STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL019-041	A. BUILDING: _____ B. WING _____	C 01/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA HOUSE	176 LASSITER HOMESTEAD ROAD DURHAM, NC 27713

(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 000	INITIAL COMMENTS A complaint survey was completed on January 29, 2021. The complaint (intake #NC00172987) was substantiated and (intake #NC00172378) was unsubstantiated. Deficiency cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600A Supervised Living for Adults with Mental Illness 27G.1100 Partial Hospitalizatiion	V 000		
V 116	27G .0209 (A) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (a) Medication dispensing: (1) Medications shall be dispensed only on the written order of a physician or other practitioner licensed to prescribe. (2) Dispensing shall be restricted to registered pharmacists, physicians, or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy. If a permit to operate a pharmacy is Not required, a nurse or other designated person may assist a physician or other health care practitioner with dispensing so long as the final label, Container, and its contents are physically checked and approved by the authorized person prior to dispensing. (3) Methadone For take-home purposes may be supplied to a client of a methadone treatment service in a properly labeled container by a registered nurse employed by the service, pursuant to the requirements of 10 NCAC 45G .0306 SUPPLYING OF METHADONE IN TREATMENT PROGRAMS BY RN. Supplying of methadone is not considered dispensing. (4) Other than for emergency use, facilities shall	V 116		

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V 116	Continued From page 1 not possess a stock of prescription legend drugs for the purpose of dispensing without hiring a pharmacist and obtaining a permit from the NC Board of Pharmacy. Physicians may keep a small locked supply of prescription drug samples. Samples shall be dispensed, packaged, and labeled in accordance with state law and this Rule. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to assure medications be dispensed only on the written order of a physician or other practitioner licensed to prescribed affecting 1 of 1 Former Client (FC#1). The findings are: Review on 1/27/21 of Former Client #1's record revealed: -Admission date of 12/15/20. -Diagnosis of Anorexia Nervosa, Binge Eating/Purging Type -Discharged 12//23/20. Review on 1/28/21 of Registered Nurse #2 record revealed: -Date of Hire: 10/17/17. -Medication Administration Attestion Letter dated 4/10/19. Review on 1/27/21 of FC#1's Discharged Medication Prescribed 12/23/21 revealed: -Folic Acid 400 mcg. -Fluoxetine Hydrochloride 60mg. -Abilify 7.5mg. -Vitamin B1 100mg. -Fluvoxamine Maleate 50mg.	V 116		

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V 116	Continued From page 2	V 116		

-Pantoprazole Sodium 40mg.
-Junel FE 1/20 birth control.
-Digestive Advantage Enzyme.
-Docusate Sodium 100mg.
-MiraLAX 17g (for solution).
-Flaxseed Oil 1000mg.
-Multivitamin 1 tablet

Interview on 1/26/21 with FC #1 revealed:
-She was leaving the facility against medical advice.
-She felt she needed a higher level of care.
-She spoke with her therapist before making her decision.
-On the evening of 12/23/21 she went to get medication from the RN #2.
-RN #2 gave her the medication in the bag.
-She left the facility and realized that she had another clients' medication.
-She called immediately, got no answer and left a message with no response.
-She called the next morning and was asked by Licensed Practical Nurse #3 if she could bring the medication by.
-She was not able to because she was out of town.
-LPN #3 asked her if she could mail the medication back.
-She told LPN #3 she would with the facility expense.
-She was told they would figure a way to do it.
-RN#2 was calling and texting her "like crazy" and said she would send money.
-She finally received an email packing form.
-She packed up the medication and sent the medication.
-Confirmed she received her medication.

Interview on 1/26/21 with Registered Nurse #2 revealed:

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V 116	Continued From page 3 -FC#1 came in the office because she was leaving, -FC#1 was leaving against medication advice on 12/23/20. -FC#1's medication were in a bag on the nurses counter. -She was organizing the medication draw. -She was trying to count medication. -She counted FC#1's medication and handed her a form to fill out. - "A lot of things were going on" at the nursing station. -Another client was being involuntarily committed and the sheriff was there. -She and FC#1 were the only two people in the office at the time. -This occurred about 6:30 p.m.; right after dinner. -She didn't know FC#1 took the medication until she called later. -She did not know how FC#1 grabbed another client's bag of medication. -FC#1 grabbed a bag that was not hers. -The nursing station was on the counter behind medication cart. -Clients had to go in the nurse office to get medication. -FC#1 grabbed another clients medication that included an inhaler and vitamins. -These medications were not ordered. -Medications that was not ordered upon admission were stored in a draw until clients discharged. -The other client was no longer at the facility. -FC#1 called the next day and said she had medication of another clients. -She couldn't find out what was missing. -Confirmed there was no documentation on incident because she didn't know anything was missing. -The other client's medications were on the other	V 116		

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V 116	Continued From page 4 side of the counter where she was organizing several different things. -Confirmed FC#1 was given the correct medication. Interview on 1/26/21 with the Director of Nursing revealed: -She started working at the facility 12/14/20. -She only knew about FC#1 being discharged AMA. -FC#1 was upset and left AMA. -That was all she knew about the case. -Before FC#1 left AMA she went out to the hospital. -FC #1 was feeling weak, went to the hospital, returned to the facility and left AMA the same day. -FC #1 left AMA on 12/23/20. -She was not aware of the client receiving another client's medication. -RN #2 was supposed to document in patient chart when medication was release and what was sent with the patient. Interview on 1/29/21 with the Chief Executive Officer revealed: -She was not aware of the situation. -RN #2 should have completed an incident report. -The chain of the command was for the RN#2 to discuss incident with the DON. -There would be retraining and other actions against RN#2. -Confirmed RN#2 had an attestation letter waiving medication administration training.	V 116		