PRINTED: 05/15/2023 FORM APPROVED

	of Health Service Re						
O I I II EIII EI	OF CORPECTION	(X1) PROVIDER/SUPPLIER/GLIA	, ,	E CONSTRUCTION		(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			COMP	LETED
						F	2
	MHLű98-163		B. WING				0/2023
						00/1	0,2020
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
MISS DA	ISY'S HOMESITE		NC 27893				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE , CROSS-REFERENCED T DEFICII	ACTION SHOULD TO THE APPROP	) BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	rs .	V 000				
	completed May 10, unsubstantiated. (I NC00201924. Defi This facility is licens category 10A NCAC Living for Adults wit This facility is licens census of 3. The standard complete the complete of the complete the complete of	nt and follow up survey was 2023. The complaints were ntake #'s NC00201695 and ciencies were cited.  sed for the following services 227G .5600C Supervised h Developmental Disabilities.  sed for 4 and currently has a survey sample consisted of clients and 1 former client.					
V 118	27G .0209 (C) Med	ication Requirements	V 118				
	only be administere order of a person audrugs.	nistration: on-prescription drugs shall d to a client on the written uthorized by law to prescribe	No.				
	clients only when au client's physician. (3) Medications, inc administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Administericurrent. Medications recorded immediate MAR is to include the (A) client's name; (B) name, strength (C) instructions for a	and quantity of the drug;	94.	MAY 2	EIVED 6 2023 icensure Sect		
1.1.1		e drug is administered; and					
ivision of He	alth Service Regulation -				· ve	Verified by po	d#Eillar

LABORATORY DIRECT Verified by DOTTING THE REPRESENTATIVE'S SIGNATURE

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	:	COMF	PLETED
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		MHL098-163	B. WING	· ·		10/2023
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MISS DA	ISY'S HOMESITE		VE STREET NC 27893			
(VA) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	201	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 1	V 118			
	drug. (5) Client requests to checks shall be rec	of person administering the for medication changes or orded and kept with the MAR appointment or consultation				
	facilty failed to ensure were recorded on the administration affect. The findings are:  Review on 5/09/23 of -52 year old female -Diagnoses included Disorder, Mood Disorder, Mood Disorder, Mood Poisorder, M	views and interviews the re medications administered at MAR immediately after ting 1 of 3 audited clients (#2).  of client #2's record revealed: admitted 12/23/03. d Major Neurocognitive order, Psychotic Disorder, al Disability, Cerebral Palsy, a Disorder, Essential rlipidemia-Unspecified, Reflux Disease, Asthma, as ted 4/26/23 for Trazodone 50 et (insomnia) 1 tablet at		The QP will ensure that all med are immdiately recorded on the after administration. Miss Daisy will ensure that all meds are transcribed and documented on MAR immediately after administ The QP will revise the MAR to redaily audit to be completed by sat each site to prevent this error from reoccurring. See attached.	MAR y's staff in the tration. reflect a staff	As of June 1, 2023 Ongoing daily.

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION S:	(X3) DATE SURVEY COMPLETED
		MHL098-163	B. WING	·	R 05/10/2023
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	03/10/2023
MISS DA	ISY'S HOMESITE		NC 27893	Т	
(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 APPROPOLICIENCY)	D BE COMPLETE
V 118	Continued From page	ge 2	V 118		
	revealed: -A bubble pack for the dispense date of 4/2  During interview on took her medication and she had taken his sleep. She never missleep. She never missleep. She never missleep. All of client #2's MA for the surveyor to re-Client #2 had receive but she did not know the MAR.	ved her Trazodone as ordered v why the it was not listed on			
	Professional stated: -Client #2 did receiv AprilApril 2023 MAR's w because they had no assistantShe understood the	5/10/23 the Qualified re an order for trazodone in were unavailable for review ot beers filed by the office requirement for medication documented on the MARs			
V 119	27G .0209 (D) Media	cation Requirements	V 119		
Sec.	guards against diver (2) Non-controlled so	sal:	* ***		

