Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R B. WING MHL092-916 05/04/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 450 BUILDING FUTURES CIRCLE LEARNING SERVICES CORPORATION-CEDAR RALEIGH, NC 27610 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual and follow up survey was completed on May 4, 2023. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .2100 Specialized Community Residential Centers for Individuals with Developmental Disabilities. This facility is licensed for 12 and currently has a census of 9. The survey sample consisted of audits of 3 current clients. V 118 27G .0209 (C) Medication Requirements V 118 RECEIVED 10A NCAC 27G .0209 MEDICATION MAY 2 6 2023 REQUIREMENTS (c) Medication administration: **DHSR-MH Licensure Sect** (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 (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 administered; and (E) name or initials of person administering the

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LABORATORY DIRECTOR'S OR PROVIDER/SAPPLIER REPRESE

PLIER REPRESENTATIVE'S SIGNATURE

en 5/19/22

(X6) DATE

If continuation sheet 1 of 3

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING: R B. WING MHL092-916 05/04/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 450 BUILDING FUTURES CIRCLE LEARNING SERVICES CORPORATION-CEDAR RALEIGH, NC 27610 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 118 Continued From page 1 V 118 drua. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure medications were given on the written order of a physician and MARs were kept current for two of three audited clients (#3 & #7). The findings are: Review on 5/3/23 of client #3's record revealed: -Admission date of 1/12/21 -Diagnoses of Traumatic Brain Injury (TBI) and Diabetes Type II Review on 5/3/23 of client #7's record revealed: -Admission date of 11/5/96 -Diagnoses of TBI and Hypertension Review on 5/3/23 of client #3's Physician Order dated 4/6/23 revealed: -"Humalog Kwikpen (diabetes) 100u- Inject 1.6

-3/23/23 & 4/21/23

date 4/6/23 revealed:

units subcutaneously three times daily before meals. No insulin after 8 PM. See sliding scale"

Review on 5/3/23 of client #3's MARs revealed the following dates of Humalog not initialed:

Review on 5/3/23 of client #7's Physician Order

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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	
		MHL092-916	B. WING		05/0	₹ 4/2023	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 450 BUILDING FUTURES CIRCLE RALEIGH, NC 27610							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
V 118	RNING SERVICES CORPORATION-CEDAR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		:	Medication Staff will run a may variance report before the er shift. Any missing initials will followed up on by the medica staff person before the end of shift. Shift Coordinators will run a medication variance report by the end of the shift as a second check. Operations Manager of up with Shift Coordinators were ensure variance reports are completed. Nursing will run a variance reported once per week.	nd of the I be ation of the efore and will follow eekly to	5/11/23 and ongoing 5/11/23 and ongoing	

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