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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, COV		(X3) DATE SUR	
			A. BUILDING: _		00	
		MHL041-613	B. WING		03/28/2	2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
M & S SUF	PERVISED LIVING, LLC		ENDSHIP CHU			
BROWNS SUMMIT, NC 27214						
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS	i	V 000			
	An annual survey was A deficiency was cited	s completed on 3/28/2019. d.				
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.					
V 118 27G .0209 (C) Medication Requirements		ation Requirements	V 118			
	only be administered order of a person autidrugs. (2) Medications shall clients only when auticlient's physician. (3) Medications, incluadministered only by unlicensed persons trepharmacist or other leprivileged to prepare (4) A Medication Admall drugs administered current. Medications a recorded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for addictions of the control of	istration: n-prescription drugs shall to a client on the written horized by law to prescribe be self-administered by horized in writing by the ding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. hinistration Record (MAR) of d to each client must be kept administered shall be y after administration. The e following:				

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

(X6) DATE TITLE

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DIVISION	n nealth Service Regu	ialion				
, ,		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
MHL041-613		B. WING		03/28	/2019	
NAME OF D		OTDEETAD	DDEGG GITY OTA	TE 7/D 00DE	, , , , , , , , , , , , , , , , , , , ,	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
M & S SUF	PERVISED LIVING, LLC		RIENDSHIP CHU			
		BROWNS	SUMMIT, NC 2	27214		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		COMPLETE DATE
IAG		,	IAG	DEFICIENCY)		
· · · · · · · · · · · · · · · · · · ·	0 " 15		1/440			
V 118	Continued From page	2 1	V 118			
	This Rule is not met					
		ews and interviews, the				
	-	e medication administration				
	was documented immediately following					
	administration affecting 2 of 3 audited clients (#1					
	& #3). The findings a	re:				
	Daviou on 2/27/2010	of alignt #11g record				
	Review on 3/27/2019	of client #1 s record				
	revealed: - Admission date: 7/1/2016					
	- Diagnoses: Attention					
		ectrum Disorder; Moderate				
	-	s; Seizure Disorder; Allergic				
	Rhinitis; Eczema; and					
	Receptive/Expressive					
		or the following medications:				
		nin D3 600 milligrams (mg),				
	1 tablet every day (QI	D), dated 8/3/2018;				
	- Vitamin B-6 100) mg, 1 tablet QD, dated				
	10/8/2018;					
		0 IU (international units), 1				
	tablet QD, dated 7/27					
		ranxene) 7.5 mg, 1 tablet				
		nxiety, dated 7/27/2018;				
		um ER 500 mg, 1 tablet BID,				
		BID (to be taken together to				
	equal 750 mg BID), d					
		0 mg, 2 tablets (=200 mg)				
	every morning (QAM)					
		0 mg, 3 tablets (=300 mg)				
		e (QHS), dated 7/27/2018; 30 mg, 1 tablet BID, dated				
	7/27/2018; and	oo mg, i tablet blb, dated				
		erin cream, apply to rash				
	- 10A 0.1/0 Euce	annorcain, apply to rasin	1			

