Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1)PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL001-119 | A. BUILDING: _____ B. WING _____ | 07/03/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CURRY'S HAVEN | 2482 ADAMS FARM COURT SNOW CAMP, NC 27349 |

| (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 |
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| V 000 | INITIAL COMMENTS<br><br>An annual survey was completed on July 3, 2025. A deficiency was cited.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living.<br><br>The facility is licensed for 2 and currently has a census of 1. The survey sample consisted of audit of 1 current client. | V 000 | 1. Corrective Measures to Address the Deficiency<br><br>• Policy and Procedure Update:<br><br>Immediate revision of the Medication Administration and Documentation Policy to emphasize accurate, real-time documentation and medication inventory protocols.<br><br>• Staff Re-Training:<br><br>All direct care staff will undergo mandatory retraining within 7 business days on:<br><br>• Proper medication documentation (including time, dose, route, and initials)<br><br>• Verification of medication availability before administration time<br><br>• Medication refusal and missed dose protocols<br><br>• Medication Inventory Protocol:<br><br>A new weekly medication inventory checklist will be implemented to ensure all prescribed medications are in stock and accounted for.<br><br>• Immediate Staff Sign-Off:<br><br>Staff will be required to review and sign off on Medication Administration Records (MARs) daily to verify accuracy. | 7/9/2025<br><br>7/18/2025 |

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| | | | 2. Preventative Measures<br><br>• Pre-fill and Cross-Check:<br><br>All medication administration will be pre-filled in the MAR and verified against the physician's orders. Second staff person will perform a cross-check for accuracy.<br><br>• Pharmacy Coordination:<br><br>Coordination with the pharmacy will be improved to set automated reminders for medication reorders and pickup/delivery follow-up.<br><br>• Error Reporting System:<br><br>A non-punitive error reporting system will be introduced to encourage staff to report near-misses or concerns promptly.<br><br>3. Monitoring and Oversight<br><br>• Responsible Party:<br><br>The Supervisor will be responsible for monitoring compliance with medication administration protocols.<br><br>4. Frequency of Monitoring<br><br>• Daily MAR Audits by the Supervisor.<br><br>• Weekly Inventory Checks conducted by designated staff and reviewed by the Supervisor.<br><br>• Monthly Compliance Review Meetings with leadership to analyze trends, reinforce training, and revise protocols if necessary.<br><br>Conclusion<br><br>These steps are designed to correct current deficiencies and to ensure ongoing compliance with medication administration and documentation standards, enhancing client safety and service quality. | |

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| V 118 | 27G .0209 (C) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(c) Medication administration:<br>(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.<br>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.<br>(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:<br>(A) client's name;<br>(B) name, strength, and quantity of the drug;<br>(C) instructions for administering the drug;<br>(D) date and time the drug is administered; and<br>(E) name or initials of person administering the drug. | V 118 | | | |

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| V 118 | Continued From page 1<br>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.<br><br>This Rule is not met as evidenced by:<br>Based on record review, observation, and interview, the facility failed to: A) Ensure the Medication Administration Record (MAR) was kept current and B) Ensure medication was available according to the physician order for one audited client (#1.) The findings are:<br><br>Review on 7/3/25 of Client #1's record revealed:<br>-Admission date of 1/28/13.<br>-Diagnoses of Attention Deficit Hyperactivity Disorder, Combined Type, Oppositional Defiant Disorder, Moderate Intellectual Developmental Disability, Arthrogryposis, Microcephaly and Hyperacusis.<br>-Physician order dated 5/26/25 for Olanzapine 10 milligrams (mg) (Antisychotic)- Take one tablet at bedtime.<br><br>Observation on 7/3/25 at 10:00 am of Client #1's medications revealed:<br>-Olanzapine 10 mg was not available.<br><br>-Review on 7/3/25 of Client #1's MAR for May 1, 2025 through July 2, 2025 revealed Olanzapine 10 mg was documented as administered on the following dates: -June:<br>-6/25- 6/30. | V 118 | | |

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STATE FORM 6899 V52I11 

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| V 118 | Continued From page 2<br><br>-July:<br>-7/1-7/2.<br><br>Interview on 7/3/25 with the Pharmacist revealed: -Client #1's doctor had not sent in the refills orders for the Olanzapine.<br>-They had tried calling Client #1's physician and sent him a fax, but he never responded back to them.<br>-She was unsure why the facility staff were not informed by the pharmacy.<br><br>Interview on 7/3/25 with Staff #2 revealed:<br>-She administered client's medications.<br>-She was responsible for reviewing medications when they arrived from the pharmacy. -She had received Client #1's bubble pack on 6/13/25 and thought that all of his medications had been packed by the pharmacist.<br>-She was not aware that Client #1's Olanzapine was not available in his bubble pack. -She had started administering Client #1's medications from the new bubble packs on 6/25/25.<br>-She acknowledged that Client #1 did not receive his Olanzapine 10 mg from 6/25/25 to 7/2/25. -She acknowledged Client #1's Olanzapine 10 mg was marked as administered from 6/25/25 to 7/2/25.<br><br>Due to the failure to accurately document medication administration and not having a medication available, it could not be determined when and if Client #1 received his medication as ordered by the physician. | V 118 | | |