STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G278	A. BUILDING _____ B. WING _____	04/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVENT FERRY HOME	904 AVENT FERRY ROAD 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 000	INITIAL COMMENTS A recertification survey and complaint survey was completed on April 13, 2021 for Intake #NC00175042. No deficiencies were cited for the complaint. However, deficiencies were cited as a result of the recertifiction survey.	W 000		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to administer medications for 1 of 3 audit clients (#2) without medication error. The finding is: During morning observations in the home on 4/13/21, client #2 was finishing up his breakfast from 7:10am-7:20am. At 7:21am, client #2 entered the medication room and was given Levothyroxine 25 mcg to ingest. Review on 4/13/21 of client #2's physician's orders signed on 2/12/21 read, Levothyroxine 25 mcg, take on empty stomach. Interview on 4/13/21 with the nurse revealed that client #2 should have taken the medication on an empty stomach if the order is written that way.	W 369	Staff will be inserviced on proper medication protocol by Nurse. Staff will be in serviced on giving medication as Prescribed and written. QP will monitor medication administration 1x monthly Program manager will monite medication administration once a week.	6/1/2021

DHSR - Mental Health
APR 23 2021
Lic. & Cert. Section

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: QIDP (X6) DATE: 4/19/2021

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.

April 19,2021
To Department of Health and Human Services
Re: Avent Ferry Recertification MHL# 092-126

Thank you for taking the time to come out to complete our Annual Survey, please find the enclosed our Plan of correction. Should you have any questions please do not hesitate to contact me.

Sincerely,
Tonya Beckwith, QIDP
(919)656-3707