Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		MHL067168	B. WING		11/0	1/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EDNA'S	PLACE		OLK CIRCLI IVILLE, NC			
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	An annual survey was completed on November 1, 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 114	V 114 27G .0207 Emergency Plans and Supplies		V 114			
	10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES  (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority.  (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.  (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies.  (d) Each facility shall have basic first aid supplies accessible for use.					
	failed to ensure dis- and repeated on ea During interview on Professional #2 sta three shifts:	view and interview, the facility aster drills were held quarterly ach shift. The findings are:  10/31/18 Qualified ted the facility operated with om, 2nd 3:00 pm - 11:00 pm,				

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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:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
711101 12/111	OF CONTROL	BENTH TO/THON NOMBER.	A. BUILDING:		CONI	LLILD
		MHL067168	B. WING		11/0	1/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EDNA'S	PLACE		OLK CIRCLI IVILLE, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 114	4 Continued From page 1		V 114			
	Review on 10/31/18 documentation reve drill for the second (January - March) of	3 of the facility's disaster drill caled no documented disaster shift during the first quarter of 2018 or for the 3rd shift parter (October - December) of				
	During interview on 10/31/18 Qualified Professional #2 stated drills at the facility had not always been completed as required. She could not find documentation of any drills conducted between December 2017 and February 2018. The Licensee implemented a new system to ensure the completion of drills on a set schedule.					
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 a client's physician.  (3) Medications, included a drugs 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;	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, a legally qualified person and a and administer medications. Iministration Record (MAR) of a de to each client must be kept a sadministered shall be ally after administration. The				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL067168	B. WING		11/01/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
EDNA'S	PLACE		OLK CIRCLI IVILLE, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	(C) instructions for (D) date and time the (E) name or initials drug. (5) Client requests checks shall be recommended.	administering the drug; ne drug is administered; and of person administering the for medication changes or orded and kept with the MAR appointment or consultation	V 118			
	facility failed admin by a physician for 2 The findings are:  -Review on 10/31/1 revealed: - 46 year old female 7/27/15 Diagnoses include undifferentiated, Mo Intellectual/Develop Disorder FL-2 signed by the Inderal (used to treangina) 10 mg one Depakote (anti-con 500 mg three tables (anti-convulsant) 50 Zyprexa (anti-psychablet every evening (anti-epileptic) 64.8 Seroquel (anti-psychablet)	views and interviews, the ister medications as ordered of 3 audited clients (#1, #3).  8 of client #1's record admitted to the facility admitted to the facility and Seizure amental Disability, and Seizure appropriate physician 6/14/18 included at high blood pressure and tablet three times daily, vulsant and mood stabilizer) at bedtime, Keppra and tablet three times daily, vulsant and mood stabilizer) at bedtime, Keppra and tablet at bedtime, shotic) 20 milligrams (mg) one g, Phenobarbital and tablet every a (used to treat depression)				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	- <u></u>	COMP	LETED
		MHL067168	B. WING		11/0	1/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
TW WILL OF T	NOVIDEN ON OUT FEIEN		OLK CIRCLI			
EDNA'S	PLACE		OLK CIRCLI IVILLE, NC			
			1			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
V 118	Continued From pa	ge 3	V 118			
		B of client #1's MAR for				
	September 2018 re	nderal to be administered at				
	8:00 am, 3:00 pm a					
		Depakote, Keppra, Zyprexa,				
		oquel and Celexa to be				
	administered at 8:0					
		e staff initial boxes to indicate				
	Inderal, Depakote,	Keppra, Zyprexa,				
		oquel and Celexa at 8:00 pm				
	on 9/14/18.					
		of the MAR included "Charting				
		not given indicate reason in				
	Nurse's Medication					
		on the reverse side of the				
		ated 9/14/8 and signed by				
		nal (QP) #1 "Medications NOT individual was in hotel due to				
		irricane Florence - Incident				
	Report completed."					
	report completed.					
	During interview on	10/31/18 client #1 stated the				
		a hotel in Charlotte for the				
	, .	her medications every day				
	and had not missed	d any doses.				
