PRINTED: 08/06/2023 FORM APPROVED

Division of Health Service Regulation

|   |             | ENT OF DEFICIENCIES AND CORRECTION   | (X1) PROVIDER/SUPPLIER/CLI<br>IDENTIFICATION NUMBER:                     | A (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |          |  |  |
|---|-------------|--|--|---|--|-------------------------------|----------|--|--|
|   |             |  | MHL052-012   |   |  |                               | R        |  |  |
| NAME OF PROVIDER OF SUPERIOR  |             |  |  | B. WING                                   |  |                               | /27/2023 |  |  |
| l   |             |  |  | ADDRESS, CITY, STATE, ZIP CODE            |  |                               |          |  |  |
|   | QUALIT      | ΓY-CARE BEHAVIORAL   | HEALTH II  | RTH STREE                                 | Γ  |                               |          |  |  |
| L   |             |  |  | LE, NC 285                                | 555  |                               |          |  |  |
| (X4) ID<br>PREFIX<br>TAG  |             | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |  | ID<br>PREFIX TAG                          | PROVIDER'S PLAN OF CORRECTION  | (X5)<br>COMPLETE<br>DATE      |          |  |  |
|   | V 00        | 0 INITIAL COMMENT  | rs .   | V 000                                     |  |                               |          |  |  |
|   |             | July 27, 2023. A defic   | up survey was completed on iency was cited.  I for the following service |   |  |                               |          |  |  |
|   |             | category: 10A NCAC for Alternative Family  | 27G .5600F Supervised Living   |   |  |                               |          |  |  |
|   |             | This facility is licensed of 2. The survey samp current clients.   | for 3 and current has a census le consisted of audits of 2               |   |  |                               |          |  |  |
| V 118  27G .0209 (C) Medication Requirements  10A NCAC 27G .0209 MEDICATION |             |  | V 118  | QCBHS will follow the                     |  | 8/10/23                       |          |  |  |
|   |             | 27C 0200 (C) M 11 11 2   |  |   | medication Requiremen  |                               |          |  |  |
|   |             | 27G .0209 (C) Medication Requirements  |  |   | Man and a second |                               |          |  |  |
|   |             | 10A NCAC 27G .0209 MEDICATION  |  |   | rules as stated and  |                               |          |  |  |
|   |             | REQUIREMENTS   |  |   | monitored by QP month  | ly or                         |          |  |  |
|   |             | (c) Medication administration:   |  |   |  | Iy OI                         |          |  |  |
|   |             | (1) Prescription or non-prescription drugs shall   |  | 1   | as needed.   |                               |          |  |  |
|   |             | only be administered to  | a client on the written order of   |   |  |                               | 1        |  |  |
|   |             | a person authorized by I   | aw to prescribe drugs.   |   |  |                               | - 1      |  |  |
|   |             | (2) Medications sha  | all be self-administered by  |   |  |                               | 1        |  |  |
|   |             | clients only when author   | rized in writing by the client's   |   |  |                               | 1        |  |  |
|   |             | physician.   |  |   |  |                               |          |  |  |
|   |             | (3) Medications, in  | cluding injections, shall be   |   |  |                               |          |  |  |
|   |             | administered only by lic   | ed by a registered asset   |   |  |                               | 1        |  |  |
|   |             | unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and                     |  |   |  |                               | - 1      |  |  |
|   |             | privileged to prepare and  | d administer medications. (4) A  |   | DHSR - Mental Health   | 1                             | - 1      |  |  |
|   |             | Medication Administrati  | on Record (MAR) of all drugs   |   | DHSK - Merica  |                               | - 1      |  |  |
|   |             | administered to each clie  | ent must be kept current.  |   | AUG 1 7 2023   |                               |          |  |  |
|   |             | Medications administere  | d shall be recorded  |   | AUG I LOLD   |                               |          |  |  |
|   |             | immediately after admin  | istration. The MAR is to   |   | - Castion  |                               |          |  |  |
|   |             | include the following: (A) client's name;  |  |   | Lic. & Cert. Section   |                               |          |  |  |
|   | 10.00       |  | and quantity of the drug;  |   |  |                               | 1        |  |  |
|   | 10.00       | (C) instructions for a   | and quantity of the drug;<br>administering the drug;                     |   |  |                               |          |  |  |
|   |             |  | e drug is administered; and (E)  |   |  |                               |          |  |  |
|   | 1           | name or initials of person   | administering the drug.  |   |  |                               |          |  |  |
| S   | ion of Heal | th Service Regulation  |  |   |  |                               |          |  |  |
| U   | KATOKYD     | IKECTOR'S OR PROVIDER/SUPI   | PLIER REPRESENTATIVE'S SIGNATURE   |   | TITLE  | (X6                           | ) DATE   |  |  |
| -   | 1KV         | rende:   | Hick   |   | (P)  | 0/                            | ,        |  |  |
|   | 4           |  | ~  |   | / / / / / /  | 1//                           | /        |  |  |

