| T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|---|--|--|--|
| | MHL028-013 | B. WING | | 10// | 26/2018 | |
| ROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, ST | ATE, ZIP CODE | | | |
| E TRAIL FACILITY | | - | | | | |
| (EACH DEFICIENCY | MUST BE PRECEDED BY FULL | ID PREFIX TAG | (EACH CORRECTIVE ACT CROSS-REFERENCED TO | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| INITIAL COMMENT | ſS | V 000 | | | | |
| 26, 2018. The comp (intake #NC001440) This facility is licens category: 10A NCA | blaint was substantiated 61). Deficiencies were cited. sed for the following service C 27G .5600C Supervised | | | | | |
| Ū | · | V 117 | | | | |
| REQUIREMENTS (b) Medication pac (1) Non-prescriptio dispensed by a pha manufacturer's labe visible; (2) Prescription me or obtained as sam tamper-resistant pa risk of accidental in packaging includes with tamper-resistant unit-of-use package may be adequate; (3) The packaging drug dispensed mu (A) the client's nam (B) the prescriber's (C) the current disp (D) clear directions (E) the name, strendate of the prescrib (F) the name, addrendate pharmacy or dispendation | kaging and labeling: In drug containers not Irmacist shall retain the el with expiration dates clearly edications, whether purchased ples, shall be dispensed in Ickaging that will minimize the gestion by children. Such plastic or glass bottles/vials In caps, or in the case of ed drugs, a zip-lock plastic bag label of each prescription st include the following: he; a name; bensing date; for self-administration; ngth, quantity, and expiration ed drug; and ess, and phone number of the nsing location (e.g., mh/dd/sa | | | | | |
| | PROVIDER OR SUPPLIER E TRAIL FACILITY SUMMARY STA (EACH DEFICIENCY REGULATORY OR L. INITIAL COMMENT A complaint survey 26, 2018. The compl (intake #NC001440 This facility is licens category: 10A NCA Living for Adults wit 27G .0209 (B) Med 10A NCAC 27G .02 REQUIREMENTS (b) Medication pac (1) Non-prescription dispensed by a pha manufacturer's laber visible; (2) Prescription me or obtained as sam tamper-resistant par risk of accidental in packaging includes with tamper-resista unit-of-use package may be adequate; (3) The packaging drug dispensed mu (A) the client's nam (B) the prescriber's (C) the current disp (D) clear directions (E) the name, strerd date of the prescrib (F) the name, addred pharmacy or disper- center), and the name | TOF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL028-013 MHL028-013 PROVIDER OR SUPPLIER STREET AD 185 ROAM MANTEO, SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A complaint survey was completed on October 26, 2018. The complaint was substantiated (intake #NC00144061). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G.5600C Supervised Living for Adults with Developmental Disabilities. 27G.0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing | TO E DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING: MHL028-013 B. WING | OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL028-013 B. WING 'ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 'ET RAIL FACILITY 185 ROANOKE TRAIL MANTEO, NC 27954 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREPIX TAG PROVIDER'S PLAN OF (EACH DEFICIENCY MIST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREPIX TAG PROVIDER'S PLAN OF (EACH CORRECTIVE ACL CROSS-REFERENCED TO DEFICIENCY (EACH DEFICIENCY MIST BE PRECIDED BY FULL TAG INITIAL COMMENTS V 000 A complaint survey was completed on October 26, 2018. The complaint was substantiated (intake #NC00144061). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. 27G .0209 (B) Medication Requirements V 117 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription medications, whether purchased or obtained as samples, shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (C) the current dispensing date; (D) cle | TO FOERFICIENCIES (M) PROVIDERSUPPLIERCLAN (A2 MULTIPLE CONSTRUCTION (A3) DATE OF CORRECTION MHL028-013 B. WING 10// RROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE 10// RE TRAIL FACILITY 136 ROAMOKE TRAIL PROVIDER'S PLAN OF CORRECTION IEE TRAIL FACILITY 136 ROAMOKE TRAIL PROVIDER'S PLAN OF CORRECTION IEE TRAIL FACILITY 136 ROAMOKE TRAIL PROVIDER'S PLAN OF CORRECTION IEE TRAIL FACILITY 136 ROAMOKE TRAIL PROVIDER'S PLAN OF CORRECTION IEE TRAIL FACILITY 136 ROAMOKE TRAIL PROVIDER'S PLAN OF CORRECTION IEE TRAIL FACILITY 136 ROAMOKE TRAIL PROVIDER'S PLAN OF CORRECTION IEE TRAIL FACILITY 136 ROAMOKE TRAIL PROVIDER'S PLAN OF CORRECTION IEE TRAIL FACILITY 136 ROAMOKE TRAIL PROVIDER'S PLAN OF CORRECTION IEE TRAIL FACILITY 136 ROAMOKE TRAIL PROVIDER'S PLAN OF CORRECTION INTIAL COMMENTS V 000 V 000 PROVIDER'S PLAN OF CORRECTION INTIAL COMMENTS V 000 V 117 10A NCAC 27G .5000 Supervised PROVIDER'S PLAN OF CORRECTION Intra facture factor of the following service catelegony: 10A NCAC 27G .5000 Supervised V 117 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING: _ | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|---------------------------------|--|-----------------------------------|-------------------------|--|
| | | MHL028-013 | B. WING | | 10/ | 26/2018 | |
| NAME OF I | PROVIDER OR SUPPLIER | | DDRESS, CITY, ST | TATE, ZIP CODE | | | |
| | KE TRAIL FACILITY | 185 ROA | NOKE TRAIL | | | | |
| CANOR | | MANTEO | D, NC 27954 | | | | |
| (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 DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| V 117 | Continued From pa | ge 1 | V 117 | | | | |
| | interviews, the facili medications for adr | et as evidenced by: views, observations and ity failed to ensure that ninistration at the facility were led as required. The findings | | | | | |
| | revealed: - 32 year old male. - Admission date of - Diagnoses of Seve Disability (IDD), Atte | 3 of client #1's record ⁻ 01/01/18. ere Intellectual Developmenta ention Deficit Hyperactivity Ehlers-Danlos Syndrome and | 1 | | | | |
| | physician order date | 3 of client #1's signed ed 10/17/18 revealed: psychotic) 2.5 milligrams - js only. | | | | | |
| | 1:30pm of client #1 - Risperidone 0.5m twice daily. | 26/18 at approximately 's medications revealed: g - take one tablet by mouth e label was "8am only." | | | | | |
| | revealed: - 51 year female. - Admission date of - Diagnoses of Mod | 3 of client #5's record ⁻ 06/02/03. Ierate IDD, Diabetes, Reflux Disease, Vitamin D | | | | | |