Division of Health Service Regulation STATE FORM

E3Y411

Division of Health Service Regulation

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  MHL098-163  NAME OF PROVIDER OR SUPPLIER  MISS DAISY'S HOMESITE  IDENTIFICATION NUMBER:  1307 GI			B. WING						
		MHL098-163	B. WING _	· ·	05/1	10/2023				
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE						
MISS DA	AISY'S HOMESITE		OVE STREE NC 27893	Т						
PREFIX	(EACH DEFICIENCY	MUST BE FRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE	(X5) COMPLETE DATE				
V 119	system, or by transfit destruction. A recorshall be maintained Documentation sha medication name, state and method, the disposing of medication witnessing destruction (3) Controlled substances Act, G.S. subsequent amendmental (4) Upon discharge remainder of his or disposed of promptle expected that the pattern of the facility and in drug supply shall no	fer to a local pharmacy for d of the medication disposal by the program.  Il specify the client's name, trength, quantity, disposal te signature of the person tion, and the person on.  ances shall be disposed of in North Carolina Controlled S. 90, Article 5, including any ments.  of a patient or resident, the ner drug supply shall be y unless it is reasonably attent or resident shall return such case, the remaining t be held for more than 30	V 119							
	Based on observation interviews the facility prescription medical against diversion for The findings are:  Review on 5/9/23 of -52 year old female and against diversion for The findings are:  Review on 5/9/23 of -52 year old female and against diversion included the findings are:  Noderate Intellectual Unspecified, Seizure Hypertension, Hyper	con, record reviews and vestaff failed to dispose of ions in a manner that guards 1 of 3 audited clients (#2).  client #1's record revealed: admitted 12/23/03.  Major Neurocognitive order, Psychotic Disorder, I Disability, Cerebral Palsy,		Miss Daisy's staff will ensure that prescribed medications are disposin a manner that guards against do To prevent that error from occurring monthly "Expired Medication Audi will be conducted. All expired premedications will be returned to So Pharmacy for disposal.	sed of liversion ng again it's" scribed outhern	Ongoing- Due Monthly beginnng June 5th, 2023.				

(X3) DATE SURVEY

Division of Health Service Regulation

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i:	COMPLETED
		MHL098-163	B. WING		R 05/10/2023
	PROVIDER OR SUPPLIER	1307 GRO	DRESS, CITY, DVE STREET NC 27893	STATE, ZIP CODE T	
(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 APPROI DEFICIENCY)	D BE COMPLETE
V 119	Chronic Mental Illne -Physicians' Orders Calcium Antacid Ch (heartburn) 1 daily a Solution eye drops of needed.  Observation on 5/9/ of client #2's medica		V 119		
	dispense date of 7/2 of 1/2023 that contarion -A bottle of Refresh with a dispense date date of 6/2022 that a substitution in the contarion - 1/2022 that a substitution - 1/2022 that a subst	12/21 and an expiration date ined about 5 tablets. Optive Solution eye drops of 1/1/21 and an expiration approximately 3/4 full. S client #2 stated staff r medications daily and she			
	-Expired medication officeClient #2 had no ad Antacid Chew tab ar Solution eye drops a	ormed the Qualified f the expired medications. s are usually taken to the ditional bottles of the Calcium and the Refresh Optive			
	Optive Solution eye medications.  Interview on 5/10/23 understood prescrip	drops were⊲s needed			

(X2) MULTIPLE CONSTRUCTION

Division of Health Service Regulation STATE FORM

E3Y411

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
					R
		MHL098-163	B. WING		05/10/2023
NAME OF	PROVIDER OR SUPPLIER			, STATE, ZIP CODE	
MISS DA	VISY'S HOMESITE		OVE STREE NC 27893	:1	
(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 SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (ENCY)	D BE COMPLETE
V 363	Continued From page	ge 5	V 363		
V 363	G.S. 122C-61 Treat facilities.	ment rights in 24-hour	V 363		
	In addition to the rig each client who is refacility has the follow (1) The right to receand prevention of physical the client's condition. The facility may see reimbursement for it treatment and prever (2) The right to have treatment or habilitatime of discharge, and discharge plan contaguither services desilive as normally as proposed and the proposed because of an unanticlient's treatment. We or his legally responsible professionals responsible professionals proposed destination or in his legally responsible professionals pro	eive necessary treatment for nysical ailments based upon and projected length of stay. It to collect appropriate is costs in providing the intion; and e, as soon as practical during tion but not later than the inidividualized written aining recommendations for gned to enable the client to cossible. A discharge plan when it is not feasible icipated discontinuation of a ith the consent of the client			
		ews and interviews, the ment an individualized		Miss Daisy's & Associates Inc. QI ensure that all discharged membereceive a discharge plan containing recommendations for further service.	ers   ng

