STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL012-145	A. BUILDING: _____ B. WING _____	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREYSTONE	114 ERWIN STREET MORGANTON, NC 28655

(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	INITIAL COMMENTS An annual survey was completed on 4/17/23. Deficiencies were 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 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.	V 000		
V 113	27G .0206 Client Records 10A NCAC 27G .0206 CLIENT RECORDS (a) A client record shall be maintained for each individual admitted to the facility, which shall contain, but need not be limited to: (1) an identification face sheet which includes: (A) name (last, first, middle, maiden); (B) client record number; (C) date of birth; (D) race, gender and marital status; (E) admission date; (F) discharge date; (2) documentation of mental illness, developmental disabilities or substance abuse diagnosis coded according to DSM IV; (3) documentation of the screening and assessment; (4) treatment/habilitation or service plan; (5) emergency information for each client which shall include the name, address and telephone number of the person to be contacted in case of sudden illness or accident and the name, address and telephone number of the client's preferred physician; (6) a signed statement from the client or legally responsible person granting permission to seek emergency care from a hospital or physician;	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL012-145	A. BUILDING: _____ B. WING _____	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREYSTONE	114 ERWIN STREET MORGANTON, NC 28655

(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 113	Continued From page 1 (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143. This Rule is not met as evidenced by: Based on record review and interview, the facility staff failed to maintain a complete client record to include consent for emergency treatment for 2 of 3 audited clients (Clients #1, #2). The findings are: Record review on 4/17/23 for Client #1 revealed: -Date of Admission-1/17/20 -Diagnoses- Schizophrenia, Bipolar, Depression, Gastroesophageal Reflux, Hyperlipidemia, Obstructive Sleep Apnea, Hypertension, Deaf. -He was his own guardian. -There was no signed consent for emergency treatment in his record. Record review on 4/17/23 for Client #2 revealed: -Date of Admission-1/17/20. -Diagnoses- Chronic Cough, Deaf, Major	V 113		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL012-145	A. BUILDING: _____ B. WING _____	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREYSTONE	114 ERWIN STREET MORGANTON, NC 28655

(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 113	Continued From page 2 Depression, Personality Disorder, Diabetes, Hypertension, Hyperlipidemia, Borderline Intellectual Functioning. -There was no signed consent for emergency treatment in his record. Interview on 4/17/23 with the Director revealed: -They had updated their intake and annual consents but were only updating for existing clients as they came due. The consent for emergency treatment was in the new packet.	V 113		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to obtain a pharmacist's or physician's review of medications every 6 months for 2 of 3 audited clients (Client #1, #2). The findings are:	V 121		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL012-145	A. BUILDING: _____ B. WING _____	04/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREYSTONE	114 ERWIN STREET MORGANTON, NC 28655

(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 121	Continued From page 3 Record review on 4/17/23 for Client #1 revealed: -Date of Admission-1/17/20. -Diagnoses- Schizophrenia, Bipolar, Depression, Gastroesophageal Reflux, Hyperlipidemia, Obstructive Sleep Apnea, Hypertension, Deaf. -Physician ordered medications on 2/17/23 included: -Lamotrigine 100mg (milligrams) (bipolar)- 1 tablet twice daily. -Olanzapine 20mg (antipsychotic)- 1 tablet at bedtime. -There was no 6 month review of psychotropic medications. Record review on 4/17/23 for Client #2 revealed: -Date of Admission-1/17/20. -Diagnoses- Chronic Cough, Deaf, Major Depression, Personality Disorder, Diabetes, Hypertension, Hyperlipidemia, Borderline Intellectual Functioning. -Physician ordered medications on 11/17/22 included: -Sertraline 100mg (depression)- 1 tablet every day. -Topiramate 25mg (bipolar) - 2 tablets every day. -Ziprasidone 40mg (antipsychotic) - 1 capsule twice daily. -There was no 6 month review of psychotropic medications. Interview on 4/17/23 with the House Manager and the Qualified Professional revealed: -Their clients only see their doctors annually. -Client #1 and Client #2 do not see a psychiatrist. Their primary care physician writes the orders for psychotropic medications.	V 121		