

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/28/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FAIR FAX	STREET ADDRESS, CITY, STATE, ZIP CODE 2535 HIGHWAY 903 SOUTH SNOW HILL, NC 28580
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>A complaint and follow up survey was completed on January 28, 2022. The complaint was unsubstantiated (Intake #NC00185200). A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>The survey sample consisted of audits of 3 of 3 current clients.</p>	V 000		
V 118	<p>27G .0209 (C) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(c) Medication administration:</p> <p>(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.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(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.</p> <p>(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:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p> <p>(D) date and time the drug is administered; and</p> <p>(E) name or initials of person administering the</p>	V 118		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/28/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FAIR FAX	STREET ADDRESS, CITY, STATE, ZIP CODE 2535 HIGHWAY 903 SOUTH SNOW HILL, NC 28580
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 1</p> <p>drug.</p> <p>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by: Based on record reviews and observations the facility failed to administer medications as ordered by a physician for 1 of 3 clients (#1). The findings are:</p> <p>Review on 01/24/22 of client #1's record revealed: -22 year old male. -Admission date of 03/03/15. -Diagnoses of Deafness, Moderate Intellectual Developmental Disability, Iron Deficiency, Anemia, History of Peptic Ulcer, Oppositional Defiant Disorder and Cerebral Palsy.</p> <p>Review on 01/28/22 of client #1's Physician orders revealed: 04/05/21 -Concerta ER 36 mg(milligrams) (treats Attention Deficit Hyperactivity Disorder) Take 1 tablet by mouth every day. 10/11/21 -Polyethylene Glycol 3350 Mix 1 capful in 8oz (ounces) (constipation) of beverage of choice and take by mouth every day.</p> <p>Review on 01/24/22 of client #1's December 2021 and January 2022 MAR revealed the following</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040-009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/28/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER FAIR FAX	STREET ADDRESS, CITY, STATE, ZIP CODE 2535 HIGHWAY 903 SOUTH SNOW HILL, NC 28580
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 2</p> <p>medications were not available to be administered: Concerta ER 36mg -12/9/21 "Med not available" -01/09/22 "Med not available/Unable to administer control meds due to him not having any medication -1/10/22 "Need Meds" -1/11/22 "Med not available/Don't have it" Polyethylene Glycol 3350 -12/22/21-12/28/21 "Med not available"</p> <p>Client #1 was unable to be interviewed due to client being at school and client #1 is deaf and has limited communication.</p> <p>During interview on 01/28/22 the Director of Operations revealed he would ensure the medication were available to be administered to all the clients.</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 118		