Division of Health Service Regulation

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		
7.1.13 . 2.1.1		1521111110/111011110/11152111	A. BUILDING:			
MHL068-128		B. WING		R 10/10/2018		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
SUNRISE	CASAWORKS AT HORIZ	ONS 211 CONN	OR DRIVE IILL, NC 27599)		
			ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
V 118	completed October 10 #NC00143303) was a complaint (intake #NO substantiated. There This facility is license category: 10A NCAC Therapeutic Homes for Substance Abuse Discontinuous 27G .0209 (C) Medication 10A NCAC 27G .0209 (C) Medication administer (1) Prescription or no only be administered order of a person autidrugs.	coo143391) was were deficiencies cited. d for the following service 27G. 4100 or Individuals with corders and Their Children ation Requirements	V 118			
	client's physician. (3) Medications, incluadministered only by unlicensed persons to pharmacist or other leprivileged to prepare (4) A Medication Admall drugs administered	ding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. Inistration Record (MAR) of the 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.					

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

(X6) DATE TITLE

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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	
		71. 201231110.		R	
		MHL068-128	B. WING		10/10/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
SUNRISE	CASAWORKS AT HORIZ	ONS CONS	IOR DRIVE HILL, NC 27599	1	
(VA) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 118	Continued From page	2 1	V 118		
	checks shall be recor	r medication changes or ded and kept with the MAR pointment or consultation			
		ews, observation and			
		/30/18. I Use Disorder, Severe, ance Use Disorder, Severe			
	medication upon adm -Ibuprofen 800 m mouth 3x daily as nee	ngs - take one tablet by eded: 2mg - dissolve one film			
	Pain Medication Shee -Ibuprofen 800m 9/26/18 a.m.	of Client #1's Non-Narcotic et revealed: g was taken daily until 00mg was administered on			
	revealed the following	of Client #1's New Orders g: dated 9/24/18 for			

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
MHL068-128		B. WING		R 10/10/2018		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SUNRISE	CASAWORKS AT HORIZ	ONS 211 CONN				
CHAPEL F			ILL, NC 27599)		
(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 APPROP DEFICIENCY)	BE COMPLETE	
V 118	Continued From page	2	V 118			
	Gabapentin 300mg - 3x per dayNurse Practition Voltaren Gel - apply tras needed for painPhysician order Cyclobenzaprine (Fle tablet (5mg) by mouth days for muscle spas-Physician order 600mg - take one tabrededPhysician order 500mg - take 2 tablet day as neededPhysician order Prednisone 20mg tab	er order dated 9/26/18 for peach shoulder 4x per day dated 9/27/18 for exeril) 5mg tablet - take one in 3x a day as needed for 15				
	#1's medication reveal available: -Ibuprofen 600 m - Gabapentin 300 -Voltaren Gel -Ibuprofen 600 m -Tylenol 500 mg Interview on 10/10/18 -She reported that she shoulder and neck and -Reported that she go -She believed the injuviolenceReported that she wa -She went to the emet the painAdmitted to taken lbb	orgs Domg g with Client #1 revealed: e had a bulging disc on her eas. bt headaches from the pain. lary was related to domestic				

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _	A. BUILDING:		
		B. WING		R	
		MHL068-128	B. WING		10/10/2018
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STA	TE ZIP CODE	
			, ,		
SUNRISE	CASAWORKS AT HORIZ	ONS CONS	NOR DRIVE		
		CHAPEI	_ HILL, NC 27599	9	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	NATE
				,	
V 118	Continued From page	e 3	V 118		
	. •				
		going to the emergency			
		because staff denied her			
	Ibuprofen on 9/26/18.				
	-Admitted taken a one	e dose on 9/26/18 in the			
	a.m.				
	-Staff told her she wa	s not allowed to take			
	Ibuprofen no more that	an three days per week.			
	-NP wrote an order fo	r Voltaren Gel.			
	-She reported the Vol	taren Gel was offered to her			
	as a substitute for Ibu				
	-She confirmed the new medications mentioned.				
	-She felt better.				
		sical therapy in the upcoming			
	week.	near arerapy in are appearing			
	WOOK.				
	Interview on 10/10/18	Swith the Nurse			
		of Health Services revealed:			
	-She monitored client				
		about client #1's daily			
		fen and the health risk.			
	-Submitted memo to				
		unter pain medication.			
		d that clients may take OTC			
	•	ore than 3 days a week.			
		a need to take medication			
	-	reek, the client must see a			
		o address the pain issue.			
	-The memo was not r	meant to over-ride the			
	physicians order.				
		to see her Primary Care			
	Provider (PCP) to see				
		for Voltaren Gel to help with			
	pain with hope to dec	rease the need for			
	lbuprofen.				
	-Client #1 went to the	emergency room twice for			
	reported pain.				
	-Client #1 was encou	raged to see PCP.			
	-Client #1 reported ha				

