

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL0601229	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ DHSR - Mental Health B. WING: _____	(X3) DATE SURVEY COMPLETED  09/19/2018
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  SHEP EL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 14548 HENRY HARRISON STILLWELL DRIVE HUNTERSVILLE, NC 28078 OCT 08 2018 Lic. & Cert. Section
--	--

(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	INITIAL COMMENTS  An annual survey was completed on September 19, 2018. Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Adults With Developmental Disabilities.	V 000 QP	QP obtained updated physicians order for client on 9/20/18.	
V 118	27G .0209 (C) Medication Requirements  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: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (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.	V 118 QA Manager  QA QP  QP	Licensure Provider updated dosage on MAR using the MAR located in home and the EHR.  Conducted review of all clients charts receiving medication to assure the presence of (1) physicians order (2) compared to MARS to assure correct medication/dosage/time correlate to physicians orders.  QA Manager reviewed Medication Administration policy w/ QP for the purpose of acknowledgement of requirements. Renew QP role and responsibility.  QP will review physicians orders and MARS for accuracy + completion	9/21/18  9/21/18  9/21/18

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Sandra Boyd* CEO  
OCT 5, 2018  
TITLE  
(X6) DATE  
STATE FORM 6966 8FK511 If continuation sheet 1 of 3

See Attachments

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL0601229	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  09/19/2018
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  SHEP EL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 14548 HENRY HARRISON STILLWELL DRIVE HUNTERSVILLE, NC 28078
--	---

(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 118	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record review, observation and interview the facility failed to ensure medications were administered to a client on the written order of a person authorized by law to prescribe drugs affecting 1 of 1 client (#1). The findings are:</p> <p>Review on 9/19/18 of client #1's record revealed: -Admission date of 12/2017; -Diagnoses including but not limited to Oppositional Defiant Disorder, Intermittent Explosive Disorder, Attention Deficit Hyperactivity Disorder, Unspecified Adjustment Reaction, other persistent mood [affective] disorders, Post Traumatic Stress Disorder chronic, unspecified convulsions, Altered mental status unspecified, Adjustment Disorder with mixed disturbance of emotions and conduct, Epilepsy, Mild Intellectual Disabilities per treatment plan dated 8/1/18; -No physicians' order present and available for review for client #1's medication Onfi 10mg.</p> <p>Observation on 9/19/18 at approximately 4:10pm of client #1's medications on site revealed: -Onfi 10mg, Label documented dispensed 9-14-18 and instructions to increase to 2 tabs pm then increase to 3 tabs pm in one week;</p> <p>Interview on 9/19/18 with client #1 revealed: -He was aware he took Onfi and aware the doctor had changed the dose, which he was currently taking;</p> <p>Interview on 9/19/18 with the Alternative Family Living (AFL) Provider revealed:</p>	V 118	<p>on a monthly basis.</p> <p>QP + Direct Care Staff (AFL) will update physicians orders as necessary - when a clients medication changes.</p> <p>QP QP will obtain updated physicians orders in a timely manner to assure and assist client w/ medication compliance.</p> <p>QP QP will contact legal Guardian or pharmacy every 6 months to assure medications, dosage and times are current and accurate.</p> <p>QA QA Manager will conduct quarterly reviews of client records/MARS to assure accuracy as it correlates to the physicians orders.</p>	10/1/18 10/1/18 10/1/18

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL060122B	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  09/19/2018
NAME OF PROVIDER OR SUPPLIER  SHEP EL HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1454B HENRY HARRISON STILLWELL DRIVE HUNTERSVILLE, NC 28078		
(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 118	Continued From page 2  -He was aware the doctor changed client #1's Onfi prescription; -He thought he had a copy of the updated prescription however could not locate. -He would call the doctor and get the order for surveyor to review, however the order was never received;	V 118		
V 736	27G .0303(c) Facility and Grounds Maintenance  10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.  This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure the home was maintained in a safe manner for 3 of 3 clients (#1, #2, #3). The findings are:  Observation on 9/19/18 at approximately 4:45pm revealed: - A smoke detector was chirping upstairs.  Interview on 9/19/18 with the Alternative Family Living (AFL) Provider revealed: - "Okay" he would make sure the batteries were changed in the smoke detectors.	V 736	All licensed facilities are monitored/visited by the QP assigned to the home on a monthly visit. The Home was last monitored by the QP on Sept. 9, 2018. All health and safety inspections were completed as a part of the monitoring visit. (See last 3 visits)	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL0601229	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  09/19/2018
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  SHEP EL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 14548 HENRY HARRISON STILLWELL DRIVE HUNTERSVILLE, NC 28078
--	---

