

PRINTED: 09/07/2018  
FORM APPROVED

## Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL082-079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  R 09/05/2018
NAME OF PROVIDER OR SUPPLIER  MERCY CARE II		STREET ADDRESS, CITY, STATE, ZIP CODE 3950 ROSEBORO HIGHWAY CLINTON, NC 28328			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
V 000	<p>INITIAL COMMENTS</p> <p>An annual and follow-up survey was attempted on September 5, 2018. According to the Administrative Assistant there are no clients being served at the facility. The last time clients were served at the facility was before May 24, 2018.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>Interview on 09/05/18 the Administrative Assistant stated:</p> <ul style="list-style-type: none"> <li>- The Licensee reported the last time a client was at the facility was before 05/24/18.</li> <li>- The agency was actively seeking admissions to the facility.</li> <li>- She was aware to notify the Division of Health Service Regulation when clients were admitted.</li> </ul>	V 000	<p>V600 Mercy Care Inc II does not have any consumers in this facility at this time we will notify DHSR as soon as consumers are admitted to Mercy Care II facility</p>	10/18/18	

Division of Health Service Regulation

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

TITLE

(X6) DATE

STATE FORM

8TQX11

If continuation sheet 1 of 1

DHSR - Mental Health

OCT 23 2018

Lic. &amp; Cert. Section

PRINTED: 09/07/2018  
FORM APPROVED

## Division of Health Service Regulation

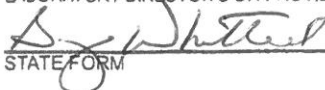
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL082-060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  R 09/05/2018
NAME OF PROVIDER OR SUPPLIER  MERCY CARE I		STREET ADDRESS, CITY, STATE, ZIP CODE 508 ROYAL LANE CLINTON, NC 28328		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS  An annual and follow up survey was completed on September 5, 2018. Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
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 file followed up by appointment or consultation with a physician.	V 118	V118 Review on 9/5/18 of Client #13 September 2018 MAR revealed the following blanks on MAR Vitamin D 9/1/18 through 9/3/18 Cychkonzaprine 9/2/18 and 9/4/18 for mid day dose. Count Record revealed that Staff signed out the above meds at the time they were due but failed to sign the MAR as required. Mercy Care Inc gave staff a warning for not signing the MAR as required and discussed with them the 6 Rights and that Documentation was very important in the administration process.  Continued on page 2	10/3/18

Division of Health Service Regulation

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

TITLE

(X6) DATE


  
STATE FORM

6899

L3UF11

Executive Director/owner

10/18/18

If continuation sheet 1 of 7

PRINTED: 09/07/2018  
FORM APPROVED

## Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL082-060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  R 09/05/2018
NAME OF PROVIDER OR SUPPLIER  MERCY CARE I		STREET ADDRESS, CITY, STATE, ZIP CODE 508 ROYAL LANE CLINTON, NC 28328		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 1</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to administer medications on the written order of a physician and failed to keep the MARs current affecting three of three clients (#1, #2 and #3). The findings are:</p> <p>Finding #1: Review on 09/05/18 of client #1's record revealed: - 64 year old male. - Admission date of 07/30/08. - Diagnoses of Cerebral Palsy, Mild Intellectual Developmental Disability, Seizure Disorder, Diabetes, Hypertension, Hyperlipidemia and Major Depression.</p> <p>Review on 09/05/18 of client #1's signed medication orders dated 03/07/18 revealed: - Vitamin D (treats vitamin D deficiency) 2,000 units - take one capsule daily. - Flexeril (Cyclobenzaprine-muscle relaxer) 5 milligrams (mg) - take one tablet three times daily.</p> <p>Review on 09/05/18 of client #1's September 2018 MAR revealed the following blanks: - Vitamin D - 09/01/18 thru 09/03/18. - Cyclobenzaprine - 09/02/18 and 09/04/18 for the midday dose.</p> <p>Interview on 09/05/18 client #1 stated he received his medication daily as ordered.</p> <p>Finding #2:</p>	V 118	<p>Continued from page 1 V118 Reviewed on 9/5/18 client Revealed the following blanks: Risperidone 9/2/18 Fexofenadine 9/2/18 Metformin 9/2/18 Mercy Care Inc reviewed medication Count Record 10/3/18 The above meds were signed out on Count Record by staff at the appropriate time and date but staff failed to document on MAR as required. Above staff was given a warning and a discussion of the rights and the importance of documentation on the MAR.</p> <p>Reviewed on 9/5/18 client 3's Record revealed signed medication order dated 8/30/18 Nystatin (Antifungal) cream Apply twice a day to rash until gone for 3 days Nystatin powder Apply twice daily during no rash times</p> <p>Continued page 3</p>	

