Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.1.12 . 27.11	o. oo		A. BUILDING:	<del></del>		
		MHL063-002	B. WING		08/2	3/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
BETHESI	DA INC		H PINE STR N, NC 2831	EET BUILDING A 5		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	rs	V 000			
	completed on Augu was substantiated ( Deficiencies were c					
	category: 10A NCAC 27G .32 Detoxification for St 10A NCAC 27G .56	_				
	census of 13. The s	sed for 18 and currently has a survey sample consisted of clients and 1 deceased client.				
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	only be administere					
	clients only when a client's physician. (3) Medications, inc	all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by				
	unlicensed persons pharmacist or other privileged to prepar (4) A Medication Ad all drugs administer current. Medication	s trained by a registered nurse, legally qualified person and legally qualified person and legally administer medications. Iministration Record (MAR) of red to each client must be kept administered shall be lely after administration. The				

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:	(X2) MULTIPLE CONSTRUCTION ( A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					   F	₹	
		MHL063-002	B. WING			3/2022	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
BETHES	DA INC		H PINE STR EN, NC 2831	EET BUILDING A 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 118	(C) instructions for (D) date and time the (E) name or initials drug. (5) Client requests checks shall be recommended.	ge 1  and quantity of the drug; administering the drug; ne drug is administered; and of person administering the  for medication changes or orded and kept with the MAR appointment or consultation	V 118				
	interviews the facilit orders for administed of four audited clier medication adminis	et as evidenced by: eview, observations, and ty failed to: A) Have physician ered medications affecting one ats (#1); and B) Ensure the stration record (MAR) was our audited clients (#1). The					
	-Admission date of	of Client #1's record revealed: 11/17/21 amphetamine Dependence.					
	orders revealed: -There were no ord one tablet dailyThere were no ord tablet daily.	of Client #1's physician's ers for Escitalopram 10 mg, ers for Aripiprazole 5 mg, one					
	medications revealer-Escitalopram 10 m						

Division of Health Service Regulation

STATE FORM 6899 G9UY11 If continuation sheet 2 of 4

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL063-002	B. WING		08/2	R 3/2022
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHES	DA INC		TH PINE STR EN, NC 2831	REET BUILDING A 15		
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 2	V 118			
	2022 through August-Escitalopram 10 mmarked when given 7/1-7/3, 7/11-7/17, 8-Aripiprazole 5 mg marked when given 7/1-7/3, 7/11-7/17, 8-Review on 8/23/22 -Escitalopram- used	was listed and was being . Blanks were observed from				
	revealed: -Agency did not have in their own medical -Facility stored the rout to them when the Client #1 was not to they would just lead he would not take the was not aware for every time the comedicationsHe confirmed that physician orders for the confirmed the formed the	medication and handed them ney needed them daily. aking his medications daily. we the date blank whenever ne medication. that they needed to have a log lient did not take their the facility failed to have administered medications. acility failed to ensure the tration record (MAR) was				
V 752	27G .0304(b)(4) Ho	t Water Temperatures	V 752			
	EQUIPMENT (b) Safety: Each fa	04 FACILITY DESIGN AND cility shall be designed, uipped in a manner that				

6899

Division of Health Service Regulation STATE FORM

G9UY11 If continuation sheet 3 of 4

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		A. BUILDING:				
	MHL063-002	B. WING			R <b>23/2022</b>	
NAME OF PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE			
BETHESDA INC		TH PINE STR EN, NC 2831	EET BUILDING A 5			
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
visitors.  (4) In areas of exposed to hot water water shall be maintained degrees Fahrenheit.  This Rule is not med Based on observation failed to maintain the 100-116 degrees Fall Observation of the fall 12:40 pm and 1:00 propersure of 120 crossinks in the Men's have temperature of 120 crossinks by the three propersure of 120 crossinks in bathroom between temperature of 120 cr	It safety of clients, staff and It the facility where clients are r, the temperature of the ained between 100-116  It as evidenced by: It as evide	V 752				

6899

Division of Health Service Regulation STATE FORM

G9UY11 If continuation sheet 4 of 4