(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 19, 2018. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Adults With Developmental Disabilities.</p>	V 000	<p>The smoke detector reportedly starting chirping at the time of the annual survey.</p>	
V 118	<p><b>27G .0209 (C) Medication Requirements</b></p> <p><b>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</b></p> <p>(c) Medication administration:</p> <p>(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.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(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.</p> <p>(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:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p> <p>(D) date and time the drug is administered; and</p> <p>(E) name or initials of person administering the drug.</p> <p>(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.</p>	V 118	<p>To ensure the health and safety of all clients the elements of the home check will be separated from the supervision log and conducted on a separate log.</p> <p>QP will conduct Health and safety check quarterly as a separate review to ensure the safety components are met by the home.</p> <p>QA Manager QP will return form to supervisor for QA review monthly.</p> <p>Licensed facility Provider Licensed home Provider will conduct "self" checks monthly of smoke detector... etc... and attach to monthly paperwork for review by QP.</p>	<p>Oct. 1, 2018</p> <p>Oct. 2018</p> <p>Oct. 2018</p>

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

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL0601229	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  09/19/2018
--	--	---	--

NAME OF PROVIDER OR SUPPLIER  SHEP EL HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 14548 HENRY HARRISON STILLWELL DRIVE HUNTERSVILLE, NC 28078
--	---

(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 118	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record review, observation and Interview the facility failed to ensure medications were administered to a client on the written order of a person authorized by law to prescribe drugs affecting 1 of 1 client (#1). The findings are:</p> <p>Review on 9/19/18 of client #1's record revealed: -Admission date of 12/2017; -Diagnoses including but not limited to Oppositional Defiant Disorder, Intermittent Explosive Disorder, Attention Deficit Hyperactivity Disorder, Unspecified Adjustment Reaction, other persistent mood [affective] disorders, Post Traumatic Stress Disorder chronic, unspecified convulsions, Altered mental status unspecified, Adjustment Disorder with mixed disturbance of emotions and conduct, Epilepsy, Mild Intellectual Disabilities per treatment plan dated 8/1/18; -No physicians' order present and available for review for client #1's medication Onfi 10mg.</p> <p>Observation on 9/19/18 at approximately 4:10pm of client #1's medications on site revealed: -Onfi 10mg, Label documented dispensed 9-14-18 and instructions to increase to 2 tabs pm then increase to 3 tabs pm in one week;</p> <p>Interview on 9/19/18 with client #1 revealed: -He was aware he took Onfi and aware the doctor had changed the dose, which he was currently taking;</p> <p>Interview on 9/19/18 with the Alternative Family Living (AFL) Provider revealed:</p>	<p>V 118 QP</p> <p>QA Manager</p>	<p>QP will make 2 unannounced visits to ensure safety and well being of client per year to include spot check of smoke detector as a QA activity and compliance w/ safety rules.</p> <p>QA will track review of health and safety checks monthly to ensure compliance and record corrective action plans for any deficiencies noted.</p>	<p>10/1/18</p> <p>10/1/18</p>

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL0601229	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  09/19/2018
NAME OF PROVIDER OR SUPPLIER  SHEP EL HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 14548 HENRY HARRISON STILLWELL DRIVE HUNTERSVILLE, NC 28078		
(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 118	Continued From page 2  -He was aware the doctor changed client #1's Onfi prescription; -He thought he had a copy of the updated prescription however could not locate. -He would call the doctor and get the order for surveyor to review, however the order was never received;	V 118		
V 736	27G .0303(c) Facility and Grounds Maintenance  10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.  This Rule is not met as evidenced by: Based on observallon and Interview the facility failed to ensure the home was maintained in a safe manner for 3 of 3 clients (#1, #2, #3). The findings are:  Observation on 9/19/18 at approximately 4:45pm revealed: - A smoke detector was chirping upstairs.  Interview on 9/19/18 with the Alternative Family Living (AFL) Provider revealed: - "Okay" he would make sure the batterles were changed in the smoke detectors.	V 736		

