` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
					R			
		MHL079-73	B. WING		02/07/2020			
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
FAITH H	FAITH HOUSE 1115 ROSEMONT DRIVE							
174111111		REIDSVIL	LE, NC 273	20				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE		
V 000	V 000 INITIAL COMMENTS		V 000					
	An annual and follo on 2/7/20. A deficie	w up survey was completed ency was cited.						
	category: 10A NCA	sed for the following service C 27G .1700 Residential cure for Children and						
V 118	27G .0209 (C) Med	ication 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 rec	orded and kept with the MAR appointment or consultation						

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

CTATEMENT OF DEFICIENCIES (VA) DROVIDED/CURRUED/A		(Y2) MI II TIDI	E CONSTRUCTION	(Y3) DATE	QLID\/EV	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		OOMI LETED	
			D WILLS		F	
		MHL079-73	B. WING		02/0	7/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		1115 ROS	EMONT DRI	VE		
FAITH H	DUSE	REIDSVIL	LE, NC 273	20		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
V 118	Continued From pa	ge 1	V 118			
	with a physician.					
	with a physician.					
	This Rule is not me					
		on, record review and y failed to ensure a Medication				
		ord (MAR) of all drugs				
		` ,				
	administered to each client was recorded immediately after administration affecting 1 of 3 clients (#1). The findings are:					
	()	Ü				
	Review on of client #1's record revealed: - An admission date of 12/4/19 - Diagnoses of Post-Traumatic Stress Disorder					
	(D/O) and Attention	Deficit Hyperactivity D/O				
	Observation on 2/3/20 of client #1's medications					
	revealed:	720 of client #1's medications				
		mg 1 tab (tablet) PO (by				
	mouth) once daily;					
		mg 1 tab PO once daily; (8				
	am)					
		I 2 tab PO with with breakfast,				
	lunch and dinner; (7					
	(d) Prazosin HCL (Hydrochloride) 2 mg 6 mg (3					
	capsules (caps)) PO every night; (6 pm) (e) Quetiapine Fumarate 200 mg 1 tab PO at 6					
	morning and 12 no					
		narate 300 mg 1 tab PO at 6				
	every evening;	indicate ood mg 1 tab 1 o at 0				
		00 mg 1 cap PO every evening				
	at 6 pm;	. , ,				
		100 mg 1 cap PO once daily				
	(8 am) and					
		mcg Nasal Spray Inhale 2				
	sprays into each no	stril once daily (8 am)]

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Division of Health Service Regulation							
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:					
					R		
MHL079-73		B. WING			7/2020		
NAME OF I		STDEET AD	DDESS CITY O	CTATE ZID CODE			
NAIVIE OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
FAITH H	OUSE		EMONT DRI				
		REIDSVIL	LE, NC 273	20			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION CLICK		(X5) COMPLETE	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		DATE	
				DEFICIENCY)			
\/ 110	Continued From no	.a. ?	V 118				
V 110	Continued From pa	ge z	V 116				
		f client #1's January					
	(1/1-1/31/20) MAR						
		tion on the MAR which					
		nad been administered					
		on 1/7/20; 1/13-1/15/20; and					
	1/19/20	tion on the MAD which					
	No documentation on the MAR which reflected #1 had been administered Meloxicam						
		/13-1/15/20; 1/19/20 and 1/21-					
	1/22/20	713-1/13/20, 1/19/20 and 1/21-					
	- No documentation on the MAR which						
	reflected #1 had been administered Lactaid						
	Original at 7 am on 1/7/20; and 1/13-1/15/20;						
	- No documentation on the MAR which						
	reflected client #1 had been administered Lactaid						
	Original at noon on 1/5/20; 1/14-1/15/20 and						
	1/31/20						
		tion on the MAR which					
	reflected client #1 had been administered Lactaid						
	Original at 5 pm on 1/5/20; 1/12/20; 1/14/20 and						
	1/26/20 - No documentation on the MAR which						
		nad been administered					
		on 1/5/20; 1/10/20; 1/12/20;					
	1/14/20; 1/19/20 an						
		tion on the MAR which					
		nad been administered					
	Quetiapine Fumara	te 200 mg at 6 pm on 1/7/20;					
	1/19/20 and 1/21-1/						
		tion on the MAR which					
		nad been administered					
		te 200 mg at 12 noon on					
		1/20 and on 1/31/20					
		tion on the MAR which					
		nad been administered					
		te 300 mg at 6 pm on 1/5/20; /19/20; 1/22/20 and 1/26/20					
		tion on the MAR which					
		nad been administered					

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Atomoxetine 100 mg on 1/5/20; 1/12/20; 1/14/20;

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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	
			,		F	₹
		MHL079-73	B. WING			7/2020
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FAITH H	OUSE		EMONT DRI LE, NC 273:			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y 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	1/19/20; 1/22/20 and - No documental reflected client #1 h Softener 100 on 1/7 - No documental reflected client #1 h Fluticasone 50 mcg. An attempt to intervunsuccessful as clienterviewed. Interview on 2/3/20 Program Manager - She felt certain administered her m failed to document medications on clie - This issue wou meeting scheduled group and individuate to document when medications to clier. The importance completed correctly meeting scheduled - This issue wou whole and individuate to document when medications to clier - He and the Prostaff would begin restricted.	d 1/26/20 cion on the MAR which had been administered Stool 7/20 cion on the MAR which had been administered had not want to be and on 2/5/20 with the revealed: client #1 had been edications; however, staff their having administered the htt #1's MAR Id be addressed during a staff for 2/8/20 with staff as a hally with those who had failed httely had administered htt #1. with the Qualified ed: he of ensuring MARs were had was on the agenda for a staff for 2/8/20 had be addressed with staff as a hally with those who had failed had be addressed with staff as a hally with those who had failed had administered	V 118			

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