Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
741512741	or connection	IDENTIFICATION NOMBER.	A. BUILDING:		JOINII EETEB	
		MHL013-159	B. WING		05/16/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CAPTAINS	S WATCH		DRIVE NE D, NC 28027			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	An annual survey was Deficiencies were cite	s completed on 5/16/22. ed.				
		d for the following category: OC Supervised Living for nental Disabilities.				
This facility is licensed for 3 and has a current census of 3. The sample consisted of audits of 3 current clients.						
V 119	27G .0209 (D) Medic	ation Requirements	V 119			
	V 119 27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30					

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

(X6) DATE TITLE

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND I EAR OF CONNECTION		A. BUILDING: _					
		MHL013-159	B. WING		05/	16/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE			
CAPTAINS	S WATCH		D DRIVE NE RD, NC 28027				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETE DATE	
V 119	Continued From page 1		V 119				
	calendar days after th	ne date of discharge.					
	This Rule is not met	as evidenced by:					
		riew, observations and					
	interviews, the facility medications in a man						
	medications in a manner that guards against diversion or accidental ingestion affecting 3 of 3						
	clients(#3 and #3). The findings are:						
	Finding #1:						
	Review on 5/12/22 of	client #1's record revealed:					
	-admission date of 3/s	5/10; Spectrum, Intermittent					
	Explosive Disorder(D						
		igeal Reflux Disorder),					
	HTN(Hypertension), (and IDD(Intellectual [Constipation, Osteopenia					
	Disability)-Moderate;	ovolopmontal					
	-physician's order dated 9/8/21 for						
	needed(prn).	g one tablet as bed as					
	Observations on 5/16	6/22 at client #1's Cyclobenzapine 10mg one					
	tablet as bed prn not						
	·						
		nd 5/16/22 of client #1's 022 and 5/2022 revealed					
	client #1 had not been						
	Cyclobenzapine 10m	g one tablet as bed prn.					
	Interview on 5/16/22	with staff #1 revealed prn					
		ed and has been re-ordered.					
	Finding #2:						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL013-159	B. WING		05	5/16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
CAPTAINS	S WATCH		D DRIVE NE			
	OLIMANDY OT		RD, NC 28027	DDOV/IDEDIO DI ANI OF	CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 119	Continued From page	e 2	V 119			
	Review on 5/12/22 of client #2's record revealed: -admission date of 1/28/11; -diagnoses of Major Depressive Disorder, OCD(Obsessive Compulsive Disorder), Intermittent Explosive D/O, IDD-Mild, Brittle Diabetes, Insomnia and GERD; -physician's order dated 8/23/21 for Artificial Tears 1-2 drops in eyes four times daily as needed. Observations on 5/16/22 at 10:10am of client #2's medications revealed Artificial Tears 1-2 drops in eyes four times daily as needed over the counter with expiration date of 3/2022. Review on 5/12/22 and 5/16/22 of client #2's MARs for 3/2022, 4/2022 and 5/2022 revealed client #2 had not been administered Artificial Tears 1-2 drops in eyes four times daily as needed.					
		with staff #1 revealed she edication was expired.				
	-admission date of 1/2 -diagnoses of Unspect Schizophrenia, IDD-N balder, insomnia and -physician's order dat medications: Naproxed daily prn and Prometlevery 4 hours prn.	cified Psychosis, Mild, GERD, overactive movement disorder; red 2/11/22 for the following en 500mg one tablet twice nezine 25mg one tablet				
	medications revealed	22 at 10:00am of client #2's Naproxen 500mg one tablet comethezine 25mg one orn not on site.				
	Review on 5/12/22 ar	nd 5/16/22 of client #3's				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL013-159		B. WING		05/16/2022		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CAPTAINS	S WATCH	514 TODD				
	QUILLA DV QT		, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 119	Continued From page 3		V 119			
	MARs for 3/2022, 4/2022 and 5/2022 revealed client #3 had not been administered Naproxen 500mg one tablet twice daily prn and Promethezine 25mg one tablet every 4 hours prn. Interview on 5/16/22 with staff #1 revealed -the prn medications were expired; -new ones have been re-ordered; -should be delivered today. Additional observations on 5/16/22 at 2:50pm of client #3's medications produced by staff #1 revealed: -Naproxen 500mg one tablet twice daily prn dispensed 5/12/22; -Promethezine 25mg one tablet every 4 hours prn dispensed 5/12/22.					
V 120	and 86 degrees Fahre (B) in a refrigerator, if degrees and 46 degre refrigerator is used fo shall be kept in a sep or container; (C) separately for eac (D) separately for ext (E) in a secure manne for a client to self-mee (2) Each facility that in controlled substances	9 MEDICATION ge: all be stored: ed cabinet in a clean, d room between 59 degrees enheit; required, between 36 ees Fahrenheit. If the r food items, medications arate, locked compartment ch client; ernal and internal use; er if approved by a physician dicate. maintains stocks of	V 120			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL013-159		B. WING		05/16/2022		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	00.10.2022	
CAPTAINS	S WATCH	514 TODI	D DRIVE NE			
OAF IAING	WAICH	CONCOR	RD, NC 28027			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
V 120	Continued From page 4		V 120			
	Substances Act, G.S. subsequent amendme	90, Article 5, including any ents.				
This Rule is not met as evidenced by: Based on records review, observations and interviews, the facility failed to ensure medications were stored separately for each client and separately for external and internal use affecting 2 of 3 clients(#2, #3). The findings are;						
	-admission date of 3/s -diagnoses of Autism Explosive Disorder(Dis	Spectrum, Intermittent /O), geal Reflux Disorder), Constipation, Osteopenia				
	medications revealed bed stored with client Finding #2: Review on 5/12/22 of	l/22 at 10:25am of client #1's Imiquimond Cream apply at #1's internal medications. client #2's record revealed:				
	Diabetes, Insomnia a	Depressive Disorder, pulsive Disorder), D/O, IDD-Mild, Brittle nd GERD; ded 8/23/21 for Tolfaftate				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL013-159	B. WING		05	/16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
CAPTAINS	S WATCH		D DRIVE NE RD, NC 28027			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 120	Observations on 5/16 medications revealed once daily as needed medications. Interview on 5/16/22 -unable to find client once daily as needed know he has the pownot in his medication.	S/22 at 10:10am of client #2's I Tolfaftate Powder apply I not with his other with staff #1 revealed: #2's Tolfaftate Powder apply I; wder; n box. on 5/16/22 at 10:25am Tolfaftate Powder apply once	V 120			

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