PRINTED: 09/07/2018  
FORM APPROVED

## Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL082-060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  R 09/05/2018
NAME OF PROVIDER OR SUPPLIER  MERCY CARE I		STREET ADDRESS, CITY, STATE, ZIP CODE 508 ROYAL LANE CLINTON, NC 28328		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 2</p> <p>Review on 09/05/18 of client #2's record revealed:</p> <ul style="list-style-type: none"> <li>- 51 year old male.</li> <li>- Admission date of 10/01/08.</li> <li>- Diagnoses of Mental Retardation, Mood Disorder Not Otherwise Specified, Diabetes and Hypothyroidism.</li> </ul> <p>Review on 09/05/18 of client #2's signed medication orders dated 06/19/18 revealed:</p> <ul style="list-style-type: none"> <li>- Risperidone (antipsychotic) 0.5mg take one tablet twice daily.</li> <li>- Fexofenadine (treats allergy symptoms) 180mg - take one tablet daily.</li> <li>- Metformin (treats Diabetes) 500mg - take 2 tablets everyday with a meal.</li> </ul> <p>Review on 09/05/18 of client #2's September 2018 MAR revealed the following blanks:</p> <ul style="list-style-type: none"> <li>- Risperidone - 09/02/18.</li> <li>- Fexofenadine - 09/02/18.</li> <li>- Metformin - 09/02/18.</li> </ul> <p>Interview on 09/05/18 client #2 stated he received his medications as ordered.</p> <p>Finding #3:</p> <p>Review on 09/05/18 of client #3's record revealed:</p> <ul style="list-style-type: none"> <li>- 41 year old female.</li> <li>- Diagnoses of Down's Syndrome, Congenital Heart Disease and Severe Intellectual Developmental Disability.</li> </ul> <p>Review on 09/05/18 of signed medication orders dated 08/30/18 revealed:</p> <ul style="list-style-type: none"> <li>- Nystatin (antifungal) cream - apply twice a day to rash until gone for three days.</li> <li>- Nystatin powder - apply twice daily during no rash times.</li> </ul>	V 118	<p>V118 Cont'd from page 2</p> <p>Review on 9/5/18 client 3's Aug MAR and Sept MAR reviewed Aug no staff initials to indicate the Nystatin cream was applied 28am on 8/31/18. Staff initials to indicate the Nystatin powder was applied on 8/30/18 28pm and 8/31/18 8am &amp; 8pm. Sept. no staff initials the Nystatin cream was administered on 9/1/18 and 9/2/18 8am. Mercy Care Inc gave above staff warning and a discussion of 6 Rights and importance of correct documentation was discussed. Mercy Care Inc Supervising Director and Executive Director will monitor MAR's more closely and staff to make sure they are documenting and documenting correctly on a daily basis. 10/18/18</p>	

PRINTED: 09/07/2018  
FORM APPROVED

## Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL082-060	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  R 09/05/2018
NAME OF PROVIDER OR SUPPLIER  MERCY CARE I		STREET ADDRESS, CITY, STATE, ZIP CODE 508 ROYAL LANE CLINTON, NC 28328		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 3  Review on 09/05/18 of client #8's August 2018 MAR and September 2018 MAR revealed: August 2018 - No staff initials to indicate the Nystatin cream was applied at 8am on 08/31/18. - Staff initials to indicate the Nystatin powder was applied on 08/30/18 at 8pm and 08/31/18 at 8am and 8pm.  September 2018 - No staff initials the Nystatin cream was administered on 09/01/18 and 09/02/18 at 8am.  Interview on 09/05/18 the Facility Director stated: - Staff should document on the MARs when medications were administered. - Staff should follow physician medication orders - Staff may have forgotten to sign the MARs however, clients received their medications as ordered.  Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the physician.	V 118		
V 291	27G .5603 Supervised Living - Operations  10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity. (b) Service Coordination. Coordination shall be maintained between the facility operator and the	V 291	V291 Observation on 9/5/18 Client 1 and client 2 has orders (PRN) for Inhaler to treat or prevent bronchospasm inhaler 2 puffs P.O. 84 hrs as needed for wheezing. Both Client 1 and 2 were in community on that day and their PRN Inhalers were at the group home. Staff failed to send with clients on that day  Continued page 5	9/6/18



