	AND PLAN OF CORRECTION (X1) PROVIDER/SU IDENTIFICATIO		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL013-178	B. WING		05/09/2019	
AME OF PR	OVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
	HOUSE, A DIVISION O	E HOPE HAVEN	RING STREET, SW			
		CONCO	RD, NC 28025			
(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 ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENTS	;	V 000			
	An annual survey wa Deficiencies were cite	s completed on 5/9/19. ed.				
	•	d for the following service 27G .5600E Supervised Substance Abuse				
V 108	27G .0202 (F-I) Perso	onnel Requirements	V 108			
	 (g) Employee training provided and, at a minimizer following: (1) general organization (1) general organization (2) training on client delineated in 10A NC and 10A NCAC 26B; (3) training to meet for client as specified in figure (4) training in infection (4) training in infection (4) training in infection (5602(b) of this Subclimember shall be avait times when a client is member shall be train including seizure mant to provide cardiopulm trained in the Heimlic aid techniques such a Cross, the American 	tion shall be documented. g programs shall be nimum, shall consist of the attional orientation; rights and confidentiality as FAC 27C, 27D, 27E, 27F the mh/dd/sa needs of the the treatment/habilitation ous diseases and is. ed under 10a NCAC 27G hapter, at least one staff ilable in the facility at all is present. That staff need in basic first aid nagement, currently trained nonary resuscitation and h maneuver or other first as those provided by Red Heart Association or their ring airway obstruction. dy shall develop and nd procedures for				

STATEMENT	of Health Service Regi OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL013-178	B. WING		04	5/09/2019
NAME OF PI	ROVIDER OR SUPPLIER	ł	ADDRESS, CITY, STATE	, ZIP CODE	00	5/05/2015
	(HOUSE, A DIVISION O	172 SPF	RING STREET, SW	,		
		CONCO	RD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
V 108	Continued From pag	e 1	V 108			
	controlling infectious diseases of personne					
	facility failed to ensur in basic first aid inclu currently trained to p resuscitation(CPR) a maneuver was availa	iew and interviews, the re at least one staff trained uding seizure management, rovide cardiopulmonary and trained in the Heimlich able in the facility at all times esent for the Residential				
	-hire date of 5/10/13 Assistant(RA); -CPR/First Aid certifi expiration date of 4/2	staff #2's record revealed: with job title of Residential cation dated 4/22/16 with an 2018; thaid certification present in				
	revealed: -work at the facility n -also a live-in staff; -does not have curre certification;	ent CPR/First Aid PR/First Aid recertification				
	revealed:	vith the Program Manager npliance with his CPR/First classes due to				

Division of Health Service Regulation STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MUI 042 470	B. WING		05/09/2019	
	ROVIDER OR SUPPLIER	MHL013-178	ADDRESS, CITY, STATE, ZIP CODE			
	(HOUSE, A DIVISION O	F HOPE HAVEN	RING STREET, SW			
			RD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	STEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 108	Continued From page	e 2	V 108			
	transportation issues -signed up to attend					
V 114	27G .0207 Emergend	cy Plans and Supplies	V 114			
	 AND SUPPLIES (a) A written fire plan area-wide disaster pl shall be approved by authority. (b) The plan shall be and evacuation proce posted in the facility. (c) Fire and disaster shall be held at least repeated for each sh under conditions that 	7 EMERGENCY PLANS for each facility and an shall be developed and the appropriate local made available to all staff edures and routes shall be drills in a 24-hour facility quarterly and shall be ift. Drills shall be conducted simulate fire emergencies. have basic first aid supplies				
	facility failed to ensur	view and interviews, the re fire and disaster drills arterly and were repeated				
		vith the Substance Abuse ne worked at the facility day from 7am-3pm.				
	-	vith the Peer Support e worked at the facility on am-11pm on Saturdays and				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL013-178	B. WING		05/09/2019	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
SERENITY	(HOUSE, A DIVISION O	F HOPE HAVEN	RING STREET, SW RD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
V 114	Continued From page	e 3	V 114			
		Interview on 5/8/19 with the Residential Assistant revealed he worked third shift at the facility and				
		Interviews on 5/8/19 with clients #1, #2 and #3 revealed they participated in drills monthly.				
	Review on 5/9/19 of the fire and disaster drill log from 6/2018-5/2019 revealed: -no night time drill conducted from 10/1/18-12/31/18; -no day time drill conducted from 1/1/19-3/31/19.					
		vith Administrative staff f missing drills will be				
V 118	27G .0209 (C) Medic	ation Requirements	V 118			
	 only be administered order of a person aut drugs. (2) Medications shall clients only when aut client's physician. (3) Medications, inclu administered only by unlicensed persons t pharmacist or other la privileged to prepare medications. (4) A Medication Adm all drugs administere kept current. Medication 	istration: on-prescription drugs shall to a client on the written thorized by law to prescribe be self-administered by thorized in writing by the uding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and				