		3 of "DHHS (Department of				
		Services) Incident and Death				
		QP #2 9/26/18 revealed:				
		9/14/18 Time of Incident: 9				
	pm."	ac incident At Opm				
		ne incident At 9pm, to administer [client #1] meds				
	•	staying at the hotel in				
		datory evacuation for				
		. Another provider (Directors				
		ou don't have to go in the girls				
		lready had meds and				
	showers; 8pm med					
		se Describe the cause of				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		MHL067168	B. WING	<del></del>	11/0	1/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDNA'S	PLACE		OLK CIRCLI			
			IVILLE, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From page 4		V 118			
	Florence confusion miscommunication.  - "Describe how this prevented in the fut measures that have. Regular dosing respoke to staff regar assignments."  Review on 10/31/18 revealed:  - 48 year old male and the communication of the communica	s type of incident may be the and any corrective to been or will be put in place				
	8/23/18 for Allegra (antihistamine) 180 mg one tablet daily, and dated 5/30/18 for Banophen (antihistamine) 25 mg one tablet twice daily until resolved.  Review on 10/31/18 of client #3's MAR for October 2018 revealed:  - Transcriptions for Flonase, Allegra, and					
	Flonase was admin 10/6/18 - 10/7/18, of medication" was had of the MAR. - A "D" written in the Allegra was adminis 10/6/18 - 10/8/18, a	e staff initial boxes to indicate histered 10/1/18 - 10/4/18, or 10/10/18 - 10/16/18; "out of andwritten on the reverse side e staff initial boxes to indicate stered 10/1/18 - 10/4/18, and 10/10/18; "out of andwritten on the reverse side andwritten on the reverse side				
	-A "D" written in the	staff initial boxes to indicate ninistered during the month of of medication" was				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL067168	B. WING		11/0	1/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDNA'S	PLACE		OLK CIRCLI IVILLE, NC			
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	nge 5	V 118			
	- The reverse side	reverse side of the MAR . of the MAR included "Charting g not given indicate reason in Notes."				
	Client #3 did not give any meaningful responses during attempted interview.					
	During interview on 10/31/18 QP #2 stated the entire community was under mandatory evacuation during a recent hurricane. The clients were evacuated to a hotel in Charlotte, approximately 4 ½ hours away. Client #1 missed her 8:00 pm medications on 9/14/18 due to a miscommunication between staff while at the hotel. She learned of the missed medications when the clients returned to the facility approximately one week later. She completed a level 1 incident report but did not notify the doctor or pharmacist of the missed medications because of the amount of time between the missed doses and the clients' return to the facility. Client #3 did not seem to suffer any adverse effects from missing her medications.					
	was responsible for accuracy and comp meidcations had be but the staff failed the MARs at the time the administered. Omi medication errors, she would complete notify the physician	a 11/1/18 QP #1 stated she or checking the MARs for coletion. She felt sure the een administered as ordered, to document thier initials on the emedications were ssions of medications were a level 1 incident report and or pharmacist.				
	medication adminis	stration it could not be s received their medications				

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DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		MHL067168	B. WING		11/01/2018	
		WITIL007 100			11/0	1/2010
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	131 SUF			₫		
EDNA'S	PLACE	JACKSON	NVILLE, NC	28546		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N.	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEFICIENCY)		
V 120	27G 0209 (F) Med	ication Requirements	V 120			
	27 0 .0200 (L) Wida	iodiion requiremente				
	10A NCAC 27G .02	209 MEDICATION				
	REQUIREMENTS					
	(e) Medication Stor	age:				
	(1) All medication s					
	(A) in a securely loo	cked cabinet in a clean,				
		ted room between 59 degrees				
	and 86 degrees Fal	hrenheit;				
	(B) in a refrigerator, if required, between 36					
	degrees and 46 degrees Fahrenheit. If the					
	refrigerator is used	for food items, medications				
		eparate, locked compartment				
	or container;					
	(C) separately for e					
		xternal and internal use;				
	. ,	nner if approved by a physician				
	for a client to self-m					
		t maintains stocks of				
		es shall be currently				
		e North Carolina Controlled				
		S. 90, Article 5, including any				
	subsequent amend	ments.				
	This Rule is not me	et as evidenced by:				
		views, observations and				
		· · · · · · · · · · · · · · · · · · ·				
		ty failed to store medications in				
		abinet for 1 of 3 audited tely for external				
		ed clients (#2, #3) and				
		client for 3 of 3 audited clients				
	(#1, #2, #3) and . T					
	(" 1, "Z, "O) and . 1	The infamige are.				