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BID, dated 6/11/2018.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDEN		IDENTIFICATION NUMBER:	A BUILDING		COMPLETED	
		7 50 5				
		MHL041-613	B. WING		03/2	8/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
TO WILL OF T	NOVIDER OR OUT FIELD					
M & S SUI	PERVISED LIVING, LLC		RIENDSHIP CHU			
		BROWNS	SUMMIT, NC 2	27214		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORT OR I	SCIDENTIFTING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	JAIE	DAIL
			+	,		
V 118	Continued From page	e 2	V 118			
	. •					
	D : 0/07/00/10	6 17 4 1/41 1415				
		of client #1's MARs dated				
	1/1/2019 to 3/27/2019					
	- The 8:00AM doses	of calcium, vitamin B-6,				
	vitamin D-3, clorazep	ate, divalproex sodium,				
	Zonisamide, levocarn	itine, and TCA 0.1% Eucerin				
	cream were not docu	mented as having been				
	administered on 3/25	/2019 and 3/27/2019;				
	- The 8:00PM doses	of clorazepate, divalproex				
	sodium, Zonisamide,	levocarnitine, and TCA				
		were not documented as				
	having been administ					
	Reviews on 3/27/2019	9 and 3/28/2019 of client				
	#3's record revealed:					
	- Admission date: 6/1					
		Control Disorder; Moderate				
		s; Type 2 Diabetes Mellitus;				
		of Pulmonary Embolism;				
		sity; Bilateral Hearing Loss;				
	•	•				
		failure) on Lithium; and				
	Vitamin D deficiency;					
		or the following medications:				
		ycol (Miralax), 17 grams in 8				
	ounces liquid 3 times	3 ,				
	Wednesday & Friday					
		tablet QD, dated 8/8/2018;				
		grams (mg), 1 tablet QD at				
	supper, dated 8/8/201	•				
	-	e (Thorazine) 200 mg, 1				
	tablet BID, dated 11/6					
		1,000 mg, 1 tablet BID with				
	meals, dated 8/8/201					
	 Aripiprazole (Al 	oilify) 5 mg, ½ tablet (=2.5				
	mg) BID, dated 12/5/2	2018;				
	- Benztropine me	esylate (Cogentin) 0.5 mg, 1				
	tablet QHS, dated 11/					
	· ·	mg, ½ tablet (=0.25 mg)				
	QHS), dated 11/6/201					
		ng, 1 tablet QHS, dated				
		<u> </u>	1	<u> </u>		

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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	
		MHL041-613	B. WING		03/28	8/2019	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE ZIP CODE	1 00/20	3/2010	
7311-A FRIENDSHIP CHURCH ROAD							
M & S SUI	PERVISED LIVING, LLC	BROWNS	SUMMIT, NC 2	27214			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE	
V 118	Continued From page	3	V 118				
	8/8/2018.						
	0/0/2010.						
	1/1/2019 to 3/27/2019 - There was no docur glycol had been admi 3/27/2019; - The 8:00 AM doses aripiprazole were not administered on 3/25/2 - The 5:00 PM dose of documented as havin 3/25/2019; - The 8:00 AM doses Metformin were not diadministered on 3/25/2 - The 8:00 PM doses benztropine mesylate were not documented administered on 3/25/2 - The 8:00 PM dose of documented as havin 1/31/2019 to 2/28/2019	of multivitamin and documented as having been //2019; of Xarelto was not g been administered on of chlorpromazine and ocumented as having been //2019 to 3/27/2019; of Metformin, aripiprazole, lorazepam and Simvastatin as having been //2019; of chlorpromazine was not g been administered from 19 and on 3/25/2019.					
		9 with client #1 revealed: es were primarily echolalic					
		y information about his					
	 He could not remem medications, but knew supposed to get at me times; 	w how many pills he was edication administration ity staff had administered					
	Interview on 3/27/201	0 with staff #1 revealed:					

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- Clients #1 and #3 were administered their

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		MHL041-613	B. WING		03/28/2019	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7311-A FRIENDSHIP CHURCH ROAD BROWNS SUMMIT, NC 27214						
(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 118	medications every darange when blank spaces facility staff notified the Professional/Director Interview on 3/27/201 - Staff #2 only administration with the medications that some and the medications that some and the profession of the profession of the medications of the profession of the medications corrow of the medications corrow of the medications corrow of the medications corrow of the medications care pharmacy; The QP/D counted a was certain that there	y as ordered; were found on the MARs, e Qualified (QP/D). 9 with staff #2 revealed: stered medications at 8:00 any problems or errors with she knew of; MARs for accuracy. 9 with the QP/D revealed: n client #1 & #3's MARs had error when the QP/D ad been administered all of ectly; me pre-packaged from the all medications weekly and	V 118			

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