	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
,	0. 00.11.20.10.1		A. BUILDING:	<u></u>			
		MHL001-132	B. WING		09/	18/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE			
DEE & G	ENRICHMENT CENT	FR # 3	STIN STREET GTON, NC 27	2 17			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENT	rs	V 000				
	An annual survey w 18, 2023. Deficienc	vas completed on September ies were cited.					
		sed for the following service C 27G .5600A Supervised th Mental Illness.					
		sed for 3 and currently has a urvey sample consisted of clients.					
V 113	27G .0206 Client R	ecords	V 113				
	(a) A client record sindividual admitted contain, but need n (1) an identification (A) name (last, first (B) client record nu (C) date of birth; (D) race, gender ar (E) admission date (F) discharge date; (2) documentation developmental disa diagnosis coded ac (3) documentation assessment; (4) treatment/habili (5) emergency infoshall include the nanumber of the persudden illness or a and telephone numphysician; (6) a signed statem	face sheet which includes: , middle, maiden); mber; nd marital status;	S				

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

TITLE (X6) DATE

Division	<u>of Health Service Re</u>	egulation			_	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL001-132	B. WING		09/1	8/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DEE & G	ENRICHMENT CENT	FR#3	TIN STREET			
		BURLING	TON, NC 27			
(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 APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
V 113	Continued From pa	ge 1	V 113			
	(8) documentation (9) if applicable: (A) documentation diagnosis according of Diseases (ICD-9 (B) medication order (C) orders and copi (D) documentation administration error (b) Each facility sharelative to AIDS or ronly in accordance	ers; ies of lab tests; and				
	facility failed to ensi affecting 3 of 3 curr The findings are: Review on 9/18/23 -Admission date of -Diagnoses of Schit Congenital Deafnes Hypothyroidism End reflux disease (GEF Hypertension.	views and interview, the ure records were complete rent clients (#1, #2 and #3). of Client #1's record revealed:				
	-Admission date of	of Client #2's record revealed: 6/4/11. chosis; Diabetes Type II,				

STATE FORM 6899 If continuation sheet 2 of 11 **EUD311**

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MHL001-132	B. WING		09/1	8/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DEE & G	ENRICHMENT CENT	FR#3	IN STREET TON, NC 27	217		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 113	Continued From pa	ge 2	V 113			
	Insomnia, Renal Ins	psy, Seizure Disorder, sufficiency. umentation of progress toward				
	-Admission date of -Diagnoses of Bipo Retardation; Parand Constipation; Inson	lar Affective Disorder; Mental oid Schizophrenia;				
	-Facility had not be for a whileReported that sinc stopped doing som do.	3 with the Owner revealed: en completing progress notes e COVID hit, facility had e of the things they used to re was no documentation of ward outcomes.				
V 118	10A NCAC 27G .02 REQUIREMENTS (c) Medication adm (1) Prescription or r only be administered order of a person a drugs. (2) Medications shadilents only when a client's physician. (3) Medications, incommodation administered only bunlicensed persons pharmacist or other		V 118			

Division of Health Service Regulation

STATE FORM 6899 EUD311 If continuation sheet 3 of 11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		SURVEY PLETED		
		MHL001-	132	B. WING		09/	18/2023
NAME OF	PROVIDER OR SUPPLIER			DRESS, CITY, S	STATE, ZIP CODE		
DEE & G	ENRICHMENT CENT	ER#3		IN STREET TON, NC 27	217		
(X4) ID PREFIX TAG		ATEMENT OF DEFIC Y MUST BE PRECED SC IDENTIFYING IN	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 118	Continued From particles (4) A Medication Act all drugs administe current. Medication recorded immediat MAR is to include to (A) client's name; (B) name, strength (C) instructions for (D) date and time to (E) name or initials drug. (5) Client requests checks shall be reconstituted in the continuation of t	dministration Refered to each clies administered ely after adminithe following: , and quantity of administering the drug is administering the drug is administering the drug is adminited for medication corded and kepting to the drug is adminited and kepting the drug is administering the drug is administ	ent must be kept shall be stration. The f the drug; he drug; inistered; and inistering the changes or t with the MAR	V 118			
	This Rule is not m Based on record re interview the facility medications were a order of a physician clients (#1, #2 and were kept current f clients (#1, #2 and Review on 9/18/23 -Admission date of -Diagnoses of Schi Congenital Deafner Hypothyroidism En reflux disease (GE HypertensionPhysician's order of -Test Blood Su	eview, observation failed to A) En administered on a for three of the failed to A). And B) Ensor three of three of three of Client #1's result 10/3/22. Zoaffective Discuss; Diabetes Mocephalitis; Gas RD); Hyperlipid	on and sure a the written ree audited sure MARs e audited gs are: ecord revealed: order; ellitus; stroesophageal emia;				

