Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
74101 1244	or contraction	IDENTIFICATION TO A TOTAL OF THE PARTY.	A. BUILDING:		J COMIT EL	125
		MHL0601238	B. WING		12/18	3/2018
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE THO	MPSON HOME	1509 BRA				
	CLIMMADY CT		TTE, NC 28214	DROWDEDIC DI AN OF CORDECTIO	N	
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	An annual survey was deficiency was cited.	s completed on 12/18/18. A				
	category: 10A NCAC	d for the following service 27G .5600F Alternative viduals with Developmental				
V 118	27G .0209 (C) Medica	ation Requirements	V 118			
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 administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR						

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL0601238	B. WING		12/1	8/2018	
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
THE THOM	MPSON HOME	1509 BRAY CHARLOT	DRIVE TE, NC 28214				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 118	Continued From page with a physician.	÷ 1	V 118				
	interviews, the facility medications were disc order and the MAR ha	iew, observations and failed to ensure continued per physician's ad instructions for dications affecting 1 of 1					
	Review on 12/17/18 or revealed: -admission date of 3/8 Cerebral Palsy, Hypo Gastroparesis, Sleep Lactose Intolerant;	B/16 with diagnoses of thyroidism, Diabetes,					
	medications: Acetazo times a week (Monda Senna Lax 8.6mg one needed), Potassium (ated 1/3/17 for the following lamide 250mg one tablet 3 y, Wednesday and Friday), e tablet daily prn(as CL ER 20meq one tablet Furosemide 80mg one					
	-physicians' orders da Glycol 3350 NF powd Doc-Q-lace 100mg or -physician's order dat tablet daily as needed -physicians' discontin medications: Potassis three times daily date	ue orders for the following um CL ER 20meq one tablet d 10/30/18, Polyethylene					
	10/12/18, Furosemide	er 17 grams daily dated e 80mg one tablet twice daily loc-Q-lace 100mg one tablet 10/13/18.					

Division of Health Service Regulation

STATE FORM BN6M11 If continuation sheet 2 of 4

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL0601238	B. WING		1:	2/18/2018	
NAME OF P	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	-		
		1509 BR	AY DRIVE				
THE THO	MPSON HOME	CHARLO	OTTE, NC 28214				
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 118	Observation on 12/18 medications on site random on site; -Senna Lax 8.6mg or -Citrucel one tablet d Further review on 12 revealed no physicial following medications -Acetazolamide 250n -Senna Lax 8.6mg or -Citrucel one tablet d Review on 12/17/18 and MARs from 10/1/18 u following: -Acetazolamide 250n not listed on the 12/2 documented as admitable protassium CL ER 20 daily no dosing instruming from 10/1-10/31 -Senna Lax 8.6mg or instructions listed on documented as admit 10/20, 10/25, 10/30, MAR and the 12/201	3/18 at 8:58am of client #1's evealed: ng one tablet 3 times a week ne tablet daily prn not on site; aily as needed not on site. /18/18 of client #1's record ns' discontinue orders for the s: ng one tablet 3 times a week ne tablet daily prn; aily as needed. and 12/18/18 of client #1's until 12/18/18 revealed the ng one tablet 3 times a week 018 MAR and not nistered from 12/1-12/18; Omeq one tablet three times ictions listed in the 10/2018 administered three times ; ne tablet daily prn no dosing the 10/2018 MAR, nistered on 10/6, 10/14, not listed on the 11/2018	V 118	DEFICIENC	· · · · · · · · · · · · · · · · · · ·		
	-Citrucel one tablet d instructions listed on 11/2018, medication MAR; -Furosemide 80mg o dosing instructions lis documented as admi -Doc-Q-lace 100mg of	actions listed on the 10/2018; aily as needed no dosing the 10/2018 MAR and the not listed on the 12/2018 The tablet twice daily no sted in the 10/2018 MAR, nistered twice daily; one tablet twice daily prn no sted in the 10/2018 MAR.					

Division of Health Service Regulation

STATE FORM BN6M11 If continuation sheet 3 of 4

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE S COMPL					
			A. BUILDING.					
		MHL0601238	B. WING		12/	18/2018		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
THE THO	MPSON HOME		AY DRIVE TTE, NC 28214					
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)		
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	COMPLETE DATE		
V 118	Continued From page	3	V 118					
	-had a lot of his medi- trying to wean down -doing well off the me- goes to the doctor re Interview on 12/18/18 -thought she had all t	his medications; edications; egularly. B with staff #1 revealed: he discontinue orders; ued several of client #1's						

Division of Health Service Regulation

STATE FORM BN6M11 If continuation sheet 4 of 4