PRINTED: 03/02/2020 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED	
MHL098-155		B. WING		R 02/24/2020		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
GENTLE HANDS I 1615 WASHINGTON STREET EAST WILSON, NC 27893						
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
		up survey was completed A deficiency was cited.				
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disabilities.				
V 118	27G .0209 (C) Medica	ation 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 recorded and kept with the MAR file followed up by appointment or consultation					

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

TITLE (X6) DATE 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	
			A. BOILDING.		D	
MHL098-155		B. WING		R 02/24/2020		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STA	TE, ZIP CODE		
GENTLE H	HANDS I	1615 WA	SHINGTON STR	EET EAST		
		WILSON	NC 27893			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE		
V 118	Continued From page 1		V 118			
	and failed to keep the of three audited client Review on 02/24/202 revealed: - 42 year old female Admission date of 0 - Diagnoses of Schizo Mild Mental Retardati and Sleep Apnea.	ew, observation and failed to administer ritten order of a physician e MARs current affecting one ts (#5). The findings are: 0 of client #5's record 1/13/14. ophrenia, Paranoid Type, fon, Hypercholesterolemia				
	order for client #5 dat - Discontinue Halope	0 of a signed physician ted 01/14/2020 revealed: ridol 5mg (used to treat 1/2 tablet by mouth at				
	2020 MAR revealed: - Haloperidol 5mg Tal mouth at bedtime Initials on the MAR that client #5 continue Haloperidol No documentation the discontinued as order	he Haloperidol was				
	11:00am of client #5's - A bubble blister pac	s medications revealed: k labeled for client #5 for d from the pharmacy on				

Division of Health Service Regulation

STATE FORM 6899 UMJI11 If continuation sheet 2 of 3

PRINTED: 03/02/2020 FORM APPROVED

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		MIII 000 455	B. WING		00	R
NAME OF D		MHL098-155		T. 7/D 00DF	02	/24/2020
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STAT ASHINGTON STRE			
GENTLE I	HANDS I		N, NC 27893			
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	e 2	V 118			
	02/21/2020.					
	During interview on 02/20/2020 client #5 revealed: -She received her medication dailyShe did not know the names of the medications she took daily. Interview on 02/24/2020 the Licensee revealed: -Client #5's doctor wrote medication orders on 01/14/2020 and the orders had mistakesThe doctor rewrote the orders on 01/15/2020Licensee contacted the doctor while surveyor was on-site and the doctor did want the Haloperidol discontinued and notified the doctor of the medication errorShe would inform all the staff of the error and correct the MAR.					

Division of Health Service Regulation

STATE FORM 6899 UMJI11 If continuation sheet 3 of 3