Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL092-725	B. WING		05/02/2019	
			1		05/02	./2019
NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
PINE VA	LLEY		ONGHORN LA	ANE		
			I, NC 27610			
(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 000	INITIAL COMMENTS		V 000			
	An Annual Survey v 2019. A deficiency v	vas completed on May 02, was cited.				
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	only be administered order of a person and drugs.  (2) Medications shat clients only when and client's physician.  (3) Medications, included and individual drugs administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Adall drugs administer current. Medication recorded immediated MAR is to include the (A) client's name;  (B) name, strength,  (C) instructions for a (D) date and time the (E) name or initials drug.  (5) Client requests a checks shall be recorded.	inistration: non-prescription drugs shall d to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the sluding injections, shall be y licensed persons, or by trained by a registered nurse, legally qualified person and e and administer medications. Iministration Record (MAR) of led to each client must be kept administered shall be lely after administration. The				

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL092-725		B. WING		05/0	05/02/2019	
	NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  5213 PRONGHORN LANE  RALEIGH, NC 27610					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 118	Continued From pa with a physician.	ge 1	V 118			
	failed to assure one medication was adr findings are:  Review on 04/30/19 revealed:  -Admitted: Septing -Diagnoses white Retardation, Person d/o with Vagus Nerve Epilepsy and Psychelic -Actively engages Services  -Physician's order hospice nurse date every 8 hoursif absystolic give one tall call hospice with add MARs Clonidine add month between Feberal 2019 Blood pressure chees and pressure chees and pressure staff wo Staff assigned client pressure readings.	view and interview, the facility of three clients (#1)'s ministered as prescribed. The of client #1's record tember 2008 (ch included Mild Mental hality d/o (disorder), Seizure ve Stimulation, Mood d/o, sosis ed in Palliative (Hospice) (ders via email from the d 01/22/19- Blood Pressure pove 170 (top number)122 (blet Clonidine .1 mg by mouth, ditional questions. Note: Per ministered average 4 times a pruary-April 2019.				

Division of Health Service Regulation
STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
NAME OF I	MHL092-725			B. WING 05/02/2019			
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  5213 PRONGHORN LANE						
PINE VALLEY RALEIGH, NC 27610							
(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 118	Continued From pa	ge 2	V 118				
	was only checked to Clonidine was given During interview on reported she:	05/02/19, the Hospice Nurse					
	-Verified the 01/22/19 order for blood pressure to be checked every 8 hours was the most recent physician's orderCame to the home weekly and monitored the Blood Pressure log readings -was not aware of the blood pressure documentation was only twice a day opposed to the required three times daily						
		vith group home staff of the					

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