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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	A. BUILDING:		
		MHL0601387	B. WING		12/23/2020	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
NEURORI	STORATIVE-SARDIS	151 NORTH	I SARDIS ROA	AD		
		CHARLOT	TE, NC 28270			
(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 APPROPRIED TO THE	BE COMPLET	Έ
V 000	INITIAL COMMENTS		V 000			
	The complaints (intak 00172271) were subswere cited.	as completed on 12-23-20. e #NC 00171963 and #NC stantiated. Deficiencies				
	category: 10A NCAC	27G .5600C Supervised Developmental Disabilities.				
V 108	27G .0202 (F-I) Perso	onnel Requirements	V 108			
	(g) Employee training provided and, at a min following: (1) general organiza (2) training on client delineated in 10A NC 10A NCAC 26B; (3) training to meet to client as specified in the plan; and (4) training in infection bloodborne pathogen (h) Except as permitted. 5602(b) of this Subcommember shall be avait times when a client is member shall be trainincluding seizure mar to provide cardiopulm trained in the Heimlice.	tion shall be documented. It programs shall be nimum, shall consist of the stional orientation; rights and confidentiality as AC 27C, 27D, 27E, 27F and the mh/dd/sa needs of the the treatment/habilitation ous diseases and s. ed under 10a NCAC 27G napter, at least one staff lable in the facility at all present. That staff the in basic first aid nagement, currently trained to onary resuscitation and the maneuver or other first aid nose provided by Red Cross,				
	equivalence for reliev (i) The governing boo	ing airway obstruction.				

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

(X6) DATE TITLE

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1 3 7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL0601387	B. WING		12/23/2020	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA			
NEURORE	ESTORATIVE-SARDIS		I SARDIS ROA TE, NC 28270	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT 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 APPROPR DEFICIENCY)	BE COMPLETE	
V 108		e 1 g and controlling infectious seases of personnel and	V 108			
	failed to ensure staff v cardiopulmonary resultechniques provided by American Heart Associated 1 of 8 staff (Staff # Review on 12-15-20 of record revealed:	ew and interview, the facility were currently trained in scitation (CPR) and first aid by the Red Cross, the ciation, or their equivalence 4). The findings are:				
	not be located in the purchase Interview on 12-15-20 -took CPR/First Aid the Cross; -worked 3rd shift;	with Staff #4 revealed: rough the American Red on shift by myself on 3rd;"				
V 123	and significant advers reported immediately pharmacist. An entry	MEDICATION Drug administration errors e drug reactions shall be	V 123			

Division of Health Service Regulation

STATE FORM STATE FORM 16899 3ZMZ11 If continuation sheet 2 of 7

PRINTED: 01/07/2021 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			E SURVEY PLETED
		MHL0601387	B. WING		12	2/23/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		151 NOR	TH SARDIS ROAD			
NEURORESTORATIVE-SARDIS CHARLOT			TTE, NC 28270			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 123	Continued From page	2	V 123			
	in the drug record. A shall be charted.	client's refusal of a drug				
	This Rule is not met					
	facility failed to report immediately to a phys	and record reviews, the medication errors sician and/or pharmacist durrent clients (Client #3).				
	-admitted 11-25-19; -diagnoses of Trauma Facial Fractures, Left Orbital Roof Fracture flush; -physician order date Oxycontin (used to trablet every 12 hours nerve pain) 75mg, 1 t HCL (used to treat blo at bedtime, Tizanidina pain) 2mg, 1 tablet at (used to improve sleet	atic Brain Injury, Multiple Orbital Bone Fracture, Getube inactive except d 11-16-20 revealed eat pain) 10mg (milligram), 1 getappead (used to treat ablet twice daily, Propanolol bod pressure) 20mg, 1 tablet e HCL (used to treat nerve bedtime, Trazodone HCL ep) 50mg, take 1.5 tablet at (used to treat attention and				
	focus) 100mg, 1 table Ointment to face (use 500units, apply to fac Baza Protect Cream infections), apply topi daily, Carbamazepine management) 300mg Docusate Sodium So	et twice daily, Bacitracin Zinc and to prevent skin infections) e lacerations twice daily, (used to prevent skin cally to G-tube site twice e (used to treat pain , 1 capsule twice daily,				

