STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
MHL009-024		B. WING			R 18/2018		
	PROVIDER OR SUPPLIER			DRESS, CITY, S	STATE, ZIP CODE		
CAROLIN	NAS HOME CARE AG	ENCY, INC	BLADENE	BORO, NC 2	8320		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	ΓS		V 000			
	on May 18, 2018. D This facility is licens 10A NCAC 27G .56	w up survey was cor deficiencies were cited sed for the following of 500C Supervised Living demental Disabilities.	ed. category:				
V 114	27G .0207 Emerge	ncy Plans and Suppl	ies	V 114			
	10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use.						
	facility failed to hold disaster, quarterly care: Interview on 5/17/18 stated the facility hard-Day shift: 8 am - 4-Evening shift: 4:00	views and interviews I disaster drills, simu on each shift. The fir 8 the Qualified Profe ad 3 shifts as follows I pm 0 pm - 12 am	lating a ndings ssional				
	-Night shift: 12 am						

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL009-024		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED		
		B. WING			R 18/2018		
	PROVIDER OR SUPPLIER	ENCY, INC	1468 RIC	DRESS, CITY, SHARDSON R			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCY MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 114	Continued From particles of the clients. For the disaster drills review on 5/17/1 stated they could not be cample of finding. For the bomb three discussions about a example of finding. For hurricane drills reports to hear if events would the clients. Interview on 5/17/1 stated they could not be discussions about a example of finding. For the bomb three discussions about a example of finding. For hurricane drills reports to hear if events are all threat she would the to the ditch. She we (emergency medical for the clients are all threat she would go to the not able to leave she hallway.	of disaster drills be vealed: 7 - 12/31/17: Hurric 7 at 3 pm, 10/12/17 6 am The description of the discussions. No documentation is was performed - 3/31/18: Bomb the set of the discussions were held to the discussion was need to the discussio	cane drills 7 at 8 pm, on of the ns were on a . Inreat drills 8 at 8 am, omb threat eld with the eat disaster ent #4 eer drills. sions with 0 "deep" e the e weather ed. threat d not really a bomb ne exit and ole e news to otten out for nd if so, f they were	V 114			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL009-024		B. WING			R 18/2018
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY,	STATE, ZIP CODE		10/2010
CAROLI	NAS HOME CARE AG	FNCY INC	ICHARDSON F ENBORO, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 114	Continued From pa	ge 2	V 114			
		re more of a discussion with d not practice evacuation to				
V 117	27G .0209 (B) Med	ication Requirements	V 117			
	(1) Non-prescription dispensed by a pharmanufacturer's labor visible; (2) Prescription more or obtained as same tamper-resistant parisk of accidental in packaging includes with tamper-resistat unit-of-use package may be adequate; (3) The packaging drug dispensed mu (A) the client's name (B) the prescriber's (C) the current dispersed in the prescriber's (D) clear directions (E) the name, strendate of the prescriber's (F) the name, addripharmacy or dispersed in the prescriber (F) the name, addripharmacy or dispersed in the prescriber (F) the name, addripharmacy or dispersed in the prescriber (F) the name, addripharmacy or dispersed in the prescriber (F) the name, addripharmacy or dispersed in the prescriber (F) the name, addripharmacy or dispersed in the prescriber (F) the name, addripharmacy or dispersed in the prescriber (F) the prescrib	kaging and labeling: In drug containers not Irmacist shall retain the Isl with expiration dates clearl edications, whether purchase ples, shall be dispensed in Ickaging that will minimize th gestion by children. Such plastic or glass bottles/vials Int caps, or in the case of Ied drugs, a zip-lock plastic be label of each prescription st include the following: Ine; In name; Is name; In name; In name; In the case of the case	ed e ag			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