	Finding #1:					
		3 of client #2's record				
	revealed:					
		admitted to the facility 1/19/13.				
		ed Autistic Disorder, Moderate				

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BUILDING:			
	MHL067168	B. WING		11/0	1/2018
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDNA'S PLACE		OLK CIRCLE NVILLE, NC			
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES BT BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
problems), Colace, Clar Melatonin (promotes sle (treats depression, anxious obsessive-compulsive of (laxative), Inderal, and E and mood stabilizer); da shampoo (treats fungal Ketoconazole cream (ar - Signed physician's ord antacid, antihistamine, I triple antibiotic ointment as needed basis.  Observation of client #2 at approximately 2:30 prover the counter topical unsecured plastic bin or drawers:  - Germ Shield, an antim on minor cuts, scrapes, Hydrocortisone Cream redness, itching and disconditions.  - Gold Bond with Lidoca temporary relief of pain burns, cuts, scrapes, insirritations.  - Scalpicin, used to treat scaly, itchy skin caused eczema and keratosis.  - Gold Bond Anti-Itch Cr	ed 2/8/18 for Ativan e5/18 for Vitamin D3 ency); dated 8/2/18 for ph cholesterol); dated treats urinary and bladder ritin (antihistamine), eep), Zyprexa; Paxil ety disorders, and disorder), Miralax Depakene (anticonvulsant eted 9/18/17 for Nizoral infections), and nti-fungal). Hers for over the counter laxative, pain reliever, et to be administered on an edications in an open, en top of client #2's chest of the nicrobial wound gel for use burns, and skin irritations. In, a topical used to treat ecomfort of skin et and itching due to minor sect bites, and minor skin et and prevent dry, rough, and skin irritations eream, used to treat pain rourns and skin irritations.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL067168	B. WING		11/0	1/2018
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
EDNA'S PLACE			OLK CIRCLI IVILLE, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 120	appeared to be unumerously observation at 2:45 medications on har cream stored in click his oral medications.  During interview on #2's parents purchar medications for him.  Review on 10/31/18 revealed:  - 48 year old male a - Diagnoses include type, Dementia due - Signed physician's Prilosec (treats hear Flovent HfA (treats Linzess (treats irritate constipation); dated 7 (relieves dry skin); (prevents asthma and Allegra (antihistamidated 9/26/18 for Lingeneralized anxiety (anti-tremor), Cloza and Lithobid (treats - Signed physician's antacid, antihistamid triple antibiotic ointras needed basis.  Observation at 2:00	counter medications used.  5 pm on 1/31/18 of client #2's and revealed Ketoconazole ent #2's medication box with s.  10/31/18 staff #1 stated client ased the over the counter n.  3 of client #3's record admitted to the facility 8/22/18. Sed Schizophrenia, paranoid a to anoxia. Se orders dated 1/31/18 for arthurn); dated 3/26/18 for asthma); dated 4/9/18 for asthma); dated 4/9/18 for asthma); dated 4/9/18 for asthma); dated 8/6/18 for Flonase	V 120			
	stored in client #3's medications.	medication box with his oral				

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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		
			A. BOILDING.			
		MHL067168	B. WING		11/0	1/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EDNA'S	PLACE		OLK CIRCLI NVILLE, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 120	Continued From page 9		V 120			
	revealed: - 46 year old female 7/27/15 Diagnoses include undifferentiated, Mo Intellectual/Develop Disorder Signed physician's Norvasc (treats hig Colace (laxative), Z pressure); dated 7/ (anticonvulsant and (anticonvulsant), ar (anti-epileptic); date (antipsychotic), Indepressure and angin and Celexa (used to - Signed physician's the counter antacid reliever, triple antib	omental Disability, and Seizure s orders dated 7/17/18 for h blood pressure and angina), destril (treats high blood 26/18 for Depakote I mood stabilizer), Keppra				
	10/31/18 at approxiplastic box contained Depakene Syrup 25 take 20 mls twice of for administration to unopened bottles of liquid medications is (antacid and laxative (anti-diarrheal), and labeled by the phareach client in the face	d cough syrup, individually macy for administration to incility (#1, #2, and #3).				
		roximately 2:30 pm on lity's medication closet				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL067168	B. WING		11/0	1/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE	-	
EDNA'S	PLACE		OLK CIRCLI			
			IVILLE, NC			
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 120	Continued From pa	ge 10	V 120			
	revealed a sign taped on the inside of the door specified topical medications were to be stored separately from oral medications.					
