

PRINTED: 09/09/2022  
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL032-262</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>09/06/2022</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WESTGLEN ROAD GROUP HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3523 WESTGLEN ROAD DURHAM, NC 27705</b>
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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><b>INITIAL COMMENTS</b></p> <p>An annual survey was completed on September 6, 2022. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>This facility is licensed for six bed and currently has a census of six. The survey sample consisted of audits of three current clients.</p>	V 000		
V 121	<p><b>27G .0209 (F) Medication Requirements</b></p> <p><b>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</b> (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to obtain drug regimen reviews every six months for one of three audited clients (Client #2) who received psychotropic drugs. The findings are:</p>	V 121	<p><i>see attached</i></p>	

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

*Elizabeth Scott, Executive Director* \_\_\_\_\_ *9/24/22*

STATE FORM 6899 1P3K11 If continuation sheet 1 of 2



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V 121	<p>Continued From page 1</p> <p>Review on 9/1/22 of Client #2's record revealed:                      -Admission date of 1/1/75.                      -Diagnoses of Mild Mental Retardation                      -Physician order dated 4/13/22 for Levetiracetam 1000 milligrams (mg) take one tablet two times a day.                      -There was no evidence of a current drug regimen review completed within the last six months for Client #2.</p> <p>Interview on 9/2/22 and 9/6/22 with the Qualified Professional revealed:                      -The document was normally filed in the chart.                      -She contacted doctor's office to obtain a copy and was awaiting a callback.                      -The doctor office could not provide a copy of the drug review for Client #2.                      -She confirmed the facility failed to obtain drug regimen reviews every six months.</p>	V 121		

## Durham County Community Living Programs, Inc.

Post Office Box 51159  
Durham, N.C. 27717-1159  
(919) 489-0682

Westglen Road Group Home  
MHL # 032-262

### Plan of Correction to Survey Completed September 9, 2022

I am submitting this Plan of Correction a few days beyond the 10-day requirement due to our shortage of staff, and the fact that I was out of town with one of our consumers for four days of the past week. I responded as quickly as I was able, and will work to be more timely in the future.

#### V 121 Medication Requirements:

To Correct the Deficiency: The QDDP at the home has verified that all medication reviews have been completed as required. This issue arose in part because this consumer takes this medication for seizures from a previous brain tumor, and not for reasons of psychiatric or psychological concern. Therefore there was a fundamental misunderstanding that this was a psychotropic medication due to its intended use.

To Prevent the Deficiency from Occurring Again: The group home managers and the QDDP's are receiving retraining/reminders to follow our policies and procedures regarding medication reviews to occur every six months. I am meeting with these staff to ensure that they understand the policies and procedures, that it is their responsibility to know which medications are psychotropic, to schedule and follow through that reviews occur as required. We are reviewing this with all responsible staff at our upcoming staff meeting. We have a peer review process in place during which the consumer files at each home are reviewed to assure quality and conformation to regulations. Medication review is one of the items checked during the peer review process.

Who will Monitor: The group home managers will list the dates that these six month reviews are due, and they will put them on the calendar at the home and schedule the appointments as required. The QDDP of the home will turn in to the Assistant Director a list of when 6 month reviews are due for each of her consumers (FL-2's and Drug Therapy Assessments). She will calendar these and monitor to make sure that they occur. The Assistant Director, who is the lead person during the peer review process will monitor randomly twice per year to be sure that the medication reviews are occurring as required.

How Often the Monitoring will Take Place: The group home managers will review their calendar monthly to make sure that any review appointments are scheduled. The QDDP will monitor to make sure that they occur, and the Assistant Director will verify this randomly during supervisions with the QDDP and twice per year during the peer review process.

Respectfully submitted,



Elizabeth Scott, BS, QDDP

Executive Director

September 24, 2022

**Durham County Community Living Programs, Inc.**  
P.O. Box 51159 Durham, NC 27717-1159  
(919) 489-0682

# Fax

To: DHSR

From:

*Elizabeth Scott*

Extension #: 24

Fax: (919) 715-8078

Pages: 6 (including cover)

Phone:

Date: 9/26/22

Re: *Inspection Response* CC:

Urgent    For Review    Please Comment    Please Reply    Please Recycle

● Comments:

*I am faxing these because they are late. I apologize for their lateness. The originals will go out in the mail tomorrow.*

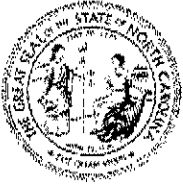
*Thank you!*

*Westglen Road Group Home*

*Elizabeth*

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**Durham County Community Living Programs, Inc.**  
Fax Number: (919) 493-0869



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**

ROY COOPER • Governor

KODY H. KINSLEY • Secretary

MARK PAYNE • Director, Division of Health Service Regulation

September 12, 2022

Elizabeth Scott  
Durham County Community Living Programs, Inc.  
P.O. Box 51159  
Durham, NC 27717

Re: Annual Survey completed September 6, 2022  
3523 Westglen Road, Durham, NC 27705  
MHL # 032-262  
E-mail Address: [ewscott@dcclp.org](mailto:ewscott@dcclp.org); [kstoekl@dcclp.org](mailto:kstoekl@dcclp.org)

Dear Ms. Scott:

Thank you for the cooperation and courtesy extended during the annual survey completed September 6, 2022.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

**Type of Deficiencies Found**

- Tag cited is a standard level deficiency.

**Time Frames for Compliance**

- Standard level deficiency must be **corrected** within 60 days from the exit of the survey, which is November 5, 2022.

**What to include in the Plan of Correction**

- Indicate what measures will be put in place to **correct** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to **prevent** the problem from occurring again.
- Indicate **who will monitor** the situation to ensure it will not occur again.

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603

MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718

[www.ncdhhs.gov/dhsr](http://www.ncdhhs.gov/dhsr) • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER

September 12, 2022  
Westglen Road Group Home  
Durham County Community Living Programs, Inc.

- Indicate **how often** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

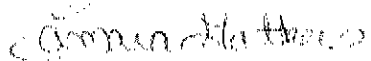
Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section  
NC Division of Health Service Regulation  
2718 Mail Service Center  
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Bryson Brown, Team Leader at (919) 855-3822.

Sincerely,



Tamar Gathers, MSW  
Facility Compliance Consultant I  
Mental Health Licensure & Certification Section

Cc: [DHSR@Alliancebhc.org](mailto:DHSR@Alliancebhc.org)  
Pam Pridgen, Administrative Supervisor