Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
			D WING				
		MHL032-523	B. WING		10/0	8/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
FAITH H	FAITH HOMES & HABILITATION, LLC 2711 FAYETTEVILLE STREET DURHAM, NC 27707						
(V4) ID	STIMMADV STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTI	ON	(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENT	rs	V 000				
	on October 8, 2021 unsubstantiated (in Deficiencies were controlled). This facility is licens	sed for the following service C 27G .5600A Supervised					
V 118 27G .0209 (C) Medication Requirements		V 118					
	only be administered order of a person and drugs. (2) Medications shat clients only when and client's physician. (3) Medications, include administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Administered all drugs administer current. Medication recorded immediated MAR is to include the (A) client's name; (B) name, strength, (C) instructions for a (D) date and time the (E) name or initials drug. (5) Client requests the	inistration: non-prescription drugs shall ad to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be all licensed persons, or by a trained by a registered nurse, a legally qualified person and and administer medications. Iministration Record (MAR) of a to each client must be kept a sadministered shall be ally after administration. The					

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	MHL032-523		B. WING		10/08/2021	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
	OMES & HABILITATIO	2711 FAY	ETTEVILLE	STREET		
IAIIIII	OWIES & HABIEHATIC	DURHAM	NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ige 1	V 118			
	file followed up by a with a physician.	appointment or consultation				
	facility failed to ens physician's order af (#1) and failed to ke one of three clients	views and interviews, the ure staff followed the fecting one of three clients eep the MAR current affecting (#2). The findings are:				
	follow the physician	dence the facility staff failed to 's order.				
	record revealed: -Admission date of -Diagnoses of Schi. Obstructive Pulmor Dependence, Cogn Hyperlipidemia, His HypertensionPhysician's order of	zophrenia, Chronic nary Disease, Chronic Nicotine lition Impairment and story of Type II Diabetes and dated 12/5/20 for 5 milligrams (mg), three				
	Records (MAR's) for -October 2021-The 325 mg was not ad 10/7September 2021-T Acetaminophen 329/3, 9/14 and 9/27 for september 2021-T	5 mg was not administered on				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL032-523	B. WING		10/0	8/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FAITH H	OMES & HABILITATIO	ON LLC:	ETTEVILLE S , NC 27707	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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)	D BE	(X5) COMPLETE DATE
V 118	325 mg was not ad 8/16, 8/17 and 8/30 Interview with the A Professional on 10/1-Client #1 did not to Acetaminophen dailed -He went to a day promake it home in time Acetaminophen. She confirmed factophysician's order for the MAR current. Review on 10/7/21 record revealed: Admission date of Diagnoses of Depte Encephalopathy, Acetamission date of Diagnoses of Dept	ministered on 8/10, 8/11, 8/13, b. dministrator/Qualified /8/21 revealed: ake the 2pm dose of ally. The second of	V 118			
	revealed: -September 2021-1	of a MAR for client #1 There were blank boxes for the ns: Lantus Solostar 100				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL032-523	B. WING		10/0	8/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FAITH H	OMES & HABILITATIO	ON. LLC	TTEVILLE S	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 118	units/ml on 9/25 thr pm doses on 9/26 a mg on 9/24 thru 9/27 thru 9/27 and Valsa "Due to the failure the medication administ determined if clients ordered by the physical line ordered by the	u 9/27; Sertraline HCL 100 mg and 9/27; Zolpidem Tartrate 10 etc.; Trazadone 100 mg on 9/24 rtan 160 mg on 9/24 thru 9/27. o accurately document tration it could no be a received their medication as sician" #1 on 10/8/21 revealed: sure why client #2 had blank tember 2021 MAR. #2 possibly refused se days. #6 failed to keep the MAR dministrator/Qualified 8/21 revealed: why there were blank spaces ember 2021 MAR. #6 failed to keep the MAR	V 118			
V 291	10A NCAC 27G .56 (a) Capacity. A factorized for the developmental disast on June 15, 2001, at than six clients at the provide services at licensed capacity. (b) Service Coordinal maintained between qualified profession	sed Living - Operations 303 OPERATIONS cility shall serve no more than a clients have mental illness or bilities. Any facility licensed and providing services to more that time, may continue to no more than the facility's mation. Coordination shall be a the facility operator and the talls who are responsible for on or case management.	V 291			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	MHL032-523		B. WING		10/0	8/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ΕΔΙΤΗ Η	OMES & HABILITATIO	ON LLC 2711 FAYE	ETTEVILLE S	STREET		
17111111	T	DURHAM	NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 291	Continued From pa	ige 4	V 291			
	Responsible Perso provided the opporrelationship with he means as visits to the facility. Reports annually to the pare legally responsible Reports may be in conference and shaprogress toward modificativity opportunitien needs and the treat Activities shall be dinclusion. Choices or legal system is in	the Family or Legally n. Each client shall be tunity to maintain an ongoing or or his family through such the facility and visits outside a shall be submitted at least ent of a minor resident, or the person of an adult resident. writing or take the form of a fall focus on the client's feeting individual goals. fies. Each client shall have s based on her/his choices, freent/habilitation plan. fesigned to foster community may be limited when the court fivolved or when health or fine a primary concern.				
	failed to assure ser maintained betwee Qualified Professio treatment/habilitatio (#2). The findings Review on 10/7/21 record revealed: -Admission date of -Diagnoses of Depi Encephalopathy, A Diabetes, Congesti Hypertension, Chro Polysubstance Abunausea.	view and interview, the facility vice coordination was in the facility operator and the nals (QP's) responsible for on affecting one of three clients are: and 10/8/21 of client #2's 5/8/20.				

