

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G224	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/13/2020
NAME OF PROVIDER OR SUPPLIER COUNTRY LANE			STREET ADDRESS, CITY, STATE, ZIP CODE 534 COUNTRY LANE HOLLY SPRINGS, NC 27540	
(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) COMPLETION DATE
W 369	<p>DRUG ADMINISTRATION CFR(s): 483.460(k)(2)</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure all medications were given without error. This affected two clients (#1 and #2.) The finding is:</p> <p>Staff failed to administer eye drops for clients #1 and #2 without error.</p> <p>During observations of the morning medication pass at 7:20am on October 13, 2020, staff took drops out of a bag labeled incorrectly and placed two drops of what were identified afterwards as ear drops into client #2's eyes. She realized it when looking at the bottle to pass the surveyor to read and immediately had the client wash his eyes out. At 7:45am client #1 refused to allow her to give him his eye drops so she said okay and called the nurse who stated okay. There were no further attempts to ask or assist him with eyedrops again.</p> <p>After the observations, the drops placed in client #2's eyes were identified as Ear drops DRO 6.5%.</p> <p>Review of the most current physician's orders revealed client #2 had an order for Systane Balance Dry to instill drops into each eye in the mornings and at bedtime as well as the drops for impacted cerumen nightly as directed. The ear drops had been placed into the eye drop bag.</p>	W 369	<p>W369 This deficiency will be corrected by the following actions:</p> <ul style="list-style-type: none"> A. RN will assess all orders. B. All physician orders will be reviewed for accuracy. C. All staff will be in service on medication procedure and following the guidelines (medication rights) for dispensing all medications D. Consumers will be assessed for the ability to self-medicate (if applicable) E. Staff will be in service on Medication Administration procedures F. RN will monitor monthly G. Residential Manager will monitor two times a week. H. Qualified Professional will monitor monthly 	11.15.2020

RECEIVED
By DHSR Mental Health Licensure & Certification at 7:59 am, Nov 02, 2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

marika whack AK

Executive Director

11-1-2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER COUNTRY LANE			STREET ADDRESS, CITY, STATE, ZIP CODE 634 COUNTRY LANE HOLLY SPRINGS, NC 27540		
(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) COMPLETION DATE	
W 369	Continued From page 1 Further review of the most current physician's orders for client #1 revealed an order for Pazeo DRO 6.7% instill drops into both eyes once daily. There was no plan or allowance written for the client not to receive as directed. Interview with the qualified intellectual disability professional (QIDP) on 10/13/2020) confirmed the physician orders should be followed as written.	W 369			

Community Alternatives – NC
Southeast Region
1001 Navaho Drive Suite 101
Raleigh, NC 27609
Phone: 984-205-2630
FAX: 984-205-2643

RECEIVED
By DHSR Mental Health Licensure & Certification at 7:58 am, Nov 02, 2020

FAX

To: Joy Alford From: Termaune Keamy
Fax: 919-715-8028 Pages: 3
Phone: 919-855-3795 Date: 11-1-2020
Re: _____ CC: _____

- Urgent For Review Please Comment Please Reply Please Recycle

Comments:

Shan K. G...



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November 1, 2020

Joy Alford, SW/OIDP
Facility Compliance Consultant I
Mental Health Licensure and Certification section
NC Division of Health Services Regulations
2718 Mail Service Center
Raleigh NC 27699-2718
919.855.3795 office
919.715.8078 fax

RE: Plan of Correction for Annual Survey Completed October 13, 2020
Country Lane Group Home
534 Country Lane, Holly Springs NC 27540
Provider Number 34G224
MHL# 092101

Dear Ms. Alford

We appreciate the courtesy extended by you while surveying the Country Lane Group Home, Holly Springs, North Carolina.

As indicated on the Plan of Correction, we will have the Deficiencies corrected for, the Annual survey completed on October 13, 2020 completed **November 15, 2020**

We are committed to providing the highest possible care for the people we serve at Country Lane Group Home.

If you have questions, please contact Cynthia Bradford, Assistant Executive Director 276.252.8193 cell 984.205.2630 ext. 238. Or JerMaine Kearney, Program Manager 984.205.2630 ext 403

Sincerely,



Marika Whack, Executive Director
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Raleigh, North Carolina, 27609
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