	During interview on 10/31/18 Qualified Professional #1 stated: - Client #2's mother purchased the over the counter creams and gave them to the client The box containing the unopened liquid medications was the facility's "overflow" supply and contained medications for each of the clients She didn't realize the topical meds were stored with the orals; she didn't realize they shouldn't be stored together.  During interview on 11/1/18 Qualified Professional #2 stated they would separate the medications by					
V 121	client and type (topi 27G .0209 (F) Medi	cation Requirements	V 121			
	governing body or of for obtaining a review regimen at least even shall be to be performant physician. The on-stree client's physician the review when med (2) The findings of the street of the stree	w: ives psychotropic drugs, the operator shall be responsible ew of each client's drug ery six months. The review rmed by a pharmacist or ite manager shall assure that in is informed of the results of edical intervention is indicated, the drug regimen review shall client record along with				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LEIED
		MHL067168	B. WING		11/01/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			OLK CIRCLI			
EDNA'S	PLACE		VILLE, NC			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				,		
V 121	Continued From pa	ge 11	V 121			
	This Rule is not me	et as evidenced by:				
		views and interviews, the				
	facility failed to obta	ain drug regimen reviews for 2				
		(#2 and #3) who received				
	psychotropic drugs.	The findings are:				
	Review on 10/31/18	3 of client #2's record				
	revealed:	of cheff #23 record				
		admitted to the facility 1/19/13.				
		ed Autistic Disorder, Moderate				
	Intellectual/Develop	mental Disability,				
	pre-diabetes.					
		s orders dated 9/11/18 for				
		notic) 15 milligrams (mg) one				
		aily, Paxil (treats depression, and obsessive-compulsive				
		e tablet twice daily, and				
	,	vulsant and mood stabilizer)				
		l) 20 ml twice daily; and dated				
		nti-anxiety) 2 mg one tablet				
		to dental appointments.				
		ew signed by the pharmacist				
	and dated 12/14/17					
		of subsequent drug regimen				
	Teviews by the phys	sician or pharmacist.				
	Review on 10/31/18	3 of client #2's MARs for				
		018 revealed transcriptions for				
	Zyprexa, Paxil, Dep	pakene and Ativan with staff				
	initials to indicate a					
	medications as orde	ered.				
	Review on 10/31/19	3 of client #3's record				
	revealed:	or oliciti #0 3 record				
		admitted to the facility 8/22/18.				
		ed Schizophrenia, paranoid				
	type, Dementia due					
		s orders dated 1/31/18 for				
		(treats depression and				
	generalized anxiety	disorder) 20 mg one tablet at				

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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	
		MHL067168	B. WING		11/0	1/2018
NAME OF PROVIDER OR SUPPLIER STREET ADD		DRESS, CITY, STATE, ZIP CODE				
EDNA'S	PLACE		OLK CIRCLI IVILLE, NC			
(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 SHOUL) CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE COMPLETE	
V 121	bedtime, Clozaril (anti-psychotic)100 mg one tablet every morning, four tablets at bedtime, Depakote (anti-convulsant and mood stabilizer) 500 mg two tablets at bedtime, and Lithobid (treats bipolar disorder) 300 mg one tablet twice daily with food.  - Drug regimen review signed by the pharmacist and dated 12/14/17.  - No documentation of subsequent drug regimen reviews by the physician or pharmacist.  Review on 10/31/18 of client #3's MARs for August - October 2018 revealed transcriptions for Lexapro, Clozaril, Depakote and Lithobid with staff initials to indicate administration of the medications as ordered.		V 121			
	#2 stated the Licens the beginning of the reviews had not bee would request the n	11/1/18 Qualified Professional see changed pharmacies at a year and the drug regimen en done since December. She sew pharmacy to conduct drug ery six months as required.				

Division of Health Service Regulation STATE FORM