### PRAISING HANDS, LLC CLINICAL SUPERVISION LOG

Date of Supervision: 4/13/18 Duration of Supervision: 30 min.  
 Consumer's Name: [REDACTED] Employee Name: Shep El  
 Type of Service:  Residential Supports  Community Living & Supports  Community Networking  
 Other: \_\_\_\_\_  
 Supervisory Contact:  Telephone  Face-to-Face  Community  Client's Residence

Purpose:

QP to provide ongoing instruction and feedback to habilitative and non-habilitative instructor in order to increase quality training and ensure "Best Practice" in providing services to the Innovations Waiver consumers.

Intervention:

- Discussed goals/progress  Medications checked  Reviewed MAR
- Observed goal completion  Discussed Innovations Waiver  Data documentation
- Checked water temperature  Checked Refrigerator  Smoke/Carbon detectors checked
- Reviewed expenditure reports  Medical updates reviewed  Discussed any concerns/issues
- Discussed Service definition  Their role/responsibility to notify/update QP
- Home neat/clean  Turning in Documents on time  Error correcting issues

Effectiveness:

- Trainer to continue to provide quality instruction and care to consumer.
- Trainer to contact QP with any issues or concerns as needed.
- Trainer to turn in necessary documents/paperwork in a timely manner (On Time)

Supervisor Comments: QP met with trainer and consumer to conduct visitation  
 supervision. Consumer shared w/QP that he continues to be upset  
 that concern will be discussed w/

Signature: [Signature] Date: 4/13/18





# PRAISING HANDS, LLC CLINICAL SUPERVISION LOG

Date of Supervision: 09/10 Duration of Supervision: 30 min.

Consumer's Name: [Redacted] Employee Name: Shel EI

Type of Service:  Residential Supports ( ) Community Living & Supports ( ) Community Networking

Other: \_\_\_\_\_

Supervisory Contact: ( ) Telephone ( ) Face-to-Face ( ) Community  Client's Residence

**Purpose:**

QP to provide ongoing instruction and feedback to habilitative and non-habilitative instructor in order to increase quality training and ensure "Best Practice" in providing services to the Innovations Waiver consumers.

**Intervention:**

- Discussed goals/progress
- Medications checked
- Reviewed MAR
- Observed goal completion
- ( ) Discussed Innovations Waiver
- Data documentation
- Checked water temperature
- Checked Refrigerator
- Smoke/Carbon detectors checked
- ( ) Reviewed expenditure reports
- Medical updates reviewed
- Discussed any concerns/issues
- ( ) Discussed Service definition
- Their role/responsibility to notify/update QP
- Home neat/clean
- Turning in Documents on time
- ( ) Error correcting issues

**Effectiveness:**

- Trainer to continue to provide quality instruction and care to consumer.
- Trainer to contact QP with any issues or concerns as needed.
- Trainer to turn in necessary documents/paperwork in a timely manner (On Time)

Supervisor Comments: QP conducted visitation with trainer & consumer  
QP observed that the home as well as the consumer  
was neat & orderly. Per consumer / trainer consumer  
continues to enjoy residing in the home. Per trainer

Supervisor Signature (QP) Yvonne H. Pugh, QP Date: 09/10

Consumer has to be prompted to complete ADL task. Peer trained consumer continues to maintain contact with family members. Consumer also completes goals (assigned) with redirection. Promoting Trainer also reported that Christian has to be reminded on ways to control anger & to refrain from taking items that do not belong to him.

# PRAISING HANDS, LLC CLINICAL SUPERVISION LOG

Date of Supervision: 9/27/18 Duration of Supervision: 30 min.  
 Consumer's Name: [REDACTED] Employee Name: Shep EI  
 Type of Service:  Residential Supports  Community Living & Supports  Community Networking  
 Other: \_\_\_\_\_  
 Supervisory Contact:  Telephone  Face-to-Face  Community  Client's Residence

Purpose:

QP to provide ongoing instruction and feedback to habilitative and non-habilitative instructor in order to increase quality training and ensure "Best Practice" in providing services to the Innovations Waiver consumers.