PRINTED: 09/07/2018  
FORM APPROVED

## Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL082-0C0	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  R WING: _____	(X3) DATE SURVEY COMPLETED  R 09/05/2018
NAME OF PROVIDER OR SUPPLIER  MERCY CARE I		STREET ADDRESS, CITY, STATE, ZIP CODE 508 ROYAL LANE CLINTON, NC 28328		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 291	<p>Continued From page 4</p> <p>qualified professionals who are responsible for treatment/habilitation or case management.</p> <p>(c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals.</p> <p>(d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain coordination between the facility operator and the professionals who are responsible for the client's treatment, affecting two of three audited clients (#1 and #2). The findings are:</p> <p>Finding #1: Review on 09/05/18 of client #1's record revealed:</p> <ul style="list-style-type: none"> <li>- 64 year old male.</li> <li>- Admission date of 07/30/08.</li> <li>- Diagnoses of Cerebral Palsy, Mild Intellectual Developmental Disability, Seizure Disorder, Diabetes, Hypertension, Hyperlipidemia and Major Depression.</li> </ul>	V 291	<p>V291</p> <p>Cont'd pgs - page 4</p> <p>Mercy Care Inc (all staff) was contacted and discussed the importance of taking Inhalers out in the community when ever each client would be out of the home. Mercy Care Inc has signed in and out Record for Inhalers to be signed out when clients leave and to sign them back in when clients return. Director will monitor on a daily basis to make sure staff are adhering to orders correctly.</p> <p>9/6/18</p>	

PRINTED: 09/07/2018  
FORM APPROVED

## Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL082-060</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/05/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>MERCY CARE I</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>508 ROYAL LANE</b> <b>CLINTON, NC 28328</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 291	<p>Continued From page 5</p> <p>Review on 09/05/18 of client #1's signed physician order dated 03/07/18 revealed ProAir HFA (used to treat or prevent bronchospasm) in hale 2 puffs by mouth every 4 hours as needed for wheezing.</p> <p>Observation on 09/05/18 at approximately 10:30am revealed:</p> <ul style="list-style-type: none"> <li>- Client #1 was attending the day program.</li> <li>- Client #1's medications revealed a ProAir inhaler was stored at the facility.</li> </ul> <p>Finding #2:</p> <p>Review on 09/05/18 of client #2's record revealed:</p> <ul style="list-style-type: none"> <li>- 51 year old male.</li> <li>- Admission date of 10/01/08.</li> <li>- Diagnoses of Mental Retardation, Mood Disorder Not Otherwise Specified, Diabetes and Hypothyroidism.</li> </ul> <p>Review on 09/05/18 of client #2's signed physician orders dated 06/19/18 revealed Albuterol HFA Ventolin (treats or prevents bronchospasms) - inhale 2 puffs every 4 hours as needed for wheezing or shortness of breath.</p> <p>Observation on 09/05/18 at approximately 10:30am revealed:</p> <ul style="list-style-type: none"> <li>- Client #2 was in the community with his 1:1 worker.</li> <li>- Client #2's Ventolin inhaler was stored at the facility with his medications.</li> </ul> <p>Interview on 09/05/18 the Facility Director stated:</p> <ul style="list-style-type: none"> <li>- Client #1 and Client #2 did not take their inhalers with them in the community.</li> <li>- She understood the inhalers needed to be available as needed per physician's orders.</li> </ul>	V 291		

PRINTED: 09/07/2018  
FORM APPROVED

## Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL082-060</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>09/05/2018</b>	
NAME OF PROVIDER OR SUPPLIER  <b>MERCY CARE I</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>508 ROYAL LANE</b> <b>CLINTON, NC 28328</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

Division of Health Service Regulation  
STATE FORM

5895

L3UF11

If continuation sheet 7 of 7





NC DEPARTMENT OF  
HEALTH AND  
HUMAN SERVICES  
Division of Health Service Regulation

ROY COOPER • Governor  
MANDY CCHEN, MD, MPH • Secretary  
MARK PAYNE • Director

# Facsimile Transmittal

Mental Health Licensure & Certification Section

To: SUNJA WANTED Fax: 910-592-4728  
 From: \_\_\_\_\_ Date: 10/11/18  
 Cc: \_\_\_\_\_ Pages: 9 w/ cover  
 RE: Heey Ace Surveys  
☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

## Confidentiality Notice

The document accompanying this teletype contains **Confidential Information** belonging to the sender that is **Legally Privileged**. The information is intended for the use of the individual or entity listed above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, use, or taking of any action or reliance on the teletype **Confidential Information** is strictly prohibited. If you have received this teletype in error, please notify us by telephone immediately to arrange for the return of the original transaction.

### Comments:


NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

### MENTAL HEALTH LICENSURE & CERTIFICATION SECTION

LOCATION: 1800 Unstead Drive, Williams Building, Raleigh, NC 27603  
 MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27609-2718  
 www.ncdhhs.gov/divar • TEL: 919-843-9795 • FAX: 919-715-8078  
 AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER