	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED R	
MHL078-159		B. WING		05/	05/30/2019	
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
DETTE	R WAY RESIDENTIA	220 CAL	VINS ROAD			
DETTE	R WAI RESIDENTIA	SHANNO	ON, NC 28386			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES XY 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) COMPLE DATE
V 000	INITIAL COMMEN	ITS	V 000			
	on May 30, 2019.	ollow-up survey was completed The complaint was ntake #NC00150726). A ed.				
	category: 10A NCA	nsed for the following service AC 27G .1700 Residential ecure for Children or				
V 118	27G .0209 (C) Me	dication Requirements	V 118			
	REQUIREMENTS (c) Medication adm (1) Prescription or only be administer order of a person a drugs. (2) Medications sh clients only when a client's physician.	ninistration: non-prescription drugs shall red to a client on the written authorized by law to prescribe nall be self-administered by authorized in writing by the				
	administered only unlicensed person pharmacist or othe privileged to prepa (4) A Medication A all drugs administe current. Medication	Icluding injections, shall be by licensed persons, or by s trained by a registered nurse er legally qualified person and ure and administer medications dministration Record (MAR) of ered to each client must be kep ns administered shall be tely after administration. The				
	MAR is to include (A) client's name; (B) name, strength (C) instructions for (D) date and time (E) name or initials drug.					

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STATEMEN	of Health Service Re	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: MHL078-159		A. BUILDING:		COMPLETED		
		B. WING		R 05/30/2019		
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	R WAY RESIDENTIA	SERVICES 220 CAL	VINS ROAD			
	ER WAT RESIDENTIAL	SHANNC	ON, NC 28386			1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pa	ige 1	V 118			
		corded and kept with the MAR appointment or consultation				
	facility failed to adm written order of a pl	views and interviews, the ninister medications on the hysician and failed to keep the sting three of three clients (#1,				
	revealed: -15 year old male. -Admission date of -Diagnoses of Cond	duct Disorder, Disruptive Othe Control Disorder and	r			
	physician orders re 03/05/19 -Risperidone (antip tablet daily.	sychotic) 1 milligram (mg) one tention Deficit Hyperactivity				
	02/05/19 -Melatonin (sleep a daily.	id) 10mg - take one tablet				
	revealed the followi	27/19 and 04/28/19.				

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If continuation sheet 2 of 5

STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED R 05/30/2019	
MHL078-159		MHL078-159	B. WING			
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		00/2010
	R WAY RESIDENTIA	220 CAL	VINS ROAD	,		
	R WAI RESIDENTIA	L SERVICES SHANNO	ON, NC 28386			
(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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pa	age 2	V 118			
	- Melatonin - 04/26	/19 and 04/27/19.				
	Interview on 05/30/ his medications da	(19 client #1 stated he received ily as ordered.	1			
	-16 year old male. -Admission date of	2's record revealed: 10/04/18. D and Conduct Disorder.				
	orders revealed: 03/05/19 -Depakote (treats S daily in the morning	9 of client #2's physician Seizures) 250mg - take once g. - take one tablet twice daily.				
	01/08/19 -Seroquel (antipsyc daily.	chotic) 50mg - take one tablet				
	revealed the follow -Depakote 250mg	- 04/27/19 and 04/28/19. - 04/27/19 at 7am and 7pm m.				
	Interview on 05/30/ his medications da	(19 client #2 stated he received ily as ordered.	1			
	Finding #3: Review on 05/30/19 revealed: -15 year old male. -Admission date of -Diagnosis of Conc					
ision of H	-	9 of client #3's signed				

STATE FORM

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If continuation sheet 3 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL078-159				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING			R 05/30/2019		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
A BETTE	R WAY RESIDENTIA	L SERVICES	VINS ROAD DN, NC 28386				
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF C	CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	HE APPROPRIATE	COMPLET DATE	
V 118	Continued From pa	age 3	V 118				
	deficiency) 500mg -Prazosin (treats hi two capsules at be -Zinc Gluconate (tre one tablet daily. 05/02/19 -Miralax (stool softe Review on 05/30/19	ne capsule daily. nate (treats mineral - take twice daily. gh blood pressure) 2mg - take dtime. eats mineral deficiency) - take ener) - take once daily. 9 of client #3's April 2019 and evealed the following blanks: 8/19 at 7pm.					
	and 05/25/19 thru 0 -Adderall - 05/27/19 -Prazosin - 05/27/1	9. 5/24/19 and 05/27/19.					
	Interview on 05/30/ his medications da	19 client #3 stated he received ily as ordered.	L L				
	-Clients went on ho indicate on their MA - She would follow staff with medicatio	up with additional training for					
		o accurately document stration it could not be					

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	of Health Service R T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED	
		MHL078-159	B. WING		R 05/30/2019	
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
RETTE	R WAY RESIDENTIA		VINS ROAD			
		SHANNO	ON, NC 28386			
(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 COMPLET THE APPROPRIATE DATE	
V 118	Continued From pa	age 4	V 118			
	determined if client as ordered by the p	ts received their medications physician.				
		nstitutes a re-cited deficiency cted within 30 days.]				

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