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	
		A. BUILDING:		R		
		MHL042-073				20/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EVERYD	AY LIVING		TRAIL ROA ER, NC 2784			
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	An annual and follo 12/20/18. Deficience	w-up survey was completed ies were cited.				
	This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living/ Alternative Family Living.					
V 118	V 118 27G .0209 (C) Medication 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 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					

Division of Health Service Regulation
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:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NOMBER.	A. BUILDING:			
MHL042-073		B. WING		R <b>12/20/2018</b>		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EVERYD	AY LIVING		TRAIL ROA ER, NC 2784			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	Continued From page 1		V 118			
	interview the facility client (#1) medication	et as evidenced by: on, record review and realized to ensure one of one on was administered on the nysician. The findings are:				
	revealed: - admitted to the - diagnoses of S Seizures and Mode Developmental Dis a physician's or					
	to the Division of Herevealed: - a physician's or	3 of a fax dated 12/20/18 sent ealth Service Regulation rder for client #1 us been ordered Trazadone 9/25/18"				
	2018 of client #1's I	3 of November & December MAR revealed: administered nightly				
	medication box rev	19/18 at 5:17pm of client #1's ealed: el: 300mg 3 by mouth QHS				
	reported:	12/19/18 the Licensee adone was changed from				

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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	
					F	₹
		MHL042-073	B. WING		12/2	0/2018
NAME OF PROVIDER OR SUPPLIER STREET ADI			DRESS, CITY, S	STATE, ZIP CODE		
EVERYDAY I IVING			TRAIL ROA ER, NC 2784			
(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 APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	PRN to nightly - she was not ab order - she contacted thave a physician's cadministered nightly - she should hav - the Qualified Promarks monthly - she would contacted tomorrow (12/20/18)	he to locate the physician's he pharmacy and they did not order for Trazadone to be / e caught the medication error rofessional reviewed the act the physician's office on )	V 118			
V 762	EQUIPMENT (d) Indoor space relicensed prior to Octominimum square for at that time. Unless Rules, residential farst, 1988 shall meet requirements: (1) Client bed square feet for sing feet when two client.  This Rule is not me Based on observation interview, the facility space had at least occupancy for 1 of Review on 12/19/18 maintained by Divis Regulation (DHSR)  - Licensed for 3 -Initial licensure	equirements: Facilities tober 1, 1988 shall satisfy the otage requirements in effect otherwise provided in these icilities licensed after October the following indoor space the following indoor space to occupancy and 160 square is occupy the bedroom.  Let as evidenced by: Lon, record review and y failed to ensure bedroom 160 square feet for single 1 client (#1). The findings are:  Let of the facility's public record ion of Health Service revealed:	V 762			

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Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
MHL042-073		B. WING		R <b>12/20/2018</b>			
	PROVIDER OR SUPPLIER	166 RUDI	DDRESS, CITY, STATE, ZIP CODE  D TRAIL ROAD  TER, NC 27844				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO			(X5) COMPLETE DATE		
V 762	bedrooms (master 192 square feet, as 120 square feet and estimated 140 square master suite and or as client designated)  Observation on 12/4:54pm revealed: - a master bedroom-clothing through-medication bott master bedroom-2 smaller bedroom-2 smaller bedroom-the master bedroom-the master bedroom-the master bedroom-prior to residing slept in the bedroom-client #1's bedroom-she planned to client #1's bedroom-if client #1's bedroom-if client #1's bedroom-she planned to client #1's bedroom-she and her hu master bedroom	suite with estimated space of second bedroom estimated d a third bedroom with an are feet of living space)the ne smaller bedroom identified d bedrooms.  19/18 between 4:47pm & om with bath nout the master bedroom ides on nightstand in the sooms (one occupied by client froom was empty)  12/20/18 the Licensee sband occupied the master room & the empty bedroom approved by construction in the master bedroom, she in client #1 currently occupied froom was approved by anted to decrease her is sband would then occupy the institutes a re-cited deficiency	V 762				

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