STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
		A. BUILDING:			R		
		MHL007-081	B. WING			9/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
PORT HI	PORT HEALTH SERVICES - RAY G SILVERTHO 1379 COWELL FARM ROAD WASHINGTON, NC 27889						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMEN	тѕ	V 000				
	completed on July unsubstantiated (in Deficiencies were of This facility is licens categories: 10A NC Abuse Intensive Ou	sed for the following service CAC 27G .4400 Substance utpatient Program and 10A Facility Based Crisis Service					
V 117		• ,	V 117				
	V 117 27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing						

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

(X6) DATE TITLE

AND BLAN OF CORRECTION . IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		A. BUILDING.		R		
		MHL007-081	B. WING			9/2021
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PORT HE	ALTH SERVICES - R	AY G SII VERTHO	VELL FARM STON, NC 27			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 117	Continued From pa	ige 1	V 117			
	practitioner.					
	Based on observatifailed to ensure that administration at the labeled as required. Observation on 7/0 12:15 pm of the factor revealed: - A white pill bottle will label for Clonidine of drawn through the reduction on the mg tab (tablets) explored pharmacy label convistaril 50 mg" was buring interview on stated she was not had been altered on in a plastic bag with Clinical Manager st pre-printed pharmacy	e facility were packaged and . The findings are: 9/21 between 11:30 am and cility's medication room with pre-printed pharmacy 0.1 mg tablets with a line medication information. e pharmacy label "Lisinopril 10 p. (expires) 8/31/22." oc plastic bag with no ntained 1 capsule; "Stock handwritten on the bag. 17/09/21 the Clinical Manager aware that a pharmacy label or that a medication was stored on no pharmacy label. The stated she was aware that licy labels should not be see's pharmacy provided				
V 119	27G .0209 (D) Med	lication Requirements	V 119			
	10A NCAC 27G .02 REQUIREMENTS	209 MEDICATION				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY PLETED			
		MHL007-081		B. WING			R 09/2021
PORT HEALTH SERVICES - RAY G SILVERTHO 1379 COV			DRESS, CITY, S VELL FARM STON, NC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 119	(d) Medication disp (1) All prescription a medication shall be guards against dive (2) Non-controlled s of by incineration, fl system, or by trans destruction. A recor shall be maintained Documentation sha medication name, s date and method, the disposing of medical witnessing destruct (3) Controlled subs accordance with the Substances Act, G. subsequent amend (4) Upon discharge remainder of his or disposed of prompt expected that the p to the facility and in drug supply shall no	osal: and non-prescription disposed of in a matersion or accidental is substances shall be lushing into septic or fer to a local pharmater of of the medication I by the program. Ill specify the client's strength, quantity, dis the signature of the pation, and the persor ion. tances shall be disple North Carolina Col S. 90, Article 5, inclu	anner that ngestion. disposed r sewer acy for disposal s name, sposal person n osed of in ntrolled uding any lent, the hably all return aining han 30	V 119			
	failed to dispose of manner that guards	et as evidenced by: ion and interview the prescription medica s against diversion o n. The findings are:	tions in a				
	Observation on 7/09/21 between 11:30 am and 12:15 pm of the facility's medication room revealed:						

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AND BLAN OF CORRECTION . IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		A. BUILDING.		R		
		MHL007-081	B. WING	<u>-</u>		9/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PORT HI	EALTH SERVICES - R	AY G SII VERTHO	VELL FARM STON, NC 2			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 119	 9 Continued From page 3 - A box contained a 100 tablet bottle of metronidazole (antibiotic) 500 mg with no pharmacy label, expired 5/2021. - A small refrigerator contained a wet box of Humulin-N (intermediate acting insulin) with no pharmacy label, expired 5/2021. - 2 boxes of risperidone (antipsychotic) 90 mg injectable, with no pharmacy label, expired 1/2020. - 4 boxes of risperidone 120 mg injectable, with no pharmacy label, expired 12/2019. - A box of propranolol (a beta blocker used to treat high blood pressure) 10 mg, expired 7/2021, with "Expired send back" handwritten on the box. During interview on 7/09/21 the Clinical Manager stated expired medications should be sent back to the pharmacy for disposal. She would ensure the expired medications were disposed of properly. 		V 119			
V 736	10A NCAC 27G .03 EXTERIOR REQU (c) Each facility and maintained in a saf manner and shall be odor. This Rule is not me Based on observations	d its grounds shall be ite, clean, attractive and orderly be kept free from offensive et as evidenced by: ions and interviews the facility it in a safe, clean and attractive	V 736			

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AND DIAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
12.11.10.10.110.110.110.110.110.110.110.		A. BUILDING:				
	MHL007-081	B. WING			२ 09/2021	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
DODT HEALTH SERVICES DA	N C SILVERTIC 1379 COV	VELL FARM	ROAD			
PORT HEALTH SERVICES - RA	WASHING	STON, NC 27	7889			
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE	
V 736 Continued From page	ge 4	V 736				
Observations on 7/0 am revealed: - Walls throughout the scratched paint The carpet in the fastains of varying sizes Bedroom #1 had an and a golf ball size of shaped brown stain, damage, on the ceiling dusty with dead bugger Bathroom #1 had an adispenser held toget tape; the air vent was fixture, broken tile on shower wall, dark stawall and shower flood slowly Bedroom #3 had an adust and bugs and fasted bedspread Bedroom #7 had an arubber base molding Emergency lights in a Bathroom #2 had an aceiling air vent An approximately 3 damage at the telepost the kitchen The kitchen had an aruburners; there were wrapped cold pizza in soap dispenser and broken; there were the behind the sink and ceiling; the entire insterior brown stains and the of the microwave had	he facility with scuffed and acility hallways had black es. In approximate 3 inch hole dent in the wall and a kidney consistent with water ing and the window sill was s. In a broken wall-mounted soap ther with clear packing-type is rusty; debris inside the light in a corner of the outside ains in between tile of shower or; and the sink drained rusty air vent, window sill had aded areas on the pproximately 4 foot section of					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
JEHN OF GORRESTION BEINT TO MICHIGANISER.		A. BUILDING:					
		MHL007-081	B. WING		R 07/09/2021		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
PORT HI	EALTH SERVICES - R	YAY (3 SII VERTH)	WELL FARM GTON, NC 2				
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉ		
V 736	Continued From pa	age 5	V 736				
	- The wooden gate was jammed and w	to the outside smoking area would not open.					
	Supervisor stated to responsible for the	n 7/07/21 the Program he local hospital was maintenance of the facility. s cited had been reported for					

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