Division of Health Service Regulation

· · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			_
		MHL0411101	B. WING		1	२ 20/2021
NAME OF PROVIDER OR SU	JPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
M & S CREEKSIDE		7312 FRIE	ENDSHIP CH	URCH ROAD		
W & 5 CREEKSIDE		BROWN	SUMMIT, NC	27214		
PREFIX (EACH DE	FICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 000 INITIAL COI	MMENT	-S	V 000			
	An Annual and Follow-Up Survey was completed on October 20, 2021. A deficiency was cited.					
This facility i category:	s licens	ed for the following service				
		G .5600C: Supervised Living elopmental Disabilities				
V 118 27G .0209 (C) Med	ication Requirements	V 118			
REQUIREM (c) Medication (1) Prescript only be admorder of a per drugs. (2) Medication clients only ordered in the control of t	ENTS on admition or r inistere erson an ons sha when au ician. ons, ince d only b persons or other preparation Ad minister dications mediate clude th ame; crength, ons for a I time th	non-prescription drugs shall d to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the alluding injections, shall be y licensed persons, or by trained by a registered nurse, a legally qualified person and a dminister medications. In ministration Record (MAR) of the each client must be kept as administered shall be ally after administration. The				

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

TITLE (X6) DATE

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
					F	,	
	MHL0411101		B. WING				
		WINLU411101			10/2	0/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
		7312 FRIE	ENDSHIP CH	URCH ROAD			
M & S C	REEKSIDE		SUMMIT, NC				
	011111111111111111111111111111111111111				211		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE	
				DEFICIENCY)			
\/ 110	Continued From no	ugo 1	V 118				
V 110	Continued From pa	ige i	V 110				
	checks shall be rec	orded and kept with the MAR					
		appointment or consultation					
	with a physician.	••					
	1 7						
	This Rule is not me	et as evidenced bv:					
		and record review, the facility					
		Rs for all clients were kept					
	current, and all medications administered were recorded immediately after being administered for three (client #1, client #2 and client #3) of three clients surveyed.						
	The findings are:						
	Review on 10-18-2	1 of client #1 's facility record					
	revealed:	,					
	- admitted 6-2-	19					
	- 70 years old						
	- diagnosed wit	h:					
		Intellectual Disability					
	- Seizure D						
	- Osteopen						
		ophageal Reflux Disease					
	- Lupus	. •					
		cephalopathy					
		7-27-21 by her physician:					
		hydrochloride (hcl) 15					
	milligrams (mg.) on						
		repine extended release (er)					
	100 mg. three, twic						
		tam 500 mg. one, twice daily					
		7-12-21 by her physician:					
		in 300 mg. two, at night					
		9-7-21 by her physician:					
		one 24 micrograms (mcg.) one,					
	145151000	g.a (1110g./ 0110,					

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	of Fleatiff Service IN		I		Τ.	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
					F	,
MHL0411101		B. WING		1	0/2021	
		1911120711101			1 10/2	UI ZUZ I
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
Mecci	DEEKSIDE	7312 FRIE	NDSHIP CH	URCH ROAD		
IVI & S CF	REEKSIDE	BROWN S	SUMMIT, NC	27214		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN .	(X5)
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
				DEI IOIENOT)		
V 118	Continued From pa	ge 2	V 118			
	turing deily					
	twice daily	4.0.04 by box abyainian.				
		4-2-21 by her physician:				
		in 10 mg. one, taken at night				
		0-18-21 at 11:40 am revealed,				
		at was ordered to be given				
		ht, already had the afternoon				
	or nighttime dose re	ecorded as having been given				
	Davidao 40 40 0	1 -				
		1 of client #2 ' s facility record				
	revealed:	40				
	- admitted 6-10	-19				
	- 61 years old					
	- diagnosed with:					
	Moderate Intellectual DisabilitySchizoaffective Disorder, Bipolar Type					
		matic Stress Disorder				
	- Mild heari	ng loss				
	- Obesity					
	- Scoliosis					
	- prescribed on 6-9-21 by her physician:					
		sodium dr (delayed release)				
	500 mg. one, twice					
		e 20 mg. one, twice daily				
	•	e 10 mg. one, twice daily				
		n 400 mg. one, three times				
	daily					
		ne hcl 25 mg. one, three times				
	daily					
		essin acetate 0.2 mg. one,				
	taken at night					
		100 mg. one, taken at night				
		5-28-21 by her physician:				
		in 40 mg. one, taken at night				
		0-18-21 at 11:00 am revealed,				
		at was ordered to be given				
		nes daily, or at night, already				
	had the afternoon a	and nighttime doses recorded				
	as given	-				

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Division	<u>of Health Service Re</u>	egulation	-			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL0411101	B. WING		F 10/2	₹ 0/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
M & S C	REEKSIDE		ENDSHIP CH SUMMIT, NC	URCH ROAD 27214		
(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 SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 3	V 118			
	revealed: - admitted 11-1 - 59 years old - diagnosed wit - Moderate - Convulsiv - Bilateral H - Depressiv - Hyperlipid - prescribed on - clorazepa daily - prescribed on - divalproex times daily - gabapenti daily - phenytoin mg. one three times - risperidon Further review on 1 each medication that twice daily, three tir	h: Mental Retardation e Epilepsy Hearing Loss ve Disorder with Anxiety Hemia 4-27-21 by her physician: te 3.75 mg. one, three times 4-2-21 by her physician: c sod Dr 250 mg. one, three in 600 mg. two, three times sod extended release 100				
	- she worked of she mistaken! indicate the afterno had already been g - "we're suppo (medications) as so - going forward	y initialed the MARs to on and nighttime medications				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	
		MHL0411101	B. WING		F 10/2	R 0/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
M&SC	REEKSIDE			URCH ROAD		
			SUMMIT, NC			
(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 APPROF	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 4	V 118			
	Professional/Director - documentation noticed, "every once - "we are in the to electronic MARs" - staff #1 is a go - "you can ' t rus mistakes" - "I [already] tole	n errors on the MARs are e in a while, but not often" process of eventually moving				

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