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## Division of Health Service Regulation

| STATE FORM  |   |  | 5899 T                                    | DAU11   | If continuation sheet 1 of 3  |                          |  |
|---|---|--|---|---|-------------------------------|--------------------------|--|
| STATE FORM  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION        |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A (X2) MULTIPLE CONSTRUCTION A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED |                          |  |
|   |   | MHL052-012   | B. WING                                   |   | R<br>07/2                     | 7/2023                   |  |
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE |   |  |   |   |                               |                          |  |
| TWINE OF THE  |   | 301 FOUR   | RTH STREET                                |   |                               |                          |  |
| QUALITY   | Y-CARE BEHAVIORAL   | HEALTH II MAYSVIL                                  | LE, NC 2855                               | 55  |                               |                          |  |
| (X4) ID<br>PREFIX<br>TAG  | X4) ID SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  (EACH DEFICIENCY MUST BE PRECEDED MATION) |  | ID<br>PREFIX TAG                          | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |                               | (X5)<br>COMPLETE<br>DATE |  |

8-10-23

Division of Health Service Regulation V 118 | Continued From page 1 V 118 Each time a PRN is (5) Client requests for medication changes or checks administered, QCBHS QP shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. will document the medication name, date, time, explanation, and results on the back of the MAR. QP will review at This Rule is not met as evidenced by: Based on least monthly monthly and record reviews, observations and interviews the facility failed to keep the MARs current for 1 of contact prescriber as 2 current clients (#2). The findings are: needed for medication Review on 7/26/23 of client #2's record revealed: -22review. year-old male admitted 6/6/17. -Diagnoses included autism spectrum disorder with accompanying intellectual impairment; When a current order is schizoaffective disorder, unspecified; attention deficit hyperactivity disorder, combined presentation; and discontinued or changed Persistent Motor Tic Disorder. -Physicians order dated by a prescriber, QCBHS 6/12/23 Vistaril Capsule (insomnia) 50mg, 1 at bedtime as needed. QP will draw a line -Physicians order dated 7/13/23 Vistaril Capsule through discontinued 50mg, 1 capsule at bedtime." medication orders, initial Review on 7/26/23 and 7/27/23 of client #2's MARs for June 2023 - July 2023 revealed: and date. Any new order -June 1 - June 30 transcription for Hydroxyzine Pam (Vistaril) 50mg 1 capsule by mouth at bedtime will be properly with staff initials to indicate the medication was documented on a new line. administered daily. -July 1 - July 26 - Hydroxyzine Pam 50mg capsule by mouth at bedtime with staff **OP** will monitor monthly initials to indicate the medication was administered and as needed, to stay in daily. -July- a handwritten transcription "EFFECTIVE medication compliance. 7/13/23 (Daily)" with staff initials to indicate the Division of Health Service Regulation TDAU11 STATEMENT OF DEFICIENCIES AND PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER:

STATE FORM If continuation sheet 2 of 3 (X3) DATE SURVEY A. BUILDING: COMPLETED MHL052-012 07/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 301 FOURTH STREET QUALITY-CARE BEHAVIORAL HEALTH II MAYSVILLE, NC 28555 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

Brendo Heck, Q1

8/10/23

Division of Health Service Regulation V 118 V 118 | Continued From page 2 medication was administered daily. -The back page of the MARs for June 2023 - July 2023 did not have any transcriptions to indicate the date, time, medication, explanation, results of taking the medication or staff initials to correspond with the daily administration of the Hydroxyzine Pam 50mg. Observation on 7/26/23 at 10:40 am of client #2's medications on hand revealed a bubble pack of Hydroxyzine Pam 50mg fluticasone 50 mcg "1 at bedtime as needed" dispensed 6/30/23. Client #2 was unavailable for interview. During interview on 7/27/23 the Qualified Professional/Director stated: -Client #2's Hydroxyzine Pam was "given to him every day because he needed it." -She was waiting on the physician for the new order to receive the medication daily. -She understood the facility was required to keep the MARs current. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.

Division of Health Service Regulation

STATE FORM

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TDAU11

If continuation sheet 3 of 3