Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
				R		₹	
		MHL019-021	B. WING		11/3	0/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
PERKINS	PERKINS PLACE 400 CAROLINA AVENUE SILER CITY, NC 27344						
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	COMPLETE DATE	
V 000	INITIAL COMMENT	-S	V 000				
		w-up survey was completed 018. Deficiencies were cited.					
	category:	sed for the following service					
	Adults with Develop	00C Supervised Living for omental Disabilities.					
V 114	27G .0207 Emerger	ncy 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.						
	shall be held at least repeated for each sunder conditions that	r drills in a 24-hour facility st quarterly and shall be hift. Drills shall be conducted at simulate fire emergencies. Ill have basic first aid supplies					
	This Dule is not meet	at an oxidenced by					
	failed to assure that	and record review, the facility the facility of the facility of the facility of the facility were of the facility on each shift. The findings					
	disaster logs from 0 2018 revealed the f	of the facilities fire and October 2017 through October ollowing information; vere conducted on first shift.					

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
			A. BUILDING.		R		
		MHL019-021	B. WING			0/2018	
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, S	STATE, ZIP CODE			
PERKINS	S PLACE		LINA AVEN				
		SILER CIT	Y, NC 2734	4		T	
(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 APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 114	Continued From pa	ge 1	V 114				
	shift Only 1 fire drill wa Only 2 disaster di second shift Only 1 disaster di shift. During interview on Director confirmed This deficiency con	vere conducted on second as conducted on third shift. rills were conducted on rill was conducted on third 11/30/18 the Executive the above information.					
V 118	and must be correct 27G .0209 (C) Med	ication Requirements	V 118				
	only be administered order of a person a drugs. (2) Medications shat clients only when at client's physician. (3) Medications, included administered only builties only builties only builties only builties on their 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,	inistration: non-prescription drugs shall d 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 y licensed persons, or by trained by a registered nurse, legally qualified person and e and administer medications. Ininistration Record (MAR) of led to each client must be kept administered shall be ely after administration. The					

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	o. oo2011011		A. BUILDING:			
		MHL019-021	B. WING		11/3	0/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PERKINS	S PLACE		DLINA AVEN			
	011111111111111111111111111111111111111		ΓY, NC 2734 Τ		011	
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	Continued From pa	ige 2	V 118			
	(D) date and time the (E) name or initials drug.(5) Client requests checks shall be recommended.	ne drug is administered; and of person administering the for medication changes or corded and kept with the MAR appointment or consultation				
	failed to assure that administered on the	et as evidenced by: and record review, the facility t all medications were written order of a Physician ited clients (#1). The findings				
	the following inform Admitted to the fa Diagnoses includ Disability, Deaf, Typ Syndrome, Progres Hypertension, Asth Apnea A Physician's ord less than 70, give 4 blood sugar in 15 m	acility on 9/16/16. le Intellectual Developmental pe I Diabetes, Ushers				
		B of Client #1's September, nber MARs revealed the on;				
	September 2018 Blood sugars range Instances where Cl	ed from 33 to 436.				

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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:		COMPLETED				
		B. WING		F				
		MHL019-021	B. WING		11/30/2018			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE				
10 101	NOVIDEN ON OUT FEILIN							
PERKIN:	S PLACE		OLINA AVEN					
		SILER CI	TY, NC 2734	4				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(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 APPRO DEFICIENCY)	PRIAIE	DATE		
				BEI IOIEROT)				
V 118	Continued From pa	ige 3	V 118					
	•							
		se tablets for blood sugar						
	readings under 70:							
	9/1/18 - 30 minut	es before lunch =						
	40@noon/43 (no tir	ne						
	recorded)/104@12:	:20/164@12:50 (consecutive						
	blood sugar reading	gs/times of readings						
	recorded).	-						
	9/15/18 - 1-2 hou	rs after breakfast = 27/37/70						
	(consecutive readings, no times indicated) 9/15/18 - 30 minutes before lunch = 41 9/19/18 - 30 minutes before dinner = 50/60 (consecutive readings, no times indicated) 9/22/18 - 30 minutes before dinner = 67. September MAR - Glucose tablet(s) signed off on 9/1/18 at 12:25 pm (no amount of Glucose tablet(s) documented).							
	tablet(s) documented).							
	October 2018 (No.)	Glucose tablets signed of on						
	the MAR during this							
	Blood sugars range							
		ient #1 should have been						
		ose tablets for blood sugar						
	readings under 70:	se tablets for blood sugar						
	10/9/18 - Bedtime	2 - 50						
	10/10/18 - 2:30 p							
	10/10/18 - Bedtin							
		nutes before dinner = 59.						
		nutes before dinner = 65.						
		signed of on the MAR during						
	this month.							
	Navanska a 0040							
	November 2018	- I france 00 to 440						
	Blood sugars range							
		ient #1 should have been						
	administered Glucose tablets for blood sugar							
	readings under 70:							
		nutes before breakfast = 63.						
		urs after breakfast = 65.						
	11/13/18 - 2:30 p							
	11/24/18 - 2:30 p	m - 3:00 pm = 32.						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL019-021	B. WING		F 11/3	R 60/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
PERKINS PLACE			DLINA AVENU TY, NC 2734				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
V 118	11/24/18 - 1-2 ho 11/24/18 - Bedtim readings, no times in 11/26/18 - 30 min 35/28/40/102 (consindicated). November MAR - 02 11/24/18 at 3:00 pm tablet(s) document During interview on overseeing Client # above information as signing off the Glucthe MARs.	outes before dinner = 59. urs after dinner = 55. ne = 57/64/171 (consecutive indicated). utes before breakfast = ecutive readings, no times Glucose tablet(s) signed off on in (no amount of Glucose	V 118				

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