Intervention:

- Discussed goals/progress
- Medications checked
- Reviewed MAR
- Observed goal completion
- Discussed Innovations Waiver
- Data documentation
- Checked water temperature
- Checked Refrigerator
- Smoke/Carbon detectors checked
- Reviewed expenditure reports
- Medical updates reviewed
- Discussed any concerns/issues
- Discussed Service definition
- Their role/responsibility to notify/update QP
- Home neat/clean
- Turning in Documents on time
- Error correcting issues

Effectiveness:

- Trainer to continue to provide quality instruction and care to consumer.
- Trainer to contact QP with any issues or concerns as needed.
- Trainer to turn in necessary documents/paperwork in a timely manner (On Time)

Supervisor Comments: QP conducted visitation to assess consumer.  
QP discussed current services/goals with trainer.  
QP reviewed AFL binder, no areas of concern noted. QP  
also reviewed MAR & med. orders for compliance. Per  
trainer consumer has to supervised care to ensure that  
 Supervisor Signature (QP) [Signature] Date: 9/27/18

Additional Supervisor Comments:

He doesn't take anything that doesn't belong to him.  
Per trained consumer needs constant reminders/  
Prompts to complete task and to remain on task to  
Prevent behaviors.

10/5/2018 Oct. 5. 2018 5:26PM

initial

Roundcube Webmail :: CH

No. 5387 P. 14/25

Subject [REDACTED]  
From <nlightner@phllc.org>  
To <laura.wallace@dhhs.nc.gov>  
Date 2018-09-21 05:50

roundcube 

---

• SKMIBT\_C45218092109310.pdf (~1.2 MB)

---

Should you need any additional information re: [REDACTED] please contact me at 980 253 8063.

Thanks,

Nadia Lightner

**Amb Depart Summary**  
**\* Final Report \***



Document Type: Amb Depart Summary  
Document Date: September 12, 2018 14:02 EDT  
Document Status: Auth: (Verified)  
Document Title/Subject: Amb Depart Summary  
Performed By/Author: MORGAN, TAMARA NP on September 12, 2018 14:02 EDT  
Verified By: MORGAN, TAMARA NP on September 12, 2018 14:02 EDT  
Encounter Info: 6426147126, CHS Neurosciences Inst. CLT Epilepsy, CLO - Clinic One Time, 9/12/2018 - 9/12/2018

**\* Final Report \***

**Amb Depart Summary (Verified)**

**Carolinas HealthCare System**  
CHS Neurosciences Inst. CLT Epilepsy  
1437 Scott Ave.  
Charlotte, NC 28203  
Phone: 704-446-1900  
Fax: 704-355-5650

**Patient Visit Summary**

Name: [Redacted] MRN: [Redacted] DOB: [Redacted] Visit Date: 09/12/2018  
Phone: [Redacted] Age: [Redacted] Sex: [Redacted] Primary Care Provider: North Charlotte Peds  
Race: African American Ethnicity: Non-Hispanic Preferred Language: English

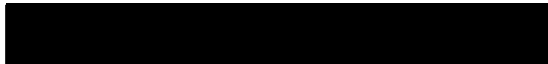
*Carolinas HealthCare System thanks you for allowing us to assist you with your healthcare needs. The following includes patient education materials and some information regarding your health. Information from today's visit may be missing or incomplete if your CHS facility/provider has yet to transition to all aspects of the electronic medical record. Should you have any questions or concerns regarding your visit, please contact your physician or healthcare provider at your convenience.*

Your regular doctor is: SINGH, RAJDEEP MD  
Your doctor or location today: MORGAN, TAMARA NP

Reason for Visit: follow up  
Today's Diagnosis: Epilepsy

Printed by: BLYTHE, ANNE S RN  
Printed on: 9/20/2018 11:59 EDT

**Amb Depart Summary**  
**\* Final Report \***



**Today's Clinical Information:**

**Height:** 68 inch  
**Weight:** 167 lb  
**BMI:** 25.39 kg/m<sup>2</sup>  
**Blood Pressure:** 116 mmHg / 77 mmHg  
**Additional Information:**

