Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
					R	
		MHL011-405	B. WING		02/06/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STATI	E. ZIP CODE		
			LIVETTE ROAD	_,		
NEW YOR	K HOMES RESIDENTIAL	CARE CENTER #4	VILLE, NC 28804			
(X4) ID				ID PROVIDER'S PLAN OF CORRECTIO		
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		
_		·		DEFICIENCY)		
V 000	INITIAL COMMENTS		V 000			
		16.11				
		and follow up survey was The complaints were				
	-	ke #NC00159068 and				
	,					
	NC00160091). A deficiency was cited.					
	This facility is licensed	d for the following service				
	0 ,	27G .5600F Supervised				
	Living for Individuals					
	Groups/Alternative Fa	amily Living.				
V 118	27G .0209 (C) Medica	ation Requirements	V 118			
	10A NCAC 27G .0209	A MEDICATION				
	REQUIREMENTS	, MEDIO, MICH				
	(c) Medication administration: (1) Prescription or non-prescription drugs shall					
	•	to a client on the written				
	•	norized by law to prescribe				
	drugs.					
	(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.					
		ding injections, shall be				
	. ,	licensed persons, or by				
		ained by a registered nurse,				
	pharmacist or other le	egally qualified person and				
		and administer medications.				
		inistration Record (MAR) of				
	-	d to each client must be kept				
	current. Medications a					
	,	after administration. The				
	MAR is to include the (A) client's name;	ioliowing.				
		nd quantity of the drug;				
	(C) instructions for ad					
	` ,	drug is administered; and				
		person administering the				
	drug.	. •				
	(5) Client requests for	medication changes or				
Sinialan afilla	alth Service Regulation					

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

TITLE (X6) DATE Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		MHL011-405	B. WING		02	R 2/ <b>06/2020</b>
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
NEW YOR	K HOMES RESIDENTIAL	CARE CENTER #4	VETTE ROAD LLE, NC 28804			
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
V 118	Continued From page 1		V 118			
		ded and kept with the MAR pointment or consultation				
	review the facility faile	as evidenced by: n, interview, and record ed to keep the MAR current nts (#3). The findings are:				
	Client #3 included: -Trazadone 50 mg 1	20 of the medications for tablet at bedtime in a pill				
	revealed: -Admitted on 10/27/1 Spectrum Disorder, S Diabetes and Express	he record for Client #3  7 with diagnoses of Autism severe Intellectual Disability, sive Language Disorder.  d 12/5/19 for Trazadone 50				
	Review on 1/22/20 ar 2019 and January 20 revealed: -No documentation of administration from 1	Trazadone 50mg				
	Living (AFL) Provider -She verified Trazado January 2020 MARIt was listed and doc 2019 MAR.	with the Alternative Family revealed: ne was not listed on the umented on the December e in a pill pack from the				

Division of Health Service Regulation

STATE FORM 6899 ODP211 If continuation sheet 2 of 3

PRINTED: 02/25/2020 FORM APPROVED

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			
							R		
		MHL011-405		B. WING		02	/06/2020		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
NEW YOR	NEW YORK HOMES RESIDENTIAL CARE CENTER #4  644 OLIVETTE ROAD ASHEVILLE, NC 28804								
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU .SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
V 118	pharmacy and was action and action action and action action action and action and action act	dministered. Id have been document with the Vice President : e medications were ompared to the individu ks and balances in place oth. ith the Qualified	for  al  t to  R.  ey  e  ion.	V 118					

Division of Health Service Regulation

STATE FORM 6899 ODP211 If continuation sheet 3 of 3