Division of Health Service Regulation

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BIW611

STATE FORM

	OF DEFICIENCIES OF CORRECTION			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		MHL013-178	B. WING		05	5/09/2019
IAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, 2	ZIP CODE		
BERENITY	HOUSE, A DIVISION O	F HOPE HAVEN	RING STREET, SW RD, NC 28025			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	O THE APPROPRIATE	COMPLET DATE
V 118	Continued From pag	e 4	V 118			
	MAR is to include the	e following:				
	(A) client's name;					
		and quantity of the drug;				
		dministering 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.					
	This Pule is not met	as evidenced by:				
	This Rule is not met as evidenced by: Based on records review, observations and					
	interviews, the facility failed to ensure					
	medications were only administered to a client					
		of a person authorized by				
	law to prescribe drug	s and a MAR of all drugs				
	administered to each	n client was kept current with				
		tered were recorded				
	-	ministration affecting 1 of 3				
	clients (2). The findir	ng are:				
	Review on 5/8/19 of	client #2's record revealed:				
	-admission date of 5					
		Use Disorder and Cocaine				
	Use Disorder;					
	-physicians' orders d	ated 2/28/19 for the				
		s: Losartan Potassium 50mg				
		D 1.25mg one tablet weekly,				
		one tablet three times a day,				
		tablet daily and Jentadueto				
	500mg one tablet tw	-				
		an's order dated 3/4/19 for				
	Vytorin 10/20mg one	a tablet daliv.	1			1

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TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
			A. BUILDING:			
		MHL013-178	B. WING		05/09/2019	
AME OF PF	ROVIDER OR SUPPLIER	STREETA	ADDRESS, CITY, STATE,	ZIP CODE		
ERENITY	(HOUSE, A DIVISION O	F HOPE HAVEN	RING STREET, SW RD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLE ⁻ DATE
V 118	Continued From page	e 5	V 118			
	medications on site r -Losartan Potassium bottle dispensed 3/5/ dispensed 4/29/19; -Vitamin D 1.25mg of 4/29/19; -Gabapentin 300mg of dispensed 3/5/19, en label, "three" times a with blue ink and "on blue ink; -Vytorin 10/20mg one 4/29/19; -Jentadueto 500mg of dispensed 4/13/19. Review on 5/8/19 of of 3/1/19-5/8/19 reveale -Losartan Potassium dates left blank 4/22- -Vitamin D 1.25mg of documented as admit the month of April (4/ -Gabapentin 300mg of documented as admit of three times daily for dosing dates left blar -Vytorin 10/20mg one administered from 3/2 order; -Jentadueto 500mg of on 3/2019, 4/2019 ar tablet once daily but from 3/1-5/7.	50mg once a day a half-full 19 and a full bottle ne tablet weekly dispensed one tablet three times a day npty bottle, on instructions day was marked through ce" a day was handwritten in the tablet daily dispensed one tablet twice daily client #2's MARs from ed the following: 50mg once a day dosing 4/30 and 5/1-5/2; ne tablet weekly inistered only two times in 75 and 4/12); one tablet three times a day inistered twice daily instead or 3/1-3/31, 4/1-4/26 and hk for 4/27-5/8; the tablet daily documented as 5-4/19 despite discontinue one tablet twice daily listed administered twice daily listed administered twice daily				
	Interview on 5/8/19 w -takes his own medic	vith client #2 revealed: cations:				

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL013-178	B. WING		05/09/2019	
AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,			009/2019
ERENITY	HOUSE, A DIVISION O	F HOPE HAVEN	RING STREET, SW			
			RD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE	(X5) COMPLET DATE
V 118	Continued From page	e 6	V 118			
	-takes his medication	s as prescribed daily.				
	revealed: -client #2 has no insu free medical clinic for -sometimes there is a -sometimes he gets r without bringing orde	a lapse in his refills; nedications discontinued				