Division of Health Service Regulation

STATE FORM

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			A. BOILDING			В		
		MHL098-163	B. WING			R 1 <b>0/2023</b>		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE				
MISS DA	AISY'S HOMESITE		VE STREE	т				
0(4) ID	SUMMADV STA		NC 27893					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECELED BY FULL  SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE		
V 363	Continued From pa	ge 6	V 363					
	enable the client to	or further services designed to live as normally as possible ited clients (Former Client ngs are:		to enable the member to live as r as possible. Quarterly the QA/QI committee will review all new adr discharges to ensure compliance	nissions	& 05-22-23		
180	<ul><li>-25 year old female</li><li>-Discharged 3/31/23</li><li>-Diagnoses included</li></ul>	3 d Intellectual Developmental						
	Disability-Severe, C Missing #2 and Lang -No documented dis					W 404		
<u></u>	-She had verbally in Professional (QP) the the facility.	FC #4's guardian stated: formed the Qualified nat FC #4 was moving from ed a discharged plan for FC						
	Attempted interview	on 5/9/23 with FC #4 was her language disorder.		* 2				
	stated: -She had contacted	the QP around March 3, t of FC #4's medications to to the new facility.	166			e- x x		
	managed care orgar of March that client F-FC #4's guardian ha #4 was moving to an -She had not provide a discharge plan.	C #4's care coordinator at the hization around the beginning FC #4 was moving out. and not informed her that FC other facility.  ed FC #4's guardian a copy of						
	-She had 60 days to -She would contact F	d not been campleted yet complete the discharge plan. Complete the discharge plan.	1.2.0		of the second section is a second section of the second section is a second section of the second section is a	5 25 6		

Division of Health Service Regulation

PRINTED: 05/15/2023

FORM APPROVED 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 MHL098-163 B. WING 05/10/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1307 GROVE STREET** MISS DAISY'S HOMESITE **WILSON, NC 27893** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 363 | Continued From page 7 V 363 determine where to send the discharge plan.

Division of Health Service Regulation

STATE FORM



1-866-768-8479 • Fax: 1-866-928-3983 Old fashioned values. Innovative ideas.

Facility:

DRUGS RETURNED TO PHARMACY

OR RELEASED TO

☐ Regular items

THE PATIENT

☐ Refrigerated Items Initial Verified Status (initial) Date Amt. \$ Count Billing Destroyed Credit Credit OF PHARMACY USE ONLY Date purd berigx3 of besseled facilisy Patient Expired FOR MEDICATIONS RELEASED WITH PATIENT Patient begredozio Discontinued Quantity Returned Date of enss Number ĕ Name, Strength & Form of Drug Patient's Name Nurse's Initial INSTRUCTIONS: Date (1)

list controlled substances separately on the form supplied by the State Drug Authority, complete applicable information in unshaded areas EQQE

I certify that the medications listed above are released to me and I understand and request that the medications are not dispensed in child-resistant containers.

Date

Signature

Witness

- keep pink copy and
- return both medication and forms to pharmacy
- or have patient or responsible party then forward forms to pharmacy. (2)

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## For Controlled Items Only

Facility:

OR RELEASED TO THE PATIENT DRUGS RETURNED TO PHARMAC

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FACILITY USE	Name, Strength & Form of Drug										
0000	Patient's Name										
	Nurse's Initial										
	Date Returned										

- list controlled substances separately on the form supplied by the State Drug Authority.
   complete applicable information in unshaded areas
   keep yellow copy and
   return both medication and form to pharmacy

