Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				B) DATE SURVEY COMPLETED	
			A. BUILDING:			,	
		MHL011-080	B. WING		01/1	0/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
FIRST S	FIRST STEP FARM-WOMEN 200 PETE LUTHER COVE ROAD CANDLER, NC 28715						
(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 000	V 000 INITIAL COMMENTS		V 000				
	on January 10, 201 This facility is licens category: 10A NCA	w up survey was completed 9. A deficiency was cited. sed for the following service AC 27G .5600E Supervised h Substance Abuse Disorders.					
V 118	27G .0209 (C) Med	ication Requirements	V 118				
Division of H	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 with a physician.						

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

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				B) DATE SURVEY COMPLETED	
		MHL011-080			F 01/1	₹ 0/2019	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 01/1	0/2013	
	TEP FARM-WOMEN		LUTHER CO				
FIRST 3	-		R, NC 28715			T	
(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 SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
V 118	Continued From page 1		V 118				
	interviews the facilit were administered a ensure all medication ordered by a person prescribe drugs for The findings are: Observation on 1/9, medications for Clie-Narcan nasal rescribed for the findings are: Observation on 1/9, medications for Clie-Narcan nasal rescribed for the findings are: No Gabapentin available for the finding for the findings are: Record review on 1-Admitted on 8/8/18 Disorder, Amphetan unspecified Deprese Post-Traumatic Strespost-Traumatic Strespost-Tra	ons, record review, and by failed to ensure medications as ordered and failed to ons administered were in authorized by law to 1 of 3 audited clients (#1). If 9 at 12:23PM of the ent #1 revealed: ue kit 4mg, dispensed on ailable. If 9/19 for Client #1 revealed: with diagnoses of Opioid Use mine Use Disorder, sion Disorder, and less Disorder. Itated 9/6/18 for Gabapentin e. No physician's order to papentin. Physician's order apentin obtained during the y dated 1/9/19. It is provided to the course of the opioid Use of the Narcan rescue kit.					

the program only wanted clients to take

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STATE FORM 6899 QSKB11 If continuation sheet 2 of 3

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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	
					R	
		MHL011-080	B. WING		01/1	0/2019
NAME OF PR	ROVIDER OR SUPPLIER			STATE, ZIP CODE		
FIRST STEP FARM-WOMEN 200 PETE LUTHER COVE ROAD CANDLER, NC 28715						
(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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
	when she was admi- She was not having Interview on 1/10/19 Professional reveale The program did not needication due to the Client #1 had a meterication to use for something like neural the prescription. The manager contact the prescription. The manager contact capapentin, however that order. Narcan was indicated apperwork from the	rological reasons. rm issue with sleep initially itted. g any sleep issues now. 9 with the Director/Qualified ed: ot accept Gabapentin as a ne potential for abuse. dical appointment and tion. The manager advised in was not accepted as a por anything other than ropathy. Client #1 did not fill acted the prescriber and to discontinue the er, the prescriber failed to ted on the discharge detox program that Client #1 rto admission. The physician,	V 118			

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