Division	of Health Service Re	egulation			TONWATNOVED
STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		MHL026-952	B. WING		05/26/2021
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		
	No MBER ON OOF TELER		AMBERSBUR		
ADRIEN	NE'S HOUSE		EVILLE, NC 28		
	CLIMMAADY CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECT	
(X4) ID PREFIX		MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOU	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	OPRIATE DATE
				DEFICIENCY)	
V 000	INITIAL COMMEN	TS	V 000		
	An annual, compla	int and follow up survey was			
	completed on May	26, 2021. The complaint was			
	unsubstantiated (in	take #NC00177135). A			
	deficiency was cite	d.			
		sed for the following service			
		C 27G .1700 Residential			
		cure for Children or			
	Adolescents.				
V 116	27G .0209 (A) Med	lication Requirements	V 116		
	100 NCAC 37C 03				
	10A NCAC 27G .02 REQUIREMENTS	U9 MEDICATION			
	(a) Medication disp	ensina:			
	(1) Medications sh	all be dispensed only on the			
		hysician or other practitioner			
	licensed to prescrit				
		Il be restricted to registered			
		cians, or other health care			
		rized by law and registered			
		plina Board of Pharmacy. If a			
		pharmacy is Not required, a			
		gnated person may assist a			
		health care practitioner with			
		as the final label, Container,			
		e physically checked and			
	dispensing.	thorized person prior to			
		take-home purposes may be			
		of a methadone treatment			
		ly labeled container by a			
		mployed by the service,			
	pursuant to the req	uirements of 10 NCAC 45G			
	0306 SUPPLYING	OF METHADONE IN			
		GRAMS BY RN. Supplying of			
		onsidered dispensing.			
		mergency use, facilities shall			
		k of prescription legend drugs			
Division of He	ealth Service Regulation		SNATURE	TITLE	(X6) DATE
	Í Í		Thomas Maxv		July 12, 2021
		+ +			
STATE FOR	M	-	⁶⁸⁹⁹ 71	3V11	If continuation sheet 1 of 4

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	(3) DATE SURVEY COMPLETED		
			A. BUILDING:		R
		MHL026-952	B. WING		05/26/2021
IAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY,	STATE, ZIP CODE	
	NE'S HOUSE		MBERSBU VILLE, NC		
(X4) ID	SUMMARY ST		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLET
V 116	Continued From pa	age 1	V 116		
	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.				
	Based on interview reviews, the facility dispensing of medi persons authorized 3 audited clients (# Finding #1: Review on 5/26/21 -12 year old male a -Diagnoses include	d Attention-Deficit der (ADHD) and Oppositional	V 116	Human Resource, Director, & AP will ensure that staff complies with the guidelines outlined in 10A NCAC 27G.0209 Medication dispensing requirements Section 1 (A); All staff members will be trained and certified by a Registered Nurse before being allowed to dispense medications the residential settings.	s in
	orders and Medicati (MAR) revealed: -Buspirone 5 milligr be taken twice daily administered at 7 a -Lamotrigine 25 mg twice daily, was sch 7 am and 7 pm (se -Quetiapine, 50 mg three times daily, w	and 5/26/21 of client #1's on Administration Record rams (mg), ordered 6/8/20 to y, was scheduled to be im and 7 pm (anxiety). g, ordered 8/5/20 to be taken heduled to be administered at izures). n, ordered 8/5/20 to be taken vas scheduled to be im, 11 am, and 7 pm		Medication administration. Section 2 (Ensure each consumer's medications counted at the time of administration a recorded immediately afterwards. While continuing to educate the consu about each medicine he is prescribed	are ind imer

713V11

	of Health Service R	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATI	E SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:			COMPLETED	
						n	
		MHL026-952	B. WING	· · · · · · · · · · · · · · · · · · ·		R 26/2021	
	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S		A		
			MBERSBUR				
ADRIEN	NE'S HOUSE		EVILLE, NC 2				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	TION SHOULD BE COMPLET THE APPROPRIATE DATE		
V 116	Continued From pa	age 2	V 116		·		
	Finding #2:						
		of client #2's record revealed:					
	-13 year-old male a						
		ed ADHD, Conduct Disorder,					
		ocial Engagement Disorder.	-				
		1 and 5/26/21 of client #2's					
	orders and MARs revealed:						
		ordered 5/14/20 to be taken					
		heduled to be administered at					
	7 am and 7 pm (Al						
	-Depakote ER (extended release) 500 mg,						
		be taken twice daily, was					
		Iministered at 7 am and 7 pm					
	(mood).	rdered 2/12/20 to be taken					
		heduled to be administered at					
	7 am and 7 pm (ar						
		26/21 at approximately					
	4:30pm revealed:						
		itials of client #1 written on a					
		red to the side. Inside the cup					
	were 3 white tablet						
		itials of client #2 written on a					
	piece of tape adhe	red to the side.					
	Interview on 5/25/2	1 staff #5 stated					
		counted at the beginning of					
	each shift.						
	-As she counted th	e medications she would pour					
	any client medication	ons to be given during her shift					
	into the cup with th						
		nside the cup labeled with					
		vere his 7 pm medications,					
		Quetiapine 50mg, and					
	Buspirone 5 mg.	al a magaligation of the state					
	-one nad complete	d a medication class prior to					
		ications. This pre-pouring ught during the class.					
. <u> </u>	ealth Service Regulation						

713V11

STATEMEN	of Health Service R T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED R 05/26/2021		
		MHL026-952						
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	ADDRESS, CITY, STATE, ZIP CODE					
ADRIENI	NE'S HOUSE		MBERSBUR VILLE, NC 2					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	Tion should be The appropriate	(X5) COMPLE DATE		
V 116	-She learned this p medications from a "shadowed" them Interview on 5/26/2 -She had been em approximately 6 ye -She had complete course. -Medications were the shift, pre-poure and then given by the medications. -Staff who assisted	brocess of pre-pouring other direct care staff when she during her orientation. 21 staff #6 stated: ployed with the agency for ears. ed a medication certification counted at the beginning of ed for the next distribution time, the staff who had pre-poured d with medication distribution day, as all staff were certified	V 116					
ision of He ATE FORM	alth Service Regulation							