STATE FORM

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If continuation sheet 2 of 7

| STATEMEN | of Health Service Re IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|---------------------|---|--------------------------------|--------------------------|
| | | MHL028-013 | B. WING | | 10/ | 26/2018 |
| NAME OF I | PROVIDER OR SUPPLIER | | DRESS, CITY, ST | | 10/ | 20/2010 |
| | | | NOKE TRAIL | | | |
| RUANUr | KE TRAIL FACILITY | MANTEC | , NC 27954 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETI DATE |
| V 117 | Continued From pa | ige 2 | V 117 | | | |
| | Deficiency, Edema Disorder. | and Major Depressive | | | | |
| | physician orders for revealed: - 5-FU/Sal Acid 10% apply to affected ar bandaid. | 8 of client #5's signed r September 2018 MAR % (treats skin conditions) - rea at bedtime and cover with a ent (moistens skin) - apply to daily. | | | | |
| | 12:30pm of client # - 5-FU/Sal Acid 10% directions for use o - Hydrophor ointme | 26/18 at approximately 5's medications revealed: % - not able to read the n the pharmacy label. ent - not able to read the n the pharmacy label. | | | | |
| | | 18 the Registered Nurse tacted the pharmacy to obtain ew labels. | | | | |
| V 118 | 27G .0209 (C) Med | lication Requirements | V 118 | | | |
| | only be administered order of a person a drugs. (2) Medications sha clients only when a client's physician. (3) Medications, inc | 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 | | | | |
| | administered only b unlicensed persons | by licensed persons, or by s trained by a registered nurse, r legally qualified person and | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | CONSTRUCTION | | E SURVEY PLETED | |
|--------------------------|---|--|---------------------------|---|-----------------------------------|-------------------------|--|
| | | MHL028-013 | B. WING | B. WING | | 10/26/2018 | |
| NAME OF F | PROVIDER OR SUPPLIER | | DDRESS, CITY, ST | ATE, ZIP CODE | 1 | | |
| ROANOP | E TRAIL FACILITY | | NOKE TRAIL), NC 27954 | | | | |
| (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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | |
| V 118 | Continued From pa | age 3 | V 118 | | | | |
| | (4) A Medication Ac all drugs administe current. Medication recorded immediate MAR is to include ti (A) client's name; (B) name, strength, (C) instructions for (D) date and time ti (E) name or initials drug. (5) Client requests checks shall be record | re and administer medications. Iministration Record (MAR) of red to each client must be kep is administered shall be ely after administration. The he following: , and quantity of the drug; administering the drug; he drug is administered; and of person administering the for medication changes or corded and kept with the MAR appointment or consultation | | | | | |
| | facility failed to adn written order of a p MARs current affec clients (#1, #2 and Finding #1: Review on 10/26/18 revealed: - 32 year old male. | eviews and interviews, the ninister medications on the hysician and failed to keep the cting three of four audited #6). The findings are: 8 of client #1's record | | | | | |
| | Disability (IDD), Att | f 01/01/18. ere Intellectual Developmental ention Deficit Hyperactivity Ehlers-Danlos Syndrome and | | | | | |
| | | 18 of client #1's signed r September 2018 revealed: | | | | | |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|---------------------------|--|----------------------------------|-------------------------|
| | | MHL028-013 | B. WING | | 10/ | 26/2018 |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| ROANO | KE TRAIL FACILITY | | NOKE TRAIL), NC 27954 | | | |
| (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 T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| V 118 | Continued From pa | ge 4 | V 118 | | | |
| | milligrams (mg) - ta | ergy-treats allergies) 180 ike one tablet daily. npoo - use daily to wash hair. | | | | |
| | | 3 of client #1's September 2018 MARs revealed the mpoo 10/18/18. | | | | |
| | September 2018 - Fexofehadine 09/2 | 28/18 thru 09/30/18. | | | | |
| | | le to participate in interview cations due to diagnosis of | | | | |
| | revealed: - 34 year old male. - Admission date of - Diagnoses of Moo | lerate IDD, Ehlers-Danlos Blind and Gastroesophageal | | | | |
| | for September 2018 | 3 of a signed physician order 3 revealed Pantoprazole ler) 40mg - take one tablet | | | | |
| | | 3 of client #2's October 2018 following blank 10/19/18. | | | | |
| | Interview on 10/26/ his medication ever | 18 client #2 stated he received yday. | 1 | | | |
| | Finding #3: Review on 10/26/18 revealed: | 3 of client #6's record | | | | |