Solostar 100 units/milliliters (ml), inject

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL032-523	B. WING		10/0	8/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FAITH H	OMES & HABILITATIO	DN. LLC	TTEVILLE S	STREET		
.,	T	DURHAM,	NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 291	Continued From pa	ge 5	V 291			
V 291	subcutaneously at I -Physician's order of milligrams (mg), on Risperidone 0.5 mg -Physician's order of Acetaminophen 32 dailyPhysician's order of Acetate 667 mg, or -Physician's order of two tablets two times-Physician's order of mg, two tablets even mg, two tablets even mg, two tablets even (MAR's) on 10/8/21 -October 2021 had refusals for client # 10/1 pm dose; Land 10/1 and 10/2; Calci	bedtime. dated 6/13/21 for Lorazepam 1 e tablet two times daily and g, one tablet two times daily. dated 9/27/21 for 5 mg, two tablets two times dated 5/26/21 for Calcium he capsule three times daily. dated 3/5/21 for Senna Plus, es daily. dated 12/5/20 for Carvedilol 25	V 291			
	dose; Lorazepam 1 mg on 10/1 pm dose; Risperidone 0.5 mg on 10/1 pm dose; Senna Plus on 10/1 and 10/2 am and pm doses, 10/4 am dose; -September 2021 had the following medication refusals for client #2: Lantus Solostar 100 units/ml on 9/29; Calcium Acetate 667 mg on 9/1, 9/3, 9/6, 9/8, 9/10, 9/13, 9/15, 9/17, 9/20, 9/22, 9/24, and 9/27-12pm doses; Senna Plus on 9/7 pm dose, 9/29 pm dose and 9/30 am and pm dosesAugust 2021 had the following medication refusals for client #2: Calcium Acetate 667 mg on 8/2, 8/4, 8/6, 8/9, 8/19, 8/11, 8/13, 8/15, 8/16, 8/18, 8/20, 8/23, 8/25/, 8/27, 8/30 12pm doses; Senna Plus on 8/2 thru 8/4 am and pm doses, 8/6 am and pm doses, 8/24 pm dose, 8/25 am and pm doses, 8/26 am dose, 8/27 pm dose and 8/28 am and pm doses.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
	MUU 000 500		B. WING		40/00/0004	
		MHL032-523			10/0	8/2021
	PROVIDER OR SUPPLIER	2711 FAYI	DRESS, CITY, S E TTEVILLE S	STATE, ZIP CODE STREET		
FAITH H	OMES & HABILITATIO	ON IIC:	NC 27707	····		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / 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)	_D BE	(X5) COMPLETE DATE
V 291	Continued From pa	ge 6	V 291			
	Interview with the A Professional on 10/-She thought client nausea on some of medications. This is medical issuesClient #2 also did of Thursdays and may medications those client #2 was possibecause her blood lif her blood was at sometimes refuse to take the insulin her lowClient #2 needed to it gives her really be refusing the Senna diarrheaThey had not talke	dministrator/Qualified /8/21 revealed: #2 possibly had diarrhea and those days she refused the s a part of her diagnosis and dialysis on Tuesdays and y have refused her				

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