**Allergies:**

Lamictal

**Problem List:**

Complex partial seizures; Epilepsy; Seizure

**Recorded at this visit:**

**Procedures**

No Procedures documented

**Medications and Immunizations Administered During This Visit**

No medication administered during this visit

**Orders this Visit**

Ambulatory Communications  
 Follow-Up Appt

**Completed Results:**

**Laboratory and Radiology this Visit (last charted value for your 09/12/2018 visit)**

No Laboratory and Radiology documented

**Medication Information:**

	<b>New Medicines to take at Home</b>	<b>Prescription</b>	<b>Next Dose Due</b>
1.	cloBAZam (cloBAZam 10 mg oral tablet) See Instructions Increase to 2 tablets at night and then increase to 3 tablets at night in 1 week	Sent to CVS/pharmacy #8260 8220 MOUNT HOLLY HUNTERSVILLE RD CHARLOTTE, NC, 2-8216	

**Amb Depart Summary**  
**\* Final Report \***



		Phone: (704)399-5303	
2.	<b>lacosamide (Vimpat 200 mg oral tablet)</b> 1 tablet by mouth two times a day	Sent to CVS/pharmacy #8260 8220 MOUNT HOLLY HUNTERSVILLE RD CHARLOTTE, NC, 2-8216 Phone: (704)399-5303	

	<b>Continue Taking These Medicines at Home</b>	<b>Next Dose Due</b>
1.	<b>ARIPiprazole (ARIPiprazole 5 mg oral tablet)</b> 1 tablet by mouth every day	
2.	<b>LORazepam (Ativan 1 mg oral tablet)</b> 1 tablet by mouth two times a day as needed for anxiety	
3.	<b>polyethylene glycol 3350 (MiraLax)</b> 17 gm by mouth as needed as needed Constipation	
4.	<b>QUETiapine (QUETiapine 200 mg oral tablet, extended release)</b> 2 tablet by mouth each night at bedtime	

\*This is a list of current information in your Carolinas HealthCare System medical record. It may include information from your visits to other offices or medications you told us were prescribed by other physicians or health care providers. If you have questions about this information, please contact your physician or health care provider.

**Scheduled Appointments:**

	Date	Time	Location	Provider	Phone Number

**Follow Up:**

**With:** TAMARA MORGAN  
**Address:** CHS NEURO INST CHT EPILEPSY, 1437 SCOTT AVENUE CHARLOTTE, NC  
**When:**

Printed by: BLYTHE, ANNE S RN  
 Printed on: 9/20/2018 11:59 EDT



**Amb Depart Summary**  
**\* Final Report \***



28203  
(704) 446-1900 Business (2)

**Comments:**

- Continue Vimpat 200 mg every 12 hours
- Increase Onfi from 10 mg (1 tablet) at bedtime to 20 mg (2 tablets) at bedtime tonight; then increase to 30 mg (3 tablets) at bedtime in 1 week
- Keep a seizure calendar
- Return to clinic with Tamara Morgan, NP and Dr. Singh shared visit in 6-8 weeks

**Standard seizure instructions**

- no driving
- no climbing
- no work at heights
- no use of ladders
- no work around open fire or electricity
- no cooking alone
- shower only, no tub baths
- no swimming alone (be accompanied by someone)

*Tamara Morgan, NP*

**Reminders:**

1. If you have questions about your medicines, please ask your Doctor or a pharmacist.
2. Please bring your medicine list and pill bottles to all Doctor visits, medical testing, or if you are going to the ER or Hospital.
3. Remember to discard old medicine lists and update any records.

**Important Phone Numbers:**

- Poison Control Center 1-800-222-1222
- National Suicide Prevention Lifeline 1-800-273-TALK (8255)
- Smoking Cessation 1-800-QUIT NOW (1-800-784-8669)
- National Domestic Violence Hotline 1-800-799-SAFE

**MyCarolinas Patient Online Access**

Carolinas Healthcare System now offers MyCarolinas. It provides secure online access to your health information. With MyCarolinas, you can:

- Send a message to your doctor
- Look at your health record
- View lab and other test results

**Amb Depart Summary**  
**\* Final Report \***



**• Pay your bill**

These are just some of the things you can do with MyCarolinas. It is free, it is secure, it is very easy to use. For more information and to get started, visit <https://my.carolinashealthcare.org> Choose **Enroll Online**.