71101211	or contribution	IDENTIFICATION TO THE MIDELLA.	A. BUILDING:			
		MHL009-024	B. WING		05/1	₹ 8/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
CAROLII	NAS HOME CARE AG	ENCY. INC	HARDSON R BORO, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 117	Continued From pa	age 3	V 117			
	Based on observat maintain labels for affecting 1 of 3 clie findings are: Review on 5/17/18 -19 year old male a -Diagnoses include mild intellectual dis dysregulation disord subsequent disord rhinitis. -Order dated 8/2/1 (micrograms) 1 spineeded. -Order dated 5/16/	et as evidenced by: ions, the facility failed to all prescription medications ints audited (client #5). The of client #5's record revealed: admitted 4/14/18. de autism spectrum disorder; ability; disruptive mood ider; attention deficit er (ADHD); child neglect er; hypertension; and allergic 7 for Flonase 50 mcg ray in each nostril daily as 17 Nicotine patch 21 mg daily. 18 for Benzoyl Peroxide 5%,				
	Observations on 5/18/18 at 5:15 pm of client #5's medications on hand revealed: -No label on Flonase 50 mcgNicotine 21 mg patches loose in the medication box. No label with client name, instructions, prescriber, dispense date, or pharmacy information as requiredNo readable label on the Benzoyl Peroxide 5% solution on hand. Interview on 5/18/18 the Qualified Professional					
		rrect situation and inform staff				
V 118	27G .0209 (C) Med	dication Requirements	V 118			
	10A NCAC 27G .02	209 MEDICATION				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL009-024		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED R 05/18/2018	
		B. WING				
	PROVIDER OR SUPPLIER	ENCY INC	DDRESS, CITY, S'CHARDSON ROIBORO, NC 28	DAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	REQUIREMENTS (c) Medication adm (1) Prescription or ronly be administered order of a person a drugs. (2) Medications shaclients only when a client's physician. (3) Medications, incadministered only bunlicensed persons pharmacist or other privileged to prepar (4) A Medication Acall drugs administer current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the (E) name or initials drug. (5) Client requests checks shall be recorded.	inistration: non-prescription drugs shall ed to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by a trained by a registered nurse or legally qualified person and ore and administer medications dministration Record (MAR) of ored to each client must be kep or sadministered shall be ely after administration. The				
	reviews, the facility medications as ord maintain current Ma	et as evidenced by: ions, interviews, and record failed to administer ered by the physician, and ARs affecting 3 of 3 clients #2, #4). The findings are:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
				A. BUILDING:			R	
		MHL009-024	ļ	B. WING			R 18/2018	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
CAROLI	NAS HOME CARE AC	GENCY, INC		HARDSON R BORO, NC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENC Y MUST BE PRECEDED LSC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 118	Continued From pa	age 5		V 118				
	Finding #1: Review on 5/17/18 -19 year old male a -Diagnoses include mild intellectual dis dysregulation disor hyperactive disord subsequent disord rhinitisOrder dated 8/2/1 (micrograms) 1 sp needed. (relief of a symptoms, such as and sneezing) -Order dated 2/5/1 (milligrams) daily. arthritic pain, swell -Order dated 2/5/1 capsules daily on a triglycerides to pre -Order dated 5/16/ -Order dated 4/4/1 tablet QID (4 times conditions i.e. schi -Order dated 8/2/1 4 hours as needed Review on 5/17/18 and May 2018 MAI -Flonase 50 mcg m documented daily -Meloxicam (Mobio been transcribed a 4/14/18 - 4/30/18Omega-3, 1 caps and documented a -Nicotine 14 mg pa documented daily -Seroquel 400 mg	admitted 4/14/18. Red autism spectrum rability; disruptive norder; attention deficient (ADHD); child never; hypertension; and 7 for Flonase 50 moray in each nostril of allergic and non-alles stuffy/runny nose s	n disorder; nood sit eglect nd allergic cg daily as ergic nasal , itching, 5 mg ; reduces ess). I (Lovaza), 4 (lower art attack) 21 mg daily. mg, 1/2 od disorder) 4 mg every iting) ent #5's April nscribed and am had am had am had illy from transcribed il 2018. d and					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED		