Division of Health Service Regulation

STATE FORM 8899 3ZMZ11 If continuation sheet 3 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	
7.1.12 1 25 11 1		152.11.11.10.11.10.11.10.11.52.11.	A. BUILDING: _			
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NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ΓE, ZIP CODE		
NEURORE	STORATIVE-SARDIS	151 NOR	TH SARDIS ROA	vD		
NEORORI	OTORATIVE-OARDIO	CHARLO	TTE, NC 28270			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 123	Continued From page	e 3	V 123			
	Duloxetine HCL (used to treat insomnia) 60mg, 1 capsule via tube at bedtime, Lansoprazole Outer UD (used to treat gas/bloating) 15mg, 1 tablet twice daily; Review on 12-7-20 of October through December 2020 revealed: -October 2020 MAR revealed 8pm medications for Client #3 were not administered on 10-26-20 which included Oxycontin 10mg, Pregabalin 75mg, Propanolol HCL 20mg, Tizanidine HCL 100mg, Trazodone HCL 50mg, Amantadine 100mg, Bacitracin Zinc Ointment, Baza Protect Cream, Carbamazepine 300mg, Docusate Sodium Softgel 100mg, Duloxetine HCL 60mg, Lansoprazole Outer UD 15mg. Review on 12-15-20 of the facility's Incident Reports from October 2020 through December 2020 revealed: -Incident report dated 10-26-20 revealed Client #3's evening medications were not administered as ordered. Further review of the incident report did not reflect notification and follow up from a physician and/or pharmacist.					
	record revealed: -hire date 8-31-20; -employed as a Life S -initial Medication Adr received 9-3-20;					
	Interview on 12-9-20 with Client #1 revealed: -staff members were responsible for administering medications; -staff were teaching her about her medications so that she could eventually administer her own					

Division of Health Service Regulation

STATE FORM 8899 3ZMZ11 If continuation sheet 4 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	E SURVEY IPLETED	
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NEURORESTORATIVE-SARDIS 151 NORTH		DRESS, CITY, STA H SARDIS ROA TE, NC 28270	•				
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETE DATE	
V 123	medications. Interview on 12-16-20 -employed with group as a Life Skills Traine -had one medication -medication error was during an evening me sleep study in which seep study in which s	o with Staff #7 revealed: home in September 2020 r; error during employment; with Client #3 and occurred edical appointment for a Staff #7 failed to administer ons prior to the medical contacted regarding the cation; Id that the client needed to nument but was not told that er medications prior to the dication error, Staff #7 and completed a review of istration procedures with the o with the Program Director ons were not missed facility for a sleep study ration; ned to the facility her ; ct the staff on what to do cations; stor or pharmacist was called tion error; nsibility of the RN;" cations from several olved (Staff #7) was	V 123				

Division of Health Service Regulation

-"I gave her (Staff #7) specific coaching on what

STATE FORM 6899 3ZMZ11 If continuation sheet 5 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			P WING			_
		MHL0601387	B. WING		12/23/202	0
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
NEURORE	STORATIVE-SARDIS		TH SARDIS ROA	AD		
040.45	CLIMMADV CT		TTE, NC 28270	DDOV/DEDIS DI ANI OF CORDECTIO	NN a	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COM	X5) PLETE ATE
V 123	Continued From page	5	V 123			
	to do it if happens aga	ain the future."				
V 131	G.S. 131E-256 (D2) H Verification	HCPR - Prior Employment	V 131			
	G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.					
	This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the Health Care Personnel Registry (HCPR) was accessed prior to hire affecting 5 of 8 staff (Staff #1, Staff #3, Staff #4, Staff #7, and the Program Director). The findings are:					
	record revealed: -hire date 9-1-20; -employed as a Life S -HCPR check comple	eted on 11-30-20. of Staff #3's personnel Skills Trainer;				

Division of Health Service Regulation

STATE FORM 8899 3ZMZ11 If continuation sheet 6 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI		
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NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
NEUROR	ESTORATIVE-SARDIS		I SARDIS ROA TE, NC 28270	AD .			
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 131	record revealed: -hire date 10-1-20; -employed as a Life S -HCPR check comple Review on 12-16-20 or record revealed: -hire date 8-31-20; -employed as a Life S -HCPR check comple Review on 12-15-20 or personnel record revealed: -hire date 3-9-20 as a personnel record reversed to Program -HCPR check comple Interview on 12-18-20 revealed: -promoted to Program September 2020; -when hired as the Pr some training with the did not get enough tr her current position; -received training from	of Staff #4's personnel Skills Trainer; Ited on 11-30-20. of Staff #7's personnel Skills Trainer; Ited on 11-30-20. of the Program Director's ealed: Case Manager; n Director on 9-19-20; Ited on 11-30-20. O with the Program Director n Director position in ogram Director she received e previous manager; aining when she moved into n the previous manager, the another Program Director	V 131				

Division of Health Service Regulation

STATE FORM 8899 3ZMZ11 If continuation sheet 7 of 7