provider of MH/DD/SA Services

September 23, 2020

Ms. Frances E. Hicks, MSW
Facility Compliance Consultant I
Mental Health Licensure and Certification Section
N.C. Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Complaint Survey completed September 16, 2020 Andrews Drive Family Care Facility 2621 Andrews Drive, Sanford, NC 27330

MHL#053-082 Intake #NC00167901

Dear Ms. Hicks:

See attached hard copy of the plan of correction (POC) for the Andrews Drive Family Care Facility's complaint survey, completed 9/16/20. We hope that you will find the attached POC acceptable. If you have questions, feel free to contact myself or Vidya Persad, Director of Operations. Otherwise, we very much look forward to your follow-up visit.

Kindest regards,

James Harris, Director Quality Management