STATE FORM

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | E SURVEY PLETED |
|--------------------------|--|--|---------------------------|--|-----------------------------------|-------------------------|
| | | MHL028-013 | B. WING | | 10/ | 26/2018 |
| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| ROANOI | KE TRAIL FACILITY | | NOKE TRAIL D, NC 27954 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| V 118 | 74 year old male. Admission date of Diagnoses of Moc Peripheral Vascular Disease, Restless I Depressive Disorde Disorder. Review on 10/26/18 physician orders da (prevents bronchos inhale 2 puffs every) Review on 10/26/18 MAR revealed "OH 10/20/18 thru 10/22 Interview on 10/26/ his medications as Interview on 10/26/ - She worked at the and 10/22/18. She was not able Spiriva as ordered. She vas not able Spiriva as ordered. She was not awar medications. Interview on the Re should have placed the blocks for client Interview on 10/26/ stated: | ⁶ 03/02/07. ⁶ Disorder, Mild IDD, ⁷ Disease, ADHD, Parkinson's eg Syndrome, Major ⁸ ar and Generalized Anxiety ⁸ of client #6's signed ⁹ ted 09/01/18 revealed Spiriva ⁹ pasm) 2.5 micrograms - ⁹ morning. ⁸ of client #6's October 2018 (on hold)" in the blocks dated ⁹ 2/18. ¹⁸ client #6 stated he received ordered. ¹⁸ staff #1 stated: ¹⁸ facility on 10/20/18, 10/21/18 ¹⁹ to administer client #6's ¹⁹ r supervisor and was told to cation as on hold. ¹⁰ e of any other missed ¹¹ PLOA (leave of absence" in the stated staff ¹¹ LOA (leave of absence" in the stated Professional | 4 | | | |
| | stated: - Client #6's Spriiva caused the medica - The facility had a | pump would not work which | | | | |

3K6611

If continuation sheet 6 of 7

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|----------------------|---|---|--|-----------------------------------|-------------------------|
| | | MHL028-013 | B. WING | | 10/ | 26/2018 |
| NAME OF F | PROVIDER OR SUPPLIER | | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| ROANOP | E TRAIL FACILITY | | NOKE TRAIL D, NC 27954 | | | |
| (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 DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| V 118 | Continued From pa | ge 6 | V 118 | | | |
| | pharmacy on 10/22 | /18. | | | | |
| | | tration it could not be s received their medications hysician. | | | | |
| | | | | | | |
| | | | | | | |