Division	of Health Service Re	egulation			FORM	APPROVED
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	E SURVEY
	0. 0011112011014	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED
		MHL032-523	B. WING		10/	08/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE	1 10/	00/2021
FAITH H	OMES & HABILITATIO	2744 547	ETTEVILLE S			
		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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	S	V 000		·	
	on October 8, 2021, unsubstantiated (int Deficiencies were c This facility is licens	ed for the following service C 27G .5600A Supervised				
V 118	27G .0209 (C) Medi	cation Requirements	V 118			
	10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (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. (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: (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 administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR					
vision of Hea	alth Service Regulation	R/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE	<del>.</del>	(Y6) DATE

<u>Division</u>	of Health Service R	egulation			FORM	APPROVED
STATEME AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	E SURVEY
		BETTH TO A TON HOUBER.	A. BUILDING:		СОМ	IPLETED
		MHL032-523	B. WING		40	/00/000 <i>4</i>
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE		08/2021
FAITH H	OMES & HABILITATIO		ETTEVILLE S			
		DURHAN	, NC 27707			
(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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD 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 ensu physician's order af (#1) and failed to ke	et as evidenced by: views and interviews, the ure staff followed the fecting one of three clients eep the MAR current affecting (#2). The findings are:				
	The following is evid follow the physician	dence the facility staff failed to so order.				
İ	record revealed: -Admission date of 4 -Diagnoses of Schiz Obstructive Pulmon Dependence, Cogni Hyperlipidemia, Hist HypertensionPhysician's order date	cophrenia, Chronic ary Disease, Chronic Nicotine tion Impairment and cory of Type II Diabetes and atted 12/5/20 for milligrams (mg), three				
	Records (MAR's) for -October 2021-The 2325 mg was not adn 10/7September 2021-The Acetaminophen 325 9/3, 9/14 and 9/27 th	2pm dose for Acetaminophen ninistered on 10/3, 10/6 and ne 2pm dose for mg was not administered on				

Division	of Health Service R	egulation			FORM	APPROVED
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION		E SURVEY IPLETED
		MHL032-523	B. WING		10,	/08/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, 8	STATE, ZIP CODE		
FAITH H	OMES & HABILITATIO	MI, LLC	ETTEVILLE 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	UI D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 2	V 118			<del>  -</del>
	325 mg was not add 8/16, 8/17 and 8/30	ministered on 8/10, 8/11, 8/13,				į
	Professional on 10/ -Client #1 did not ta Acetaminophen dail	ke the 2pm dose of				
	make it home in tim Acetaminophen.	e to take his 2pm dose of the lity staff failed to follow the				
	The following is evidenthe MAR current.	lence the facility failed to keep				
	Review on 10/7/21 a record revealed: -Admission date of 8	and 10/8/21 of client #2's				
İ	-Diagnoses of Depre					
	Diabetes, Congestiv Hypertension, Chror	e Heart Failure, Essential				
1	nausea. -Physician's order da Solostar 100 units/m	ated 8/2/21 for Lantus illiliters (ml), inject				
	Tartrate 10 mg, one	ated 6/13/21 for Zolpidem tablet at bedtime. ated 5/5/21 for Sertraline HCL				
	-Physician's order da	ated 3/5/21 for Trazadone t bedtime and Valsartan 160				
	Review on 10/8/21 o revealed: -September 2021-The following medication: alth Service Regulation.	f a MAR for client #1 here were blank boxes for the s: Lantus Solostar 100				:

Division of Health Service Regulation

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	08/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY,	STATE, ZIP CODE		0072021
	IOMES & HABILITATIO	DURHAM	ETTEVILLE , NC 27707			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 118	units/ml on 9/25 thru pm doses on 9/26 a mg on 9/24 thru 9/2 thru 9/27 and Valsar "Due to the failure to medication administ determined if clients ordered by the phys Interview with staff #-She was really not spaces on her Septe-She thought client # medications on thos-She confirmed staff current for client #2. Interview with the Ac Professional on 10/8-She was not sure won client #2's Septer	u 9/27; Sertraline HCL 100 mg nd 9/27; Zolpidem Tartrate 10 7; Trazadone 100 mg on 9/24 tran 160 mg on 9/24 thru 9/27. It accurately document ration it could no be received their medication as ician.  1 on 10/8/21 revealed: sure why client #2 had blank ember 2021 MAR. 12 possibly refused e days. 15 failed to keep the MAR 15 failed to keep the MAR 16 ministrator/Qualified 16 ministrator/Qualified 16 ministrator/Qualified 16 ministrator/Qualified 16 ministrator/Qualified 16 ministrator/Qualified 16 ministrator/Qualified 17 ministrator/Qualified 17 ministrator/Qualified 17 ministrator/Qualified 17 ministrator/Qualified 17 ministrator/Qualified 17 ministrator/Qualified 17 ministrator/Qualified 17 ministrator/Qualified 17 ministrator/Qualified 17 ministrator/Qualified 17 ministrator/Qualified 17 ministrator/Qualified 18 ministrator/Qualified 18 ministrator/Qualified 18 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualified 19 ministrator/Qualifi	V 118			
V 291	10A NCAC 27G .560 (a) Capacity. A facil six clients when the developmental disable on June 15, 2001, arthan six clients at the provide services at n licensed capacity. (b) Service Coordinate maintained between qualified professional	ed Living - Operations  3 OPERATIONS ity shall serve no more than clients have mental illness or illities. Any facility licensed and providing services to more at time, may continue to o more than the facility's eation. Coordination shall be the facility operator and the is who are responsible for or case management.	V 291			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2711 FAYETTEVILLE STREET  DURHAM, NC 27707  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 291  Continued From page 4  (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility, and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals.  (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.	Division	of Health Service R	egulation				MAPPROVED
MHL032-523    NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE	STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	E SURVEY
AMME OF PROVIDER OR SUPPLIER  FAITH HOMES & HABILITATION, LLC  (X4) ID PREFIX TAG  CONTINUED TO THE APPROPRIATE  V 291  Continued From page 4  (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally reports be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals.  (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan.  Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.			DENTIFICATION NOMBER.	A. BUILDING:	<del></del>		
FAITH HOMES & HABILITATION, LLC  (X4) ID PREFIX TAG  (X4) ID PROVIDERS PLAN OF CORRECTION SHOULD BE CAMPLETE DATE  (X5) TAG  (X6) ID PROVIDERS PLAN OF CORRECTION SHOULD BE CAMPLETE DATE  (X6) PREFIX TAG  (X6) ID PROVIDERS PLAN OF CORRECTION SHOULD BE CAMPLETE DATE  (X6) PREFIX TAG  (X7) ID PROVIDERS PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CAMPLETED TO THE APPROPRIATE DATE  (X6) PREFIX TAG  (X6) PREFIX TAG  (X7) ID PROVIDERS PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CAMPLETED TO THE APPROPRIATE DATE  (ACM) PREFIX TAG  (ACM) PREFIX TAG  (ACM) PREFIX TAG  (C) Participation of the Family or Legally Responsible Person. Each client shall be provided the appropriate participation or his family through such means as visits to the facility and visits outside the facility. Reports shall be bubmitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals.  (d) Program Activities Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.			MHL032-523	B. WING		10	/08/2021
FAITH HOMES & HABILITATION, LLC  2711 FAYETTEVILLE STREET DURHAM, NC 27707    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE    V 291	NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		, OO, LUL 1
SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION)  V 291  Continued From page 4  (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.	FAITH H	OMES & HABILITATION	ON, LLC 2711 FAY	ETTEVILLE S			
REGULATORY OR LSC IDENTIFYING INFORMATION)  V 291  Continued From page 4  (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals.  (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.	(X4) JD	SUMMARY STA		<u> </u>			
(c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.	PRÉFIX TAG	(EACH DEFICIENCY REGULATORY OR L	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP	HOULD BE	COMPLETE
Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals.  (d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan.  Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.	V 291	Continued From pa	ge 4	V 291		<u> </u>	<del> </del>
		Responsible Persor provided the opport relationship with hel means as visits to the facility. Reports annually to the pare legally responsible pare legally responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare responsible pare res	n. Each client shall be unity to maintain an ongoing or or his family through such the facility and visits outside is shall be submitted at least ent of a minor resident, or the person of an adult resident, writing or take the form of a certain individual goals. The esting individual goals es. Each client shall have to based on her/his choices, ment/habilitation plan. The esigned to foster community may be limited when the court volved or when health or				
This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure service coordination was maintained between the facility operator and the Qualified Professionals (QP's) responsible for treatment/habilitation affecting one of three clients (#2). The findings are:  Review on 10/7/21 and 10/8/21 of client #2's record revealed: -Admission date of 5/8/20Diagnoses of Depression, Anxiety, Encephalopathy, Acute Renal Failure, Type II Diabetes, Congestive Heart Failure, Essential Hypertension, Chronic Kidney Disease, Polysubstance Abuse and Hematemesis with nauseaPhysician's order dated 8/2/21 for Lantus		Based on record rev failed to assure serv maintained between Qualified Profession treatment/habilitation (#2). The findings at Review on 10/7/21 at record revealed: -Admission date of 5-Diagnoses of Depre Encephalopathy, Act Diabetes, Congestive Hypertension, Chron Polysubstance AbusenauseaPhysician's order da	riew and interview, the facility ice coordination was the facility operator and the als (QP's) responsible for affecting one of three clients re:  and 10/8/21 of client #2's also also also also also also also als				
Solostar 100 units/milliliters (ml), inject			illiliters (ml), inject				

