PRINTED: 08/06/2018 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA				3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED	
		MHL026-912	B. WING		07/24/2018		
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	<u> </u>		
UNITY UC	UNITY HOME CARE II 1419 MILTON STREET						
UNITTHO	IWE CARE II	SPRING L	AKE, NC 2839	0			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENTS		V 000				
	An annual survey was 2018. A deficiency w	s completed on July 24, as cited.					
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disabilities.					
V 118	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		V 118				

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. Bolebillo.				
		MHL026-912	B. WING		07	//24/2018	
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADD			E, ZIP CODE			
UNITY HO	ME CARE II		LTON STREET				
	T		LAKE, NC 28390				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 118	Continued From page	e 1	V 118				
	maintain an accurate audited (clients #1, # Finding #1 Review on 07/24/18 or revealed: -Admission date of 12-Diagnoses of Severe Disruptive Impulse Contention Deficit Hype Combined Type, Enu Rasmussen's Encept Thoracolumbar Scolie Disorder.	ews, interviews and y failed to administer ed by the physician and MAR for 3 of 3 clients 3, #4). The findings are: of client #1's record 2/10/10. e Mental Retardation, ontrol Conduct Disorder, eractivity Disorder, resis, Encopresis, nalitis, Constipation, osis and History of Seizure					
	Review on 07/24/18 orders revealed: 06/12/18	of client #1's Physician's					
	-Divalproex 500mg(u Take 1 tablet by mour- Chlorpromaz 200mg disorders such as sch manic-depression) Ta morning, 1 tablet by r by mouth at bedtimePropranolol 10mg(us (chest pain), hyperter heart rhythm disorder circulatory conditions the morning, take 1 ta	(used to treat psychotic nizophrenia or ake 1 tablet by mouth every mouth at 1pm and 2 tablets sed to treat tremors, angina nsion (high blood pressure),					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BOILBING.	A. BUILDING:		
		MHL026-912	B. WING		07/24	/2018
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, STA	TE, ZIP CODE		
UNITY HO	ME CARE II		FON STREET LAKE, NC 2839	0		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From page 2		V 118			
	06/12/18 -Discontinue Strattera attention deficit hyper capsule by mouth twick Review on 07/24/18 or revealed the following -Divalproex 500mg-0 07/23/18 at 7:00pmChlorpromaz 200mg 7:00am and 07/23/18 -Propranolol 10mg-07 at 7:00am and 07/23/	a 60mg(used to treat ractivity disorder) Take 1 ce daily. of client #1's July 2018 MAR blanks: 7/12/18, 7/13/18 at 7:00pm, -07/12/18 and 07/13/18 at at 7:00pm.				
	2018 MAR revealed: -Strattera 60mg was to present from 07/01/18 administered even the been discontinuedObservation on 06/24	transcribed and initials were 3-07/24/18 as being bugh the medication had 4/18 of client #1's current ck did not have Strattera				
		client #1 was not familiar ut did state he received his				
	orders revealed: 01/09/18 -Denta 5000 Plus(use	6/22/13. ental Retardation. of client #3's Physician's ed as a medication to After brushing, flossing and				

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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	
MHL026-912		B. WING		07/24/2018		
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, STA	TE, ZIP CODE		
UNITY HO	ME CARE II			n		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 118	PROVIDER OR SUPPLIER STREET ADDRE 1419 MILTON SPRING LAKI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		V 118			

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Interview on 07/24/18 client #4 stated he received

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		MHL026-912	B. WING		07	/24/2018
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	E, ZIP CODE		
UNITY HO	ME CARE II	SPRING	LAKE, NC 28390			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	page :		V 118			
	know why staff were medication that was remedication that was related to the pharmacy had not the changes. -He would address w MAR. -Client #1's Strattera he did not know why initial the medication Due to failure to accurate administration it could	B staff #1 stated he did not continuing to initial for a no longer being given. B the Licensee revealed: on orders were changed and it updated the MAR to reflect with staff the blanks on the had been discontinued and the staff were continuing to was being administered. Brately document medication of not be determined if clients ations as ordered by the				

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