room. Division of Health Service Regulation

-Client #1 had a MRI done in the emergency

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _	COMPLETED			
					R	
MHL068-128		B. WING		10/10/2018		
NAME OF D	ROVIDER OR SUPPLIER	ethet an	DRESS, CITY, STA	TE ZID CODE		
NAIVIE OF P	ROVIDER OR SUPPLIER			TE, ZIP GODE		
SUNRISE	CASAWORKS AT HORIZ	ONS.	IOR DRIVE HILL, NC 27599			
			TILE, NC 27598			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 118	Continued From page	e 4	V 118			
	-There were no descr concreteA neurosurgery docton emergency roomThe neurosurgeon dineededDoctor connected CI management departnutClient #1 PCP change to 600mg and the emother pain medication	riptive findings; nothing or saw client #1 at the id not feel like surgery was ient #1 to the pain nent at the hospital. ged Ibuprofen from 800 mg ergency room prescribed is.				
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736			
	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.					
	failed to ensure facilit in a safe and attractiv Observation on 10/10 of the individual apart -Apartment 209-6: -There was cloth furniture item. Difficul apartmentApartment 209-7: -There were cloth-Apartment 209-8:	n and interview, the facility y grounds were maintained re manner. The findings are: 1/18 at 1:30 p.m. to 2:30 p.m. tments revealed: 1/18 ing on the floor and on every				

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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. BUILDING: _	A. BUILDING:			
MHL068-128		B. WING	B. WING		R 10/10/2018		
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
SUNRISE	CASAWORKS AT HORIZ	ONS 211 CON	NOR DRIVE				
		CHAPEL	HILL, NC 27599				
(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 736	Continued From page 5		V 736				
	-Apartment 211-4: - Lamp light in the working; it's the only in the closet door track. -Dry wall on the indicate of the closet door track. -Dry wall on the indicate of the close of the wall in the living in the wall in the living in the close of the wall in the close of the	te living room was not light in that room. In the bedroom was off living room, about 12 inches exposed wired hanging out of coom. Set door in the bedroom was eplaced. Was broken for about one was put in; apartment m. In and peeled in the kitchen. loset door off track.					
	-They had to put in a broken.	B with clients revealed: work order to fix anything about one month to fix the					
	requested broken iter	ns.					
	weeklyClients must submit management staffManagement staff w Property Manager of	inspected the apartment maintenance request to ould submit request to the					

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE, ZIP CODE 211 CONNOR DRIVE CHAPEL III. NC 27899 (X4) ID PREST, STREET ADDRESS. CITY. STATE, ZIP CODE 211 CONNOR DRIVE CHAPEL III. NC 27899 (X4) ID PREST, STATEMENT OF DEFICIENCY STATEMENT OF DEFICIENCES TAG (X5) ID PREST, STATEMENT OF DEFICIENCY STATEMENT OF DEFICIENCES TAG (X5) ID PREST, STATEMENT OF DEFICIENCY STATEMENT OF DEFICIENCES TAG (X6) ID PREST, STATEMENT OF DEFICIENCY STATEMENT OF DE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 211 CONNOR DRIVE CHAPEL HILL, NC 27599 (X4) ID PREFIX TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) V 736 Continued From page 6 Property Manager regarding maintenance issuesConfirmed maintenance took a long time to									
SUNRISE CASAWORKS AT HORIZONS CHAPEL HILL, NC 27599 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 736 Continued From page 6 Property Manager regarding maintenance issuesConfirmed maintenance took a long time to			MHL068-128	B. WING		10	/10/2018		
CHAPEL HILL, NC 27599 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 736 Continued From page 6 Property Manager regarding maintenance issuesConfirmed maintenance took a long time to	NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) V 736 Continued From page 6 Property Manager regarding maintenance issuesConfirmed maintenance took a long time to	SUNRISE	CASAWORKS AT HORIZ	ONS		9				
Property Manager regarding maintenance issuesConfirmed maintenance took a long time to	PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETE		
	V 736	Property Manager reg	parding maintenance issues.	V 736					

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