STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		COMPLETED		
						R	
		MHL092-643 B. WING 08/23/2		/2018			
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE			
HEALING	HEALING TRANSITIONS WOMEN'S FACILITY  3304 GLEN ROYAL ROAD						
	OUR MAA DV OTA		GH, NC 27603		101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / 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 000	INITIAL COMMENT	rs	V 000				
	on August 23, 2018 substantiated (Intak Deficiencies were c	eited. sed for a 10A NCAC 27G 320					
V 118	27G .0209 (C) Med	ication Requirements	V 118				
	only be administered order of a person a drugs.  (2) Medications shat clients only when as client's physician.  (3) Medications, include administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Adall 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 ad 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 regally qualified person and administer medication liministration Record (MAR) or red to each client must be ke administered shall be ely after administration. The	e, s. of ept				

Division of Health Service Regulation
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:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL092-643		B. WING			R <b>23/2018</b>
	PROVIDER OR SUPPLIER  G TRANSITIONS WON	MEN'S FACILITY	3304 GLE	DRESS, CITY, S N ROYAL RO , NC 27603	STATE, ZIP CODE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 1		V 118			
	interview, the facilit drugs were adminis person authorized b	et as evidenced by: ion, record review and y failed to assure pres stered on the written or by law to prescribed dr ed clients (#2). The fin	criptions rder of a rugs for				
	maintained by Divis Regulation revealed -An approved V 10A NCAC 27G .02 "[m]edications shall clients only when a client's physician allow clients to self- medications withou	Vaiver dated 05/22/18 209 (c)(2) provides, I be self-administered uthorized in writing by Renewal of the waiver administer their own t authorization in writir no other rules regardi	Rule by the r will				
	of the facility's med -of the three cli #2 had medication -Client #2's me of medicationmos the bottle was unre	20/18 between 5:30-6 ications revealed: ents in the program, o in the medication area dications consisted of st of the written informadable readable informame of medication)	nly client I a bottle ation on rmation				
	Review on 08/20/18 revealed:	3 of client #2's record 8/19/18					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		F	,
		MHL092-643	B. WING			3/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HEALING	G TRANSITIONS WON	MEN'S FACILITY	N ROYAL RO , NC 27603	DAD		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 118	- No physicia - Intake liste Sertaline Hydrochlo and Hydroxyzine 28  During interview on - She was no the bottle was and bottle of medication provided by the clie Other medications they self administer asleep at the time a  During interview on Coordinator reporte - She though medications include physician's orders - Clients adr for a short time (no	of Substance Use an's orders d the following medications oride 100 mg 1/2 tablet daily 5 mg one twice a day 108/20/18, staff #1 reported: ot sure what the medication in could not read the bottle. That in was the only medication ent at the time of admission. could be kept on the client as red. However, client was and she would follow up.	V 118			
V 221	10A NCAC 27G .32 (a) Social setting of residential facility wand other non-med are experiencing pland other drugs. (b) Individuals recestructured residentiof immediate medic physician services (c) The facility is designed.	letoxification is a 24-hour which provides social support lical services to individuals who hysical withdrawal from alcoholeiving this service need a lial setting but are not in need cal services; however, back-up shall be available, if indicated, esigned to assist individuals in cess and to prepare them to	V 221			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE : COMPI		
		MHL092-643	B. WING 08			R / <b>23/2018</b>	
NAME OF I	PROVIDER OR SUPPLIER		I.	STATE, ZIP CODE	1 00/2	5/ <b>2</b> 010	
	G TRANSITIONS WON	3304 GLE	N ROYAL RO				
HEALING	3 TRANSITIONS WON	RALEIGH	, NC 27603		1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 221	Continued From pa	age 3	V 221				
	rehabilitation progra	am.					
	_						
		et as evidenced by: eview and interview, the facility					
		vices were provided to					
	persons only within its licensure scope of						
	practice. The findin	gs are:					
	Review on 08/20/18 of the facility's records revealed: -Facility census between 08/01-20/18 listed a person on "observation" status						
	-No record for the person on observation that						
	indicated, admission date, no identifying						
	During interviews b	etween 08/20/18- 08/23/18,					
	three of three staff	reported:					
		so serves as a shelter for the					
	homeless population after 4 pmshelter is operated in a portion of the building not licensed						
	as social detoxifica	tion.					
		a month, the shelter was					
	was utilized.	I the vacant beds from detox					
	-Often the police	ce brought persons over					
	_	ith the shelter or detox for					
	capacity.						
		08/23/18, the Program					
	Coordinator reporte	ed: policy is not to turn anyone					
	away who is is nee						
	-The person or	n observation was a former					
		on the detoxification side was					
		son on observation was in er for Opioid treatment,					
		red in July and detoxed there					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SL COMPLE  A. BUILDING:		SURVEY PLETED		
		MUI 002 642	B. WING			R
NAME OF		MHL092-643		CTATE ZID CODE	00/2	23/2018
	PROVIDER OR SUPPLIER	3304 GI F	N ROYAL R	STATE, ZIP CODE OAD		
HEALING	G TRANSITIONS WON	MEN'S FACILITY	NC 27603			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 221	Continued From pa	ge 4	V 221			
V 221	prior to coming to the	ge 4 ne shelter. For safety, she was x side of the facility.	V 221			

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