**Completed Action List:**

- \* Perform by MORGAN , TAMARA NP on September 12, 2018 14:02 EDT
- \* Sign by MORGAN , TAMARA NP on September 12, 2018 14:02 EDT
- \* VERIFY by MORGAN , TAMARA NP on September 12, 2018 14:02 EDT

resend

Subject Fwd: [REDACTED]  
From <nlightner@phllc.org>  
To <laura.wallace@dhhs.nc.gov>  
Date 2018-09-25 04:46



---

• SKMBT\_C45218092109310.pdf (~1.2 MB)

---

Hi, I left you a message re: the attached prescription, that you reported that you never received via the plan of correction. Please give me a call to confirm that you received the prescription. I can be contacted at 980 253 8063.

Thanks,

Nadla H. Lightner, QP

----- Original Message -----

Subject: [REDACTED]  
Date: 2018-09-21 05:50  
From: nlightner@phllc.org  
To: laura.wallace@dhhs.nc.gov

Should you need any additional information re: [REDACTED] please contact me at 980 253 8063.

Thanks,

Nadla Lightner

**Amb Depart Summary**  
**\* Final Report \***



Document Type: Amb Depart Summary  
Document Date: September 12, 2018 14:02 EDT  
Document Status: Auth (Verified)  
Document Title/Subject: Amb Depart Summary  
Performed By/Author: MORGAN, TAMARA NP on September 12, 2018 14:02 EDT  
Verified By: MORGAN, TAMARA NP on September 12, 2018 14:02 EDT  
Encounter info: 6426147126, CHS Neurosciences Inst CLT Epilepsy, CLO - Clinic One Time, 9/12/2018 - 9/12/2018

**\* Final Report \***

**Amb Depart Summary (Verified)**

**Carolinas HealthCare System**  
CHS Neurosciences Inst CLT Epilepsy  
1437 Scott Ave  
Charlotte, NC 28203  
Phone: 704-446-1900  
Fax: 704-355-5650

**Patient Visit Summary**

Name: [REDACTED] MRN: [REDACTED] DOB: [REDACTED] Visit Date: 09/12/2018  
Phone: [REDACTED] Age: [REDACTED] Sex: [REDACTED] Primary Care Provider:  
North Charlotte Peds  
Race: African American Ethnicity: Non-Hispanic Preferred Language:  
English

*Carolinas HealthCare System thanks you for allowing us to assist you with your healthcare needs. The following includes patient education materials and some information regarding your health. Information from today's visit may be missing or incomplete if your CHS facility/provider has yet to transition to all aspects of the electronic medical record. Should you have any questions or concerns regarding your visit, please contact your physician or healthcare provider at your convenience.*

**Your regular doctor is:** SINGH, RAJDEEP MD  
**Your doctor or location today:** MORGAN, TAMARA NP

**Reason for Visit:** follow up  
**Today's Diagnosis:** Epilepsy

Printed by: BLYTHE, ANNE S RN  
Printed on: 9/20/2018 11:59 EDT

**Amb Depart Summary**  
**\* Final Report \***



**Today's Clinical Information:**

**Height:** 68 Inch  
**Weight:** 167 lb  
**BMI:** 25.39 kg/m<sup>2</sup>  
**Blood Pressure:** 116 mmHg / 77 mmHg  
**Additional Information:**

**Allergies:**

Lamictal

**Problem List:**

Complex partial seizures; Epilepsy; Seizure

**Recorded at this visit:**

**Procedures.**

No Procedures documented

**Medications and Immunizations Administered During This Visit**

No medication administered during this visit

**Orders this Visit**

**Ambulatory Communications**  
**Follow-Up Appt**

**Completed Results:**

**Laboratory and Radiology this Visit (last charted value for your 09/12/2018 visit)**

No Laboratory and Radiology documented

**Medication Information:**

	<b>New Medicines to take at Home</b>	<b>Prescription</b>	<b>Next Dose Due.</b>
1.	cloBAZam (cloBAZam 10 mg oral tablet) See Instructions Increase to 2 tablets at night and then increase to 3 tablets at night in 1 week	Sent to CVS/pharmacy #8260 8220 MOUNT HOLLY HUNTERSVILLE RD CHARLOTTE, NC, 2-8216	

Printed by: BLYTHE, ANNE S RN  
Printed on: 9/20/2018 11:59 EDT

**Amb Depart Summary**  
**\* Final Report \***



		Phone: (704)399-5303	
2.	<b>lacosamide (Vimpat 200 mg oral tablet)</b> 1 tablet by mouth two times a day	Sent to CVS/pharmacy #8260 8220 MOUNT HOLLY HUNTERSVILLE RD CHARLOTTE, NC, 2-8216 Phone: (704)399-5303	