MHL009-024			B. WING			R 18/2018	
	PROVIDER OR SUPPLIER	ENCY, INC	1468 RICI	DRESS, CITY, SHARDSON R		·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIE / MUST BE PRECEDE SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From particles of the particle	I documented as a gevery 4 hours a 2018 MAR. I on 5/18/18 the for Flonase was be order for client to 21 mg. order for Seroqual D. sorder for Omeges daily. and 5/18/18 of compared as a documented a series of client #4's Markeded. I anemia (by hist I anemia (by h	pharmacy PRN. t #5's nicotine uel changed to ga 3 was elient #4's disorder, ntellectual cory). n 1 mg TID (3 ciety) con 4 mg arch, April and o be given ented as 12 n, and 8 as given April the May 2018 pharmacy	V 118			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED		
	MHL009-024		B. WING			R 18/2018	
NAME OF	PROVIDER OR SUPPLIER			DRESS, CITY, S	STATE, ZIP CODE		10,2010
CAROLI	NAS HOME CARE AG	ENCY, INC		HARDSON R			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L:		CIENCIES DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From particles and active active and active acti	razepam to be error on the physic and 5/18/18 of admitted 3/26 d schizoaffectivate intellectual by. 18 for Triamcing thin layer BID at a MARs revealed transcribolone Acetonid BID as needed in of 2 weeks of the MAR. 18 the Qualified itted to the factiving) facility over the MAR. 19 with medication of with medication of the Mark of the Mar	yscian's part. orrect the om PRN to a client #2's /13. ve disorder, disability; clone Acetonide as needed for 2 as as needed for client #2's ed: ced for order e 0.1% cream d. (Order was in 3/29/18). ery 8 hours as Professional fility from an AFL whed by the obic in April was 5 mg in April	V 118			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
	MHL009-024		B. WING		05/1	R 8/2018	
NAME OF I	PROVIDER OR SUPPLIER	WIII LOOD-O		DRESS CITY S	STATE, ZIP CODE	1 03/1	0/2010
	NAS HOME CARE AG	FNCY. INC	1468 RICI	HARDSON R	OAD		
				BORO, NC 2			
(X4) ID PREFIX TAG		TEMENT OF DEFICI ' MUST BE PRECED SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 8		V 118			
	medication adminis determined if clients as ordered by the p	s received their					
V 736	27G .0303(c) Facilit	ty and Grounds	Maintenance	V 736			
	10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a safe manner and shall be odor.	REMENTS I its grounds sha e, clean, attracti	all be ve and orderly				
	This Rule is not me Based on observati maintain the facility orderly manner. Th	ons the facility f in a safe, clean	ailed to				
	Observations on 5/3:30 pm revealed: -Hole in hall bathrooder -Paint in hall bathrooder pattern extending a the floorClient #2's room: It the bottom and top Paint worn from paidiscolored in a smuthardware on 2 drawdresser worn awayKitchen: Cabinet six bases a late in blister.	om wall near toi om discolored i pproximately 12 Door was split/o sections. Door inted surfaces o idged appearan vers of nightstar	let. n a splatter n inches from racked along facing split. of door. Walls ce. No nd. Finish on to touch. 3				
	broken slats in blind Paneling by the electrom the wall. 2 fly split and torn. No c sink. -Kitchen floor sticky	ctrical box split swatters hangir over over the lig	and detached ng on wall, both ghts above the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED		
AND FLAN	BERTH TO MONTHONIBET.		_1\.	A. BUILDING:				
		MHL009-024		B. WING			₹ <mark>8/2018</mark>	
NAME OF I	PROVIDER OR SUPPLIER	ST	TREET ADD	DRESS, CITY, S	STATE, ZIP CODE			
CAROLII	NAS HOME CARE AG	ENCY INC		IARDSON R ORO, NC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
V 736	Continued From pa	ige 9		V 736				
	-Front storm door w forcefully slammed.	vould not close unless						
	This deficiency has original cite on 2/22 within 30 days	been cited 3 times since/17 and must be correc	e the eted					

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