STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI. AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
712 . 271	0. 00.11.20.10.1		A. BUILDING:			
		MHL068-117	B. WING		03/0	₹ )3/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAGGIE	ALVIS WOMEN'S HA	J FWAY HOUSE	STATESIDE HILL, NC 27			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMEN	TS	V 000			
		ow up survey was completed Deficiencies were cited.				
	This facility is licensed for the following service category: 10A NCAC 27G .5600E Supervised Living for Adults with Substance Abuse Dependency.					
		sed for 12 and currently has a urvey sample consisted of clients.				
V 118	27G .0209 (C) Med	lication Requirements	V 118			
	118 27G .0209 (C) Medication Requirements  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					

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL068-117	B. WING			R <b>03/2023</b>
	PROVIDER OR SUPPLIER	I FWAY HOUSE 114 NEW	DRESS, CITY, S' STATESIDE D HILL, NC 275	DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	drug. (5) Client requests checks shall be rec	ge 1 for medication changes or orded and kept with the MAR appointment or consultation	V 118			
	facility failed to kee two of three audited The findings are:  a. Review on 3/3/2 revealed: -Admission date of -Diagnoses of Opio	views and interviews, the p the MAR current affecting d current clients (#1 and #2).  3 of client #1's record				
	Review on 3/3/23 of #1 revealed:  -Order dated 11/16/milligrams (mg) (Secondary dated 10/6/2 micrograms (mcg) in morning Vitamin B-1 100 mg tablet in the mornin Quetiapine 100 mg twice a day Lithium 300 mg (Big twice a day)	f physician's orders for client  /22 for Levetiracetam 500 eizures), one tablet twice a day  /22 for Folic Acid 1000 (Folate deficiency), one tablet  // (Thiamine Deficiency), one				

Division of Health Service Regulation

STATE FORM 6899 PEYV11 If continuation sheet 2 of 5

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL068-117	B. WING			R <b>03/2023</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
MAGGIE	ALVIS WOMEN'S HA	I EWAY HOUSE 114 NEW	STATESIDE	DRIVE		
WIAGGIL	ALVIS WOMEN S HA	CHAPEL	HILL, NC 27	516		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 2	V 118			
	times a day Gabapentin 800 mg times a day Prazosin 1 mg (Ant Retention), three ta Review on 3/3/23 o February 2023-No s for the following me -Folic Acid 1000 mg -Levetiracetam 500 -Vitamin B-1 100 mg -Quetiapine 100 mg -Lithium 300 mg on -Buprenorphine 8-2 2/18 3pm dose -Buspirone 10 mg dose and 2/19 3pm	Anxiety), two tablets three g (Seizures), one tablet three ihypertensive and Urinary blets at bedtime f MARs for client #1 revealed: staff initials as administered edications: ag on 2/1 thru 2/13 and 2/18 mg on 2/6 7am dose g on 2/6 7am dose 2/6 7am dose mg on 2/6 7am dose and on 2/6 7am dose, 2/18 3pm dose g on 2/6 7am dose, 2/18 7am dose				
	the following medic -Folic Acid 1000 mc -Levetiracetam 500 doses -Lithium 300 mg on -Buprenorphine 8-2 7pm dose -Buspirone 10 mg of	taff initials as administered for ations: ag on 1/20 thru 1/27 and 1/31 mg on 1/1 and 1/2 9pm  1/1 and 1/2 9pm doses mg on 1/2 3pm dose and 1/6 on 1/6 7am dose, 1/1 and 1/2				
	revealed: -Admission date of -Diagnoses of Alcol	12/20/22. nol Use Disorder, Opioid Use				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7t. BOILDING.		_   R	
		MHL068-117	B. WING		1	3/2023
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAGGIE	ALVIS WOMEN'S HA	I FWAY HOUSE	STATESIDE HILL, NC 27			
(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 CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 118	Continued From pa	age 3	V 118			
	Disorder, Depressi	s Use Disorder, Bipolar I on, Generalized Anxiety tion Disorder Hyperactivity				
	#2 revealed: -Order dated 1/6/23	of a physician's order for client 3 for Trazodone 50 mg 5 Disorders), one tablet at				
		of a MAR for client #2 revealed: initials as administered on 1/26 done.				
	-She thought there #1 January and Fe client #1 would son downstairs to get h -She also thought of appointments during to get her medication -She wasn 't sure to client #2's January	client #1 possibly had medical ng the time she was supposed ons. why staff left blank spaces on 2023 MAR. ff failed to keep the MARs				
	Director revealed: -She thought client 2023 MARs had bla would sometimes r -She wasn 't sure for January 2023.	#1's January and February ank spaces because client #1 efuse to take her medication. why client #2's MAR was blank ff failed to keep the MARs #1 and #2.				
		o accurately document stration it could not be				

Division of Health Service Regulation

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		MHL068-117	B. WING		I	<b>⊰</b> 03/2023
NAME OF PROVIDER OR SUPPLIER  MAGGIE ALVIS WOMEN'S HALFWAY HOUSE  STREET ADDRESS, CITY, STATE, ZIP CODE  114 NEW STATESIDE DRIVE  CHAPEL HILL, NC 27516						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
	Continued From page determined if clients as ordered by the p	s received their medications	V 118			

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STATE FORM 6899 PEYV11 If continuation sheet 5 of 5



March 17, 2023

MAR 2 8 2023

**DHSR-MH Licensure Sect** 

Freedom House Recovery Center 104 New Stateside Drive Chapel Hill, NC 27516

MHL: # 068-117

Re: Maggie Alvis House Survey 3/3/2023

This plan of correction is in response to the annual survey completed March 3, 2023.

V118 - 27G 0209 (C) - Medication Requirements

Findings: Based on record reviews and interviews, the facility failed to keep the MAR current affecting two of the three audited current clients (#1 and #2).

**Measures to Correct:** The Director of Outpatient Services, Program Manager, and HR Director will continue to assure that staff have the required trainings within the specified time frame. Training and/or retraining for all staff will be conducted in proper medication observation/administration procedures. In addition, medication policies and procedures will be reviewed with all staff that monitor medications.

**Measure to prevent:** The Program Manager as supervised by the licensed clinical supervisor/Director of Outpatient Services will review the MARs daily to ensure that all medications have appropriate notations and signatures. Monthly, the team nurse will review the MARs to ensure all forms and affiliated documentation are in alignment with the rules and regulations.

Who will monitor and how often: The Program Manager will monitor the MARs daily for appropriate completions and the team nurse will monitor monthly to ensure compliance.

Director of Outpatient and Residential Services



