STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NUMBER.	A. BUILDING:				
		MHL078-278	B. WING			R 12/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, ZIP CODE				
ROBESC	DN #1		THAGE ROAD				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ID PROV ' MUST BE PRECEDED BY FULL PREFIX (EACH C		(EACH CORRECTIVE AC CROSS-REFERENCED TO	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE DEFICIENCY)		
∨ 000	INITIAL COMMENTS		V 000				
	An annual, complaint and follow up survey was completed on August 12, 2019. The complaint was unsubstantiated. Deficiencies were cited.						
	category: 10A NCA	sed for the following service AC 27G .5600C Supervised h Developmental Disabilities.					
V 118	27G .0209 (C) Med	ication Requirements	V 118				
	<ul> <li>only be administered order of a person a drugs.</li> <li>(2) Medications shat clients only when an client's physician.</li> <li>(3) Medications, include the distribution of the privileged to prepare privileged to prepare (4) A Medication Ad all drugs administered only bunk administered on the privileged to prepare (4) A Medication Ad all drugs administere current. Medication and the distribution of the distributication of the distrib</li></ul>	inistration: non-prescription drugs shall ed to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by trained by a registered nurse, legally qualified person and e and administer medications. Iministration Record (MAR) of red to each client must be kep s administered shall be ely after administration. The					

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Division of Health Service Regulation         STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         MHL078-278			CONSTRUCTION		(X3) DATE SURVEY COMPLETED R 08/12/2019		
		IDENTITION TON NOMBER.	A. BUILDING:				COM
		MHL078-278	B. WING				
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ROBESC	NI #1	601 CAR	THAGE ROAD	1			
OBE3C		LUMBER	RTON, NC 283	58			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
V 118	Continued From page 1		V 118				
	with a physician.						
	This Rule is not me						
	Based on record reviews and interviews, the facility failed to administer medications on the						
		hysician and failed to keep the					
		ting two of three clients (#1					
	and #3). The finding	gs are:					
	Finding #1:						
	Review on 8/07/19	of client #1's record revealed:					
	-41-year old female						
	-Admission date of	7/01/11. ressive Disorder, Intellectual					
		eneralized Epilepsy, Seizure					
		mia, and Hyperlipidemia.					
	Review on 8/07/19	- 8/09/19 of client #1's signed					
	physician orders re	vealed:					
	2/08/19 Essitelenrom (tree	to doproceion) 20 milligrams					
	(mg)- One tablet da	ts depression) 20 milligrams aily.					
	Review on 8/07/19	- 8/09/19 of client #1's June					
		the following blanks:					
	- Escitalopram - 6/2	21/19 at 8am.					
	Interview on 8/07/1	9 client #1 stated she received	k				
	her medications da	ily as ordered.					
	Finding #2:						
		of client #3's record revealed:					
	-48-year old male. -Admission date of	7/01/11					
		ectual Disability (Moderate),					
	Seizure Disorder, H						

STATE FORM

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Division of Health Service Regulation           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
MHL078-278		IDENTIFICATION NOMBER.	A. BUILDING:				
		MHL078-278	B. WING			R 08/12/2019	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ROBESO	N #1		THAGE ROAD RTON, NC 283				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF		(X5) COMPLET	
PRÉFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE	
V 118	Continued From page 2		V 118				
	Hemiplegia, Anxiety Disorder, Allergic Rhinitis, Generalized Epilepsy.						
	Review on 8/07/19 - 8/09/19 of client #3's signed physician orders revealed: 2/08/19						
	-Gabapentin (treats seizures) 300mg- One capsule three times daily. -Atorvastatin (treats cholesterol) 20mg- One						
	tablet daily.	s seizures) 50mg- One capsule	e				
		- 8/09/19 of client #3's May 9 MARs revealed the following /19.					
	August 2019 -Gabapentin - 8/05 -Zonisamide - 8/06						
		9 client #3 neither confirmed eived medications as ordered					
	medication adminis	o accurately document stration it could not be s received their medications ohysician.					

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