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Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|----------------------------|---|-------------------------------|--------------------------|--|
| 701012701 | or connection | IDEITH IO/HIOH HOMBER. | A. BUILDING: | | | | |
| | | MHL023-204 | B. WING | | 09/1 | ; 5/2020 | |
| NAME OF P | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | |
| QUEST #1 | 115 EPPS RETREAT | 115 EPPS SHELBY, I | RETREAT LAN NC 28150 | DING | | | |
| (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 APPROPE DEFICIENCY) | BE | (X5) COMPLETE DATE | |
| V 000 | INITIAL COMMENTS | | V 000 | | | | |
| | 15, 2020. The compla (Intake# NC0016184: This facility is license | • | | | | | |
| V 118 | 27G .0209 (C) Medic | 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 administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR | | | | | | | |

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: MHL023-204 | | | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | |
|--|---|---|----------------------|--|--------------------------------|--------------------------|
| | | B. WING | B. WING | | | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET | ADDRESS, CITY, STATE | ZIP CODE | | |
| QUEST #1 | 15 EPPS RETREAT | | S RETREAT LANDI | NG | | |
| | | | Y, NC 28150 | | | |
| (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 ((EACH CORRECTIVE ACTI) CROSS-REFERENCED TO TI DEFICIENC | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| V 118 | Continued From page 1 | | V 118 | | | |
| | file followed up by ap with a physician. | pointment or consultation | | | | |
| | facility failed to ensur were trained to admir Registered Nurse (RI | ew and interviews, the e one of one audited staff nister medications by a N), pharmacist, or other on for 2 of 2 clients (Clients | | | | |
| | -admitted on 11/1/16. | , Anxiety, Mood Disorder, ectual Development | | | | |
| | physician orders date revealed: -his daily medications | nd 9/10/20 of Client #1's ed 3/19/20 and 8/12/20 s included Haldoperidol, R, Benztropine, Zyprexa, | | | | |
| | -admitted on 10/28/10 -diagnoses of Infantile with Hallucinations, N Development Disorde Review on 5/19/20 ar physician orders date revealed: | e Autism, Psychotic Disorder | | | | |

Division of Health Service Regulation

STATE FORM 8899 X9NR11 If continuation sheet 2 of 4

Division of Health Service Regulation

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | |
|---|--|---|---------------------|--|----------------------------------|--------------------------|
| | | B. WING | B. WING | | | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STATE | E, ZIP CODE | | 0/15/2020 |
| OUEST # | AE EDDO DETDEAT | 115 EPP | S RETREAT LAND | ING | | |
| QUEST#1 | 15 EPPS RETREAT | SHELBY | , NC 28150 | | | |
| (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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| V 118 | V 118 Continued From page 2 | | V 118 | | | |
| | Colace, Zyprexa, Lan | notrigine, and Benztropine. | | | | |
| | 8/29/20 revealed: -"Bellum Professional ServicesMedication Recording." -a docusigned signatu completed, reviewed Interview on 5/20/20 of the medication training to pass a test for community same as a test for community passed the testshe reviewed the fact Administration Record them to the doctor or community." | Training Administration & Training Administration | | | | |
| | -in meetings they also | with the AFL providering he took was on-line. So went over medication | | | | |
| | administrationhe was not sure if an meetings or not. | RN was present in the | | | | |
| | Officer revealed: -the Bellum Professio an on-line course for -an agency nurse dev when a new nurse was | with the Chief Executive nal Training Services was medication administration. veloped the curriculum and as hired they always to see if they wanted to | | | | |

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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 | | |
|---|--|---|--|--|--------------------------------|-------------------------------|--|--|
| MHL023-204 | | B. WING | | | C 09/15/2020 | | | |
| NAME OF P | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | | |
| QUEST # | QUEST #115 EPPS RETREAT 115 EPPS RETREAT LANDING SHELBY, NC 28150 | | | | | | | |
| (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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE | | |
| V 118 | -there was a compete the course that had to administering medica -the RN then signed t course was complete -the RN does monthly | ency-based test at the end of obe passed before | V 118 | | | | | |

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