Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION		
ANDILAN	or correction.	IDENTIFICATION NOMBER.	A. BUILDING:			PLETED
MIII 000 000		B. WING	B WING		С	
MHL020-083			5		04	/01/2021
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
THE OVER	RLOOK	205 HAM	IPTON CHURCH R	OAD		
		MURPHY	7, NC 28906			
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 000	00 INITIAL COMMENTS		V 000			
	A complaint survey w (Intake number NC00 cited.	as completed 4/1/21. 1169618) Deficiencies were				
	_	d for the following service 27G. 5600A Supervised Mental Illness.				
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					

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:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
					c	
MHL020-083		B. WING		04/01/2021		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
THE OVE	RLOOK		IPTON CHURCH R	OAD		
			/, NC 28906			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
V 118	18 Continued From page 1		V 118			
	with a physician.					
	This Rule is not met	as evidenced by:				
	Review on 1/14/21, 1/15/21, 3/25/21 and 4/1/21					
	of August 2020 - November 2020 MARs and					
	physician orders for Client #1 revealed: -Paliperidone ER 6 mg 2 tablets at bedtime					
	ordered on 8/31/20 was not administered on					
	9/15/20Flagyl 500 mg 4 tablets a day for 1 day was ordered on 10/28/20 and was not documented on the MAR as administered on 10/29/20. Review on 4/1/21 of facility incident report regarding 10/29/20 medication error and dated 10/29/20 revealed:					
		dministered as ordered but				
	T	nted on emar [Electronic				
	Medication Administra	ation Record]. Staπ unseled on always using				
		edications and to review for				
	accuracy after saving	before closing"				
	Due to the failure to a	accurately document				
	medication administra	ation it could not be				
		1 received Flagyl 500 mg 4				
	tablets a day for 1 da physician.	y as ordered by the				
	, ,					
	Record review on 11/	/9/20, 11/13/20, and 3/25/21				
	for Client #2 revealed	l:				
	-Admission date: 12/					
	agnoses: Intellect וט-	ual Disability - Mild; Major				

Division of Health Service Regulation

STATE FORM 6899 GMGF11 If continuation sheet 2 of 3

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
						С
		MHL020-083	B. WING		04	/01/2021
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STAT			
THE OVERLOOK 205 HAMPTON CHURCH ROAD MURPHY, NC 28906						
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 118	Continued From page 2		V 118			
	Unspecified Trauma a Disorder; DiGeorge S Problems-Scoliosis-F	syndrome; Gastrointestinal requent Migraines. 20 at 3:25 PM of Client #2's :				
	-Mirtazapine 15 mg 1	•				
	November 2020 MAR Client #2 revealed: -Paroxetine HCL 40 n 4/28/20 was not admi and 9/29/20. -Mirtazapine 15 mg 1	as and physician orders for ng 1 tablet daily ordered on inistered on 9/1/20, 9/2/20, tablet at bedtime was as not administered on				

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