Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                  | ` '                 |   | (X3) DATE SURVEY<br>COMPLETED |  |  |
|--|---|---|---------------------|---|-------------------------------|--|--|
| 74101 1244                                       | or connection   | BERTIN IS WISH NOMBER.  | A. BUILDING:        |   |                               |  |  |
|  |   | MHL013-165  | B. WING             |   | R<br>05/14/2019               |  |  |
| NAME OF PI                                       | ROVIDER OR SUPPLIER   | STREET AL   | DDRESS, CITY, STAT  | E, ZIP CODE   |                               |  |  |
| OLDENBU  | OLDENBURG 1005 OKLAHOMA STREET  |   |                     |   |                               |  |  |
|  |   |   | OLIS, NC 28083      |   |                               |  |  |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLETE                   |  |  |
| V 000  | INITIAL COMMENTS  |   | V 000               |   |                               |  |  |
|  | An annual survey was deficiency was cited.  | s completed on 5/14/19. A   |                     |   |                               |  |  |
|  | category: 10A NCAC  | d for the following service<br>27G .5600C Supervised<br>Developmental Disabilities. |                     |   |                               |  |  |
| 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 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 |   |                     |   |                               |  |  |

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:   |   |              | (X3) DATE SURVEY<br>COMPLETED |    |
|--|--|--|---|--------------|-------------------------------|----|
|  |  |  | A. BUILDING:  |              |                               |    |
| MI   |  | MHL013-165   | B. WING   |              | R<br><b>05/14/2019</b>        |    |
| NAME OF PI                                       | ROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, STA  | TE, ZIP CODE |                               |    |
| OLDENBL  | IRG  |  | AHOMA STREE   |              |                               |    |
|  |  | KANNAPO  | DLIS, NC 28083  | 3            |                               |    |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                                | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |              | BE COMPLE                     | TE |
| V 118  | Continued From page 1  |  | V 118   |              |                               |    |
|  | file followed up by apwith a physician.  | pointment or consultation  |   |              |                               |    |
|  | This Rule is not met as evidenced by: Based on records review, observations and interviews, the facility failed to ensure medications were administered as prescribed affecting 1 of 3 clients (#3). The findings are:  Review on 5/14/19 of client #3's record revealed: -admission date of 3/1/07 with diagnoses of Bipolar Disorder, Intellectual Developmental Disability-Moderate, Recurrent Urinary Tract Infections, Allergies, Acne, Gastro Esophageal Reflux, Vitamin D Deficiency, Dermatitis, Hyperlipidemia and Dysplastic Nevus; -physician order dated 3/27/19 for Flonase 50mcg 2 sprays in each nostril twice daily. |  |   |              |                               |    |
|  |  |  |   |              |                               |    |
|  | medications on site re   | 19 at 3:53pm of client #3's evealed Flonase 50mcg 2 twice daily not present at                                 |   |              |                               |    |
|  | 3/1/19-5/14/19 reveal -dosing date of 5/14 a and circled; -instructions on the M initials circled indicate -documentation on th indicated medication for 5/14 am dose.   | am for Flonase was initialed  IAR form documented ed "other;" e back of the MAR form Flonase was not available |   |              |                               |    |
|  | Interview on 5/14/19   | with staff #3 revealed:  |   |              |                               |    |

Division of Health Service Regulation

STATE FORM 8899 29I011 If continuation sheet 2 of 3

Division of Health Service Regulation

|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |                      | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                                |                          |
|--------------------------|--|---|----------------------|---|--------------------------------|--------------------------|
|                          |  |   | 7. BOILDING          |   |                                | R                        |
|                          |  | MHL013-165  | B. WING              | <del></del>   | 05                             | /14/2019                 |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET  | ADDRESS, CITY, STATE | E, ZIP CODE   |                                |                          |
| OLDENBU                  | JRG  |   | KLAHOMA STREET       | •   |                                |                          |
|                          | Г  |   | POLIS, NC 28083      |   |                                |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC | ON SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| V 118                    | continued From page -if medication not on a -refills are sent to the then delivered to the transporting clients be day program; -no medications were Interview on 5/14/19 -used her Flonase las -did not use her Flona was out of it.  Interview on 5/14/19 Administrator reveale -will address issue im | site, waiting on a refill; main office/day program facility by the staff ack to the facility from the delivered today. with client #3 revealed: st night; ase this morning because with the Regional d: | V 118                | DEFICIENC   | Y)                             |                          |
|                          |  |   |                      |   |                                |                          |

Division of Health Service Regulation

STATE FORM 8899 29I011 If continuation sheet 3 of 3