<b>Continue Taking These Medicines at Home</b>		<b>Next Dose Due</b>
1.	<b>ARIPiprazole (ARIPiprazole 5 mg oral tablet)</b> 1 tablet by mouth every day	
2.	<b>LORazepam (Ativan 1 mg oral tablet)</b> 1 tablet by mouth two times a day as needed for anxiety	
3.	<b>polyethylene glycol 3350 (MiraLax)</b> 17 gm by mouth as needed as needed Constipation	
4.	<b>QUETiapine (QUETiapine 200 mg oral tablet, extended release)</b> 2 tablet by-mouth each night at bedtime	

\*This is a list of current information in your Carolinas HealthCare System medical record. It may include information from your visits to other offices or medications you told us were prescribed by other physicians or health care providers. If you have questions about this information, please contact your physician or health care provider.

**Scheduled Appointments:**

Date	Time	Location	Provider	Phone Number

**Follow Up:**

**With:** TAMARA MORGAN  
**Address:** CHS NEURO INST CHT EPILEPSY, 1437 SCOTT AVENUE CHARLOTTE, NC  
**When:**

Printed by: BLYTHE, ANNE S RN  
 Printed on: 9/20/2018 11:59 EDT

**Amb. Depart Summary**  
**\* Final Report \***



28203  
(704) 446-1900 Business (2)

**Comments:**

- Continue Vimpat 200 mg every 12 hours
- Increase Onfi from 10 mg (1 tablet) at bedtime to 20 mg (2 tablets) at bedtime tonight, then increase to 30 mg (3 tablets) at bedtime in 1 week
- Keep a seizure calendar
- Return to clinic with Tamara Morgan, NP and Dr. Singh shared visit in 6-8 weeks

**Standard seizure instructions:**

- no driving
- no climbing
- no work at heights
- no use of ladders
- no work around open fire or electricity
- no cooking alone
- shower only, no tub baths
- no swimming alone (be accompanied by someone)

*Tamara Morgan, NP*

**Reminders:**

1. If you have questions about your medicines, please ask your Doctor or a pharmacist.
2. Please bring your medicine list and pill bottles to all Doctor visits, medical testing, or if you are going to the ER or Hospital.
3. Remember to discard old medicine lists and update any records.

**Important Phone Numbers:**

- Poison Control Center 1-800-222-1222**
- National Suicide Prevention Lifeline 1-800-273-TALK (8255)**
- Smoking Cessation 1-800-QUIT NOW (1-800-784-8669)**
- National Domestic Violence Hotline 1-800-799-SAFE**

**MyCarolinas Patient Online Access**

Carolinas Healthcare System now offers MyCarolinas. It provides secure online access to your health information. With MyCarolinas, you can:

- Send a message to your doctor
- Look at your health record
- View lab and other test results

**Amb. Depart Summary**  
**\* Final Report \***



**• Pay your bill**

These are just some of the things you can do with MyCarolinas. It is free. It is secure. It is very easy to use. For more information and to get started, visit <https://my.carolinashealthcare.org> Choose **Enroll Online**.

**Completed Action List:**

- \* Perform by MORGAN , TAMARA NP on September 12, 2018 14:02 EDT
- \* Sign by MORGAN , TAMARA NP on September 12, 2018 14:02 EDT
- \* VERIFY by MORGAN , TAMARA NP on September 12, 2018 14:02 EDT



**DHSR - Mental Health**

**OCT 08 2018**

**Lic. & Cert. Section**

**October 5, 2018**

**TO: NC Department of Health and Human Services**

**Division of Health Service Regulation**

**2718 Mail Service Center**

**Raleigh NC 27699-2718**

**ATTN: Laura S. Wallace**

**Facility Compliance Consultant**

**FROM: Praising Hands, LLC**

**RE: POC For Annual Survey**

**Shep El Home**

**14548 Henry Harrison Stillwell Drive**

**Huntersville NC 28078**

**MHL# 060-1229**

**Enclosed is the Plan of Correction for named home above. Original mailed also.**

**Sandra Lloyd**

**CEO**

