STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         MHL071-025		CORRECTION Í ÍDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED R
		B. WING		04/	06/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ALEXAN	DER HOUSE		W ROAD V, NC 28425			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 000	INITIAL COMMENT	ſS	V 000			
		w up survey was completed aficiencies were cited.				
	category: 10A NCA	sed for the following service C 27G .5600C Supervised h Developmental Disabilities.				
V 108	27G .0202 (F-I) Per	rsonnel Requirements	V 108			
	<ul> <li>(g) Employee training provided and, at a r following:</li> <li>(1) general organiz</li> <li>(2) training on clier delineated in 10A N 10A NCAC 26B;</li> </ul>	cation shall be documented. ing programs shall be minimum, shall consist of the cational orientation; nt rights and confidentiality as ICAC 27C, 27D, 27E, 27F and				
		t the mh/dd/sa needs of the n the treatment/habilitation				
	bloodborne pathoge (h) Except as perm .5602(b) of this Sub member shall be av times when a client member shall be tra	ens. itted under 10a NCAC 27G ochapter, at least one staff vailable in the facility at all is present. That staff ained in basic first aid				
	to provide cardiopu trained in the Heiml techniques such as the American Heart	anagement, currently trained Imonary resuscitation and lich maneuver or other first aid those provided by Red Cross Association or their eving airway obstruction.				
	(i) The governing b implement policies reporting, investigation	oody shall develop and and procedures for identifying ting and controlling infectious diseases of personnel and	,			

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

TITLE

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION		E SURVEY	
AND PLAN OF CORRECTION		RRECTION IDENTIFICATION NUMBER:		A. BUILDING:		PLETED
		MHL071-025	B. WING			R 04/06/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
		2195 NEV	V ROAD			
ALEXAN	DER HOUSE	BURGAW	, NC 28425			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TI	HE APPROPRIATE	DATE
				DEFICIENCY	Y)	
V 108	Continued From pa	ige 1	V 108			
	clients.					
	This Bula is not m	at an avidanced by:				
	This Rule is not me					
	Based on record review and interview, the facility failed to ensure staff were currently trained in					
	cardiopulmonary resuscitation (CPR), Heimlich					
		er first aid techniques provided				
	by the Red Cross, t	he American Heart				
		r equivalence for 2 of 3 staff				
		Qualified Professional (QP),				
	Staff #2). The findi	ngs are:				
	Review of the Staff	#2's personnel file revealed:				
	-Hired 5/20/09.					
		CPR and first aid training				
		eted by an online course. The				
		s not the American Red Cross				
	or the American He	eart Association.				
	Review of the Licer	nsee/QP's personnel file				
	revealed:					
	-Hired 5/20/09.					
		CPR and first aid training				
		eted by an online course. The				
		s not the American Red Cross				
	or the American He	eart Association.				
	Interview on 1/6/19	the Licensee/QP stated:				
		bically staffed with 1 staff on				
		worked the day shift and either				
	Staff #2 or #3 work					
		tion for CPR and first aid				
		and Staff #2, the instructor that				
		ng in the past was unavailable.				
		ook the same CPR and first				
	ald course 3/1/18. ealth Service Regulation	This was a computer based				

Division	of Health Service Re	egulation			FURIN	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL071-025		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING		R 04/06/2018		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ALEXAN	DER HOUSE	2195 NEV BURGAW	V ROAD /, NC 28425			
(X4) ID			ID	PROVIDER'S PLAN OF CORREC		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETE DATE
V 108	Continued From pa	ge 2	V 108			
	did not include any competency validat	aid computer on-line program "hands on" skills training or ion equivalent to American merican Heart Association.				
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	<ul> <li>only be administered order of a person and drugs.</li> <li>(2) Medications shat clients only when an client's physician.</li> <li>(3) Medications, include the client's physician.</li> <li>(3) Medication and all drugs administered only be unlicensed persons pharmacist or other privileged to prepare (4) A Medication Ad all drugs administer current. Medications and the current. Medications are corded immediate MAR is to include the (A) client's name;</li> <li>(B) name, strength,</li> <li>(C) instructions for a (D) date and time the the current is the current of the curr</li></ul>	inistration: ion-prescription drugs shall d to a client on the written uthorized by law to prescribe III be self-administered by uthorized in writing by the luding injections, shall be y licensed persons, or by trained by a registered nurse, legally qualified person and e and administer medications. ministration Record (MAR) of red to each client must be kept s administered shall be ely after administration. The				

Division	of Health Service Re	aulation			FORM	APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		MHL071-025	B. WING			R 06/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ALEXAN	IDER HOUSE		W ROAD V, NC 28425			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETE DATE
V 118	Continued From pa	ge 3	V 118			
Division of h	facility failed to adm ordered by the phys accurate MAR for 1 findings are: Review on 4/6/18 or -27 year old male a -Diagnoses includer Autism, psychotic d specified; post traun history. -Orders dated 10/20 Escitalopram 5 mg (Depression, anxiet -Order/instructions Spray, 1 spray in ea Flonase for 3 days. relief of nasal congr including sinusitis a -Order dated 2/19/1 nostril twice daily. (5 allergy symptoms) Review on 4/6/18 or MAR revealed Esci been documented a 1/1/18 - 1/31/18. Review on 4/6/18 or and April 2018 MAF -Flonase 1 spray in 2/20/18 - 2/22/18. -Flonase was not tr	views and interviews, the inister medications as sician and maintain an of 1 audited clients (#1). The f client #1's record revealed: dmitted 3/18/09. d mild mental retardation, isorder not otherwise matic stress disorder by 5/17 and 2/14/18 for (milligrams), 1½ tablets daily. y) dated 2/19/18 for Afrin Nose ach nostril 20 minutes after (Afrin is used for temporary estion caused by conditions nd allergies) 8 for Flonase 1 spray in each Seasonal and year-round f client #1's January 2018 talopram 5 mg, 1 tablet had as administered daily from f client #1's February, March,				

Division	of Health Service Re	egulation			FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         MHL071-025			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		B. WING		R 06/2018		
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ALEXAN	DER HOUSE	2195 NEV	-			
			, NC 28425			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 4	V 118			
	-Flonase, 1 spray ir and 8 pm, was elec April 2018 MAR and	from 2/23/18 - 3/31/18. In each nostril twice daily, 8 am stronically transcribed to the d had been documented as daily from 4/1/18 - 4/6/18 (8				
	Telephone interview on 4/6/18 the pharmacy staff stated: -They did not receive an order in February 2018 for Afrin nasal spray for client #1. -The electronic order for Flonase dated 2/19/18 read to administer 1 spray in each nostril twice daily.					
	Professional stated -She had changed February 2017 MAF The order in Februa one 5 mg tablet dai administered the co mg, 1½ tablets daily -The monthly MARs pharmacy. The fac orders e-scripted to -She had interprete order/instructions o to be time limited for sprays. -Client #1 received February 2018 and sprays. -She did not realize transcribed electror and was being door -The client was no	the dates and used an old R for the January 2018 MAR. ary 2017 for Escitalopram was ly. She was sure the staff had prrect dose of Escitalopram 5 y in January 2018. s were printed/supplied by the ility did not get copies of the pharmacy.				
	physician in Februa					
Division of H	ealth Service Regulation		·			

If continuation sheet 5 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL071-025		CX1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		B. WING		R 04/06/2018		
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
LEXANI	DER HOUSE		W ROAD W, NC 28425			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 118	Continued From pa	ige 5	V 118			
	medication adminis	o accurately document stration it could not be s received their medications ohysician.				