STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  MHL054-164  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS. CITY, STATE, ZIP CODE  WITH A PURPOSE FAMILY CARE #1  DOVER, NC. 28526  [M4] ID PREFTY PROVIDER OR SUPPLIER  STREET ADDRESS. CITY, STATE, ZIP CODE  WITH A PURPOSE FAMILY CARE #1  DOVER, NC. 28526  [M4] ID PREFTY PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCES EACH DETRICHING INFORMATION PREFTY PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCES EACH DETRICHING INFORMATION PREFTY PROVIDER OR SUMMARY STATEMENT OF DEFICIENCES EACH DETRICHING INFORMATION PREFTY PROVIDER STATEMENT OF DEFICIENCES EACH DETRICHING INFORMATION PREFTY PROVIDER STATEMENT OF DEFICIENCES OF PROVIDERS PLAN OF CORRECTION CEACH CORRECTION SHOULD BE COMMETTE CHAPTER  V 000  INITIAL COMMENTS  An annual and follow up survey was completed on May 19, 2022. A deficiency was cited.  This facility is licensed for 3 and currently has a census of 2. The survey sample consisted of audits of 2 current clients.  V 118  10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication shall be self-administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications, including injections, shall be administered only by licensed persons, or by unificensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medications administration the written order of a person authorized in writing by the client's physician. (3) Medications administration to each client must be kept current. Medications administered shall be recorded immediately after administered; and (E) name or initials of person administered; and (E) name or initials of person administering the drug. (D) date and time the drug is administered; and (E) name or initials of person administering the drug.	Division	of Health Service Re	egulation			
MAME OF PROVIDER OR SUPPLIER  TREET ADDRESS, CITY, STATE, ZIP CODE  2204 LOVICK ROAD DOVER, NC 28256  102 SUMMARY STATEMENT OF DEFCIENCIES PREFIX TAG  NOTIFICATION OF THE PROVIDER STATE  (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  VO00  INITIAL COMMENTS  An annual and follow up survey was completed on May 19, 2022. A deficiency was cited.  This facility is licensed for the following service category: 10A NCAC 27G. 5600A, Supervised Living for Adults with Mental Illness.  This facility is licensed for 3 and currently has a census of 2. The survey sample consisted of audits of 2 current clients.  V118  10A NCAC 27G. 0209 MEDICATION REQUIREMENTS (c) Medication Requirements (d) Medications shall be self-administered by clients only when authorized in writing by the clients physician.  (3) Medications, including injections, shall be administered or other legally qualified person and privileged to prepare and administer medications.  (4) A Medication Administration Record (MAR) of all drugs administered to a client nust be kept current. Medications administer medications.  (4) Medication administeration Record (MAR) of all drugs administered to a client must be kept current. Medications administered thall 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; (C) date and time the drug is administered; and (E) name or initials of person administering the	STATEMENT OF DEFICIENCIES					
WITH A PURPOSE FAMILY CARE #1    DOVER, NC 28526   DOVER, NC 28526			MHL054-164	B. WING		1
WITH A PURPOSE FAMILY CARE #1    CAN   ID   PREFIX   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   (EACH DEFICIENCY MUST BE PRECEDED BY FULL   TAG   PREFIX	NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE	1
CALID   SUMMARY STATEMENT OF DEFICIENCES   PROVIDERS PLANO CORRECTION   CACH OF DEFICIENCY MUST BE RECEDED BY PILL   REGULATORY OR LSC IDENTIFYING INFORMATION)   PRETIX TAG   TAG   CROSS-REFERENCED TO THE APPROPRIATE   DATE	WITH A F	PURPOSE FAMILY CA	ARE #1 2204 L	OVICK ROAD		
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			or person administering the			-

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Division	of Health Service Re	egulation				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	-	MHL054-164	B. WING		R <b>05/19/2022</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
WITH A	PURPOSE FAMILY CA	ARF #1 2204 LO	VICK ROAD NC 28526			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLE	
V 118	(5) Client requests checks shall be rec	nge 1 for medication changes or corded and kept with the MAR appointment or consultation	V 118	ŵ .		Berlingtonen (v.
	facility failed to keep one of two clients (#Review on 05/18/22 revealed: - 66 year old male Admission date of - Diagnoses of Schi Alcohol Abuse, Mild Disability and High Review on 05/18/22 physician order date - Hydrochlorothiazio 12.5 milligrams (mg	views and interviews, the p the MARs current affecting #2). The findings are:  2 of client #2's record  7 02/01/12.  8 izophrenia-Paranoid Type,  8 Intellectual Developmental Cholesterol.  2 of client #2's signed ed 04/28/22 revealed: 8 de (treats high blood pressure) 9) - take one tablet daily.		The Qualified Profe	ssianal 7/13/	22
	May 2022 MARs re: Hydrochlorothiazide indicate the medica ordered.  Interview on 05/18/2 stated: - The pharmacy had Hydrochlorothiazide	2 of client #2's April 2022 and vealed no transcribed entry for and no staff initials to tion was administered as 22 the Qualified Professional d not put the order for a on the May 2022 MAR.		will review All MAR review   document imm when client goes to doctris appt. on the for newly added med	is and to	

Division of Health Service Regulation

Elizabeth Soneth 7/13/22 Administrator

If continuation sheet 2 of 3

PRINTED: 05/31/2022 **FORM APPROVED** 

DIVISION	of Health Service Re	egulation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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WITH A	PURPOSE FAMILY CA	RE #1 2204 LOV	ICK ROAD IC 28526		
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V 118	MAR.  Due to the failure to medication adminis	e was added to the current  accurately document tration it could not be ent received their medications	V 118	The QP contacted to pharmacy of a mark of remarked for the medication. QP remarks that the concern. Staff will meds to makes and for all given medicated for the given medicated with the pharmacy make swe makes to make the pharmacy make swe makes to completed and new meds are padded updated.	was 1/13/22 new Es viewed sign priors.

Division of Health Service Regulation TATE FORM

Elizabeth Smith 7/13/22 Administratore

STATE FORM

If continuation sheet 3 of 3