1JOJ11

Division of Health Service Regulation						APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL032-523		(X2) MULTIPLE CONSTRUCTION A. BUILDING:  B. WING		(X3) DATE SURVEY COMPLETED		
						NAME OF
FAITH H	OMES & HABILITATIO	ON, LLC 2711 FAY	ETTEVILLE : , 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 CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPRO	LLD RE	(X5) COMPLETE DATE
V 291	Continued From pa	ge 5	V 291			<del> </del>
	subcutaneously at the Physician's order of milligrams (mg), one Risperidone 0.5 mg -Physician's order of Acetaminophen 325 dailyPhysician's order of Acetate 667 mg, one Physician's order of two tablets two time Physician's order of two tablets two time Physician's order of two tablets ever Review of Medication (MAR's) on 10/8/21 -October 2021 had the refusals for client #2 10/1 pm dose; Lantu 10/1 and 10/2; Calci and 10/6 pm doses; Lorazepam 1 Risperidone 0.5 mg on 10/1 and 10/2 am dose; September 2021 had refusals for client #2 units/ml on 9/29; Cal 9/3, 9/6, 9/8, 9/10, 9/9/24, and 9/27-12pm pm dose, 9/29 pm dodosesAugust 2021 had the refusals for client #2 8/2, 8/4, 8/6, 8/9, 8/1 8/18, 8/20, 8/23, 8/25 Senna Plus on 8/2 tham and pm doses, 8/25 am and dose, 8/25 am ar great series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and series and	pedtime. lated 6/13/21 for Lorazepam 1 le tablet two times daily and lone tablet two times daily. lated 9/27/21 for long, two tablets two times lated 5/26/21 for Calcium le capsule three times daily. lated 3/5/21 for Senna Plus, lated 3/5/21 for Senna Plus, lated 3/5/20 for Carvedilol 25 long 12/5/20 for Carvedilol 25 long 13/5/20 for Carvedilol 25 long 14/5/20 for Carvedilol 25 long 15/6/20 for Carvedilol 25 long 16/6/20 for Carv	V 291			
	alth Service Regulation	28 am and pm doses.				

PRINTED: 10/. FORM APPR

Division	n of Health Service R	<u>egul</u> ation			PRINTE FORM	D: 10/. /IAPPR
I STALEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DAT	E SURVEY
		MHL032-523	B. WING			IFCE LED
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE ZID CODE		08/2021
FAITH H	OMES & HABILITATIO	ON, LLC 2711 FAY	ETTEVILLE S	TREET		
(X4) ID	<del></del>	DURHAN	I, NC 27707			
PRÉFIX TAG	TOTAL DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)		(X5) COMPLETE DATE
V 291	Continued From pa	ge 6	V 291			<del> </del>
	-She thought client; nausea on some of medications. This is medical issuesClient #2 also did d Thursdays and may medications those d -Client #2 was possi because her blood s -If her blood was at a sometimes refuse to take the insulin her blowClient #2 needed to it gives her really bac refusing the Senna d diarrhea.	#2 possibly had diarrhea and those days she refused the a part of her diagnosis and lialysis on Tuesdays and have refused her ays. bly refusing the insulin ugars are controlled. a good reading she would take the insulin. If she did alood sugar would get too be off of the Senna because it diarrhea. She was possibly ue the issues with the				

STATE FORM

Alani Pagel

1JOJ11

If continuation sheet 7 of 7

MHL 032-523

V118-

Faith Homes & Habilitation 2711 Jayetteville Street Durham. NC 27707

Client #1-

The administrator failed to put a plan in place to ensure that all residents attending a day program will receive their afternoon (2:00 PM medications). A plan was discussed with the primary care physician of all residents to which this pertains. The PCP changed the administration time to 3:00 PM, which allows time for afternoon medications to be administered.

The administrator facilitated having these orders changed in November during the PCP's visit.

## Client #2-

The staff was coached, and training was facilitated on the significance of administering medications and properly recording this in the MAR. The administrator has implemented an additional step to ensure that all medications are passed and recorded. Faith Homes uses electronic MARs, the staff is to leave out of the screen showing that the medications have been passed and then go back into it. If the medication was not recorded properly the first time it will be caught the second time. This new step was implemented on November 30, 2021.

V291-

The administrator discussed Client #2 with her PCP. The discussion included Client #2's refusing her medications due to her nausea and/or feeling bad after dialysis. The PCP had a discussion with client #2 and made changes to her medications. The medication changes have rectified the issue of medications being refused.

The administrator is working closely with the staff and monitoring any medication refusals. The PCP will be notified immediately if any medications are refused more than twice monthly. This new step was implemented on November 30, 2021.

Alou Mondo December 2, 2021