Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X3) DATE SURVEY COMPLETED		
AND FEAR OF CONNECTION IDENTIFIC		IDENTIFICATION NO.	A. BUILDING: _				
MHL012-019		B. WING		06/0	6/2019		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
SCI-EMER	RGENT NEED RESPITE O	ENTER	AR STREET FON, NC 2865	5			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 000	000 INITIAL COMMENTS		V 000				
	An annual and follow up survey was completed on 6/6/19. A deficiency was cited.						
	This facility is licensed for the following service category: 10A NCAC 27G .5100 Community Respite Services for All Disability Groups.						
V 118	27G .0209 (C) Medic	ation Requirements	V 118				
	V 118 27G .0209 (C) Medication Requirements 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 file followed up by appointment or consultation						

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

(X6) DATE TITLE

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
			A. BUILDING:					
		MHL012-019	B. WING		R 06/06/2019			
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
SCI-EMER	SCI-EMERGENT NEED RESPITE CENTER 101 POPLAR STREET							
MORGANTON, NC 28655								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE			
V 118	Continued From page	: 1	V 118					
	This Dule is not met	oo oyidanaad byr						
	review the facility fails were administered on physician and the Me Record (MAR) was ke	n, interview and record ed to ensure all medications ly on the written order of a dication Administration ept current affecting one of						
	one client (Client #1).	The findings are:						
	-admission date of 6/8 -diagnoses of Person Intellectual Developm Palsy, BiPolar Disord Epilepsy and non-epil Intermittent Asthma, F Post-Traumatic Stress	ality Disorder, Moderate ental Disorder, Cerebral er, Depressive Disorder, leptic seizures, Mild Panic Disorder and s Disorder. summary - admission date						
	of Client #1's medicat -Ferrous Sulfate - 325 - dispensed - 5/10/19	5 milligrams (mg) - one daily						
	-Advair Diskus - 250 r - inhale one puff - 2 ti 5/10/19 -Melatonin - 3 mg - tw dispensed 5/10/19 -Cyclobenzaprine HC dispensed 2/14/19	L - 10 mg - one daily -						
	hours as needed - dis	one tablet daily every 8 spensed 3/25/19 and 4/18/19 one spray in each nostril 2						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED			
					_		
					R		
		MHL012-019	B. WING		06/06/2019		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
	101 POPLAR STREET						
SCI-EMER	RGENT NEED RESPITE C	ENTER MORGAL	NTON, NC 2865	5			
			1				
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	(- /		
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPI			
IAG		,	IAG	DEFICIENCY)			
V 118	Continued From page	2	V 118				
	times a day as neede	d - dispensed 2/18/19					
	-all the medications w	ere dispensed prior to the					
	client's most recent h	ospital stay.					
		,					
	Review on 6/5/19 of (Client #1's MAR dated June					
	2019 revealed:	Sherit #13 Wir it dated burie					
		tions were listed become					
		tions were listed, however					
	none had been admir	nistered					
	Review on 6/5/19 of 0	Client #1's discharge					
	summary "Final repor	t" from the hospital dated					
		·					
	6/5/19 revealed: -the above medications were not listed as being						
	discontinued.	ns were not nated as being					
	discontinued.						
	D : 0/5/40 64	511					
		Client #1's hospital report					
	(untitled) dated 5/15/	19 revealed:					
	-"My Medicine List"						
	-"stop taking the follow	wing medications"					
	-Ferrous Sulfate - 325	5 mg - one daily					
		- one tablet, 2 times a day					
	, ,	mcg - 50 mcg - inhale one					
	puff - 2 times a day	mog comog initale one					
	'	re tablete at hadtime					
	-Melatonin - 3 mg - tw						
	-Cyclobenzaprine HC	-					
	_	- one tablet daily every 8					
	hours as needed						
	-Saline Nasal Spray -	one spray in each nostril 2					
	times a day as neede	ed					
	-the hospital report wa						
	physician.	5 ,					
	F, 55.5						
	Interview on SIE/10	ith the facility Administrator					
	Interview on 6/5/19 with the facility Administrator						
	revealed:						
	-the observed medications for Client #1 were						
	from her previous facility prior to her being						
	hospitalized.						
		pital changed a lot of her					
	medications and they had been sent to the						
	_	naa been sent to the	1				
	pharmacy.		- 1				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		A. BUILDING: _					
		MHL012-019	B. WING		R 06/06/2019		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
SCI-EMER	RGENT NEED RESPITE (101 POP	LAR STREET				
MORGANTON, NC 28655							
(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 COMPLETE		
V 118	V 118 Continued From page 3		V 118				
	-he was going to pick medications from the soon as they were re -when asked if any or medications in the boradministered today, if administer those that Observation on 6/6/1 revealed: -the medications in Odispense dates of 6/5-the medications were current orders dated -the medications obsiapproximately 3:25 p box or in the medications.	tup all of her current pharmacy this evening as ady. If the above observed by for Client #1 would be the said "Yes, they'll need to be administered." 9 at approximately 9:30 a.m. Ilient #1's box all had by 19. Ilient #1's correct according to the 6/5/19. Ilierved on 6/5/19 at .m. were not in the client's					
	2019 revealed: -all the medications listed were current and initialed as given according to the physician's order.						
	revealed: -he placed the medic longer taking in his o -that was where they	itive came to destroy them.					
	-she was able to find medications that had the hospital stay. -there was no physic document that was p	the list of the above been discontinued during an signature on the rovided. I pages to the document that					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED			
					R		
		MHL012-019	B. WING		06/06/2019		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
		101 POPL	AR STREET				
SCI-EMER	RGENT NEED RESPITE C	MORGANT	ON, NC 2865	5			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE		
V 118	Continued From page	e 4	V 118				
V 118	. 3	e 4 ot signed by the physician.	V 118				

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