Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED MHL092-426 B. WING 07/16/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1232 PENSELWOOD DRIVE STARKEY LOWERY'S SUPERVISED LIVING HC RALEIGH, NC 27604 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 Staff took Medication An annual survey was completed on July 16, Administration Training 2021. A deficiency was cited. on 8/30/2021 This facility is licensed for the following service categories: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living and 10A NCAC 27G .5100 Community Respite Services Always read the label for Individuals of All Disability Groups and document on the V 118 27G .0209 (C) Medication Requirements MAR each time a V 118 medication is administered 10A NCAC 27G .0209 MEDICATION REQUIREMENTS and Make sure of the (c) Medication administration: (1) Prescription or non-prescription drugs shall Right Client only be administered to a client on the written order of a person authorized by law to prescribe Right Drug druas. Right Dose (2) Medications shall be self-administered by clients only when authorized in writing by the Right Route client's physician. Right Time Right Documentation (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. QP or Staff will monitor on a monthly basis to make sure (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: it will not occur again (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 (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 STATE FORM

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If continuation sheet 1 of 3

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		18	A. BUILDING:		COM	MPLETED	
		MHL092-426	B. WING				
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS CITY S	STATE, ZIP CODE	07/	16/2021	
STARKE	EY LOWERY'S SUPER		NSELWOOD [
	_	RALEIGI	H, NC 27604				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRI PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE AP DEFICIENCY)		IIDPE	(X5) COMPLETE DATE	
V 118	Continued From page	ge 1	V 118				
	file followed up by a with a physician.	ppointment or consultation					
	Interview the facility of current affecting one findings are: Review on 7/16/21 of Admitted: 5/11/12 -Diagnoses: Profound Developmental Disable Convulsive Epilepsy -Physician's order data-Famotidine 20mg (mouth twice a day (he-Rosuvastatin Calcium once a day (lower "bata-Famotidine 20mg, taday -Rosuvastatin Calcium orally once a day Record review on 7/16/21 wellower won 7/16/21 wellower on 7/16/21 we	in, record review and failed to keep the MAR of one client (#1). The final client for cl					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED 07/16/2021		
			MHL092-426						
	NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE, ZIP CODE			0111012021		
	STARKE	Y LOWERY'S SUPER	VISED LIVING HC 1232 PEN	NSELWOOD I					
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE		
	V 118	listed on the May, Ju -Client #1 had taken prescribed -Reviews the MARs -She did not notice t listed on the MARs	ge 2 une and July 2021 MARs the medications daily or as daily, "just an oversight" he medications were not Il medications to client #1	V 118					
							- 1		