Division of Health Service Regulation

STATE FORM 6899 EUD311 If continuation sheet 4 of 11

	Of Fleatiff Service IN				Taras = .==	a=
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
			A. BUILDING:			
		MHL001-132	B. WING		09/1	8/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
		321 AUS	TIN STREET	,		
DEE & G	ENRICHMENT CENT	FR#3	TON, NC 27	217		
(V4) ID	STIMMADY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX	-	/ MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
				DEFICIENCY)		
V 118	Continued From pa	ige 4	V 118			
	'					
	Observation on 0/1	9/22 at 1:20 pm of Client #1!a				
	medications reveale	8/23 at 1:30 pm of Client #1's				
	-Glucometer was a					
	-Glucoffieler was a	valiable.				
	Review on 9/18/23	of Client #1's MAR for July 1,				
		ember 18, 2023 revealed:				
		e marked as checked twice				
	daily everyday for the					
	, , ,	•				
	Review on 9/18/23	of Client #1's Glucometers (2)				
	recordings for July	11, 2023 through September				
		olood sugars were not				
	checked as ordered	d on the following dates:				
	-July:					
		15-7/16 (none); 7/24 (once);				
	, , , , , ,	once) 7/29-7/31 (once).				
	-August:	0/4/				
		; 8/4 (none); 8/5 (once); 8/6				
		ce); 8/10/-8/12 (once); 8/15				
		; 8/22-8/25 (once); 8/26-8/28				
	(none); 8/31 (once) -September:					
		3-9/4 (once); 9/6-9/8 (once);				
	9/10-9/13 (once); 9					
	0/10/0/10 (0/100), 0/	7.10 0, 10 (0.1.00).				
	-Facility did not follo	ow physician's order of				
		s blood sugars twice a day.				
		rongfully indicated that his				
	sugars had been ch	necked twice daily everyday.				
		o accurately document				
		tration and not having all daily				
		ald not be determined if Client				
	#1 blood sugars ha	d been checked twice a day.				
	Davious on 0/40/00	of Client #2's record reveal - 4				
		of Client #2's record revealed:				
	-Admission date of					
		chosis; Diabetes Type II, epsy, Seizure Disorder,				
	Insomnia, Renal Ins					

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AND DIAM OF CODDECTION INDESTREE ATION AND DEC		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		MHL001-132	B. WING		09/1	8/2023
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
DEE & G	ENRICHMENT CENT	FR#3	IN STREET TON, NC 27	217		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	-Physician's orders -Eucerin- Apply -There were no phy following: -Metamucil- Ta -Polyethylene C liquid and drink dail Observation on 9/1 Client #2's medicat -Eucerin was not av -Metamucil was no -Polyethylene Glyco Review on 9/18/23 2023 through Septe -All the medications given daily everyda -Client #2's Eucerin available at the hor they were being ad -Client #2's Polyeth available at the hor physician's orderDue to the failure to medication adminis medication available Client #2 received I the physician. Review on 9/18/23 -Admission date of -Diagnoses of Bipo Retardation; Paran Constipation; Inson -Physician's orders	dated 11/7/22: / topically to feet at bedtime /sician's orders for the ke 1 packet three times daily. Glycol 3350- Mix 17 gm in ly. 8/23 at about 1:45 pm of ions revealed: /vailable. of 3350 was available. of Client #2's MAR for July 1, ember 18, 2023 revealed: /s mentioned were marked as /y for the period covered. In and Metamucil were not me, but the MAR indicated that ministered. /ylene Glycol 3350 was me, but did not have a 10 accurately document /stration and not having /se, it could not be determined if nis medications as ordered by of Client #3's record revealed: 6/14/11. lar Affective Disorder; Mental oid Schizophrenia; mnia; Prediabetes.	V 118			

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STATE FORM 6899 EUD311 If continuation sheet 6 of 11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED		
		MHL001-132		B. WING		09/	18/2023
	PROVIDER OR SUPPLIER BENRICHMENT CENT	ER # 3	321 AUST	DRESS, CITY, S IN STREET TON, NC 27	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Review on 9/18/23 packages revealed -Zolpiderm was not -Packages were dis Review on 9/18/23 2023 through Septe -Medication mentio daily everyday for the -Client #3's Zolpide home, but staff congiven on his MARDue to the failure the medication adminis #3's Zolpiderm availed termined if he recordered by the physological process of the condition of the properties of the condition of the pack become time. -Regarding Client # was in the pack become timeRegarding Client # was in the pack become timeShe was responsible medications were of delivered by the physological processShe was responsible medications were of delivered by the physological processShe mad gotten us them correctly, so selatest medication on 9/5/23.	of Client #3's medic available. Spensed on 9/5/23. of Client #3's MAR fromber 18, 2023 revened was marked as ne period covered. It was not available tinued to mark medication and not having that it could not be be covered his medication. With the Owner revolution of the covered was medicated sician. With the Owner revolution of the covered was all medication and not having the continue order or to be continue order order or to be continue order order order o	for July 1, ealed: given e at the ication as ent eng Client e ons as vealed; se gars were ders. Client #2's have his end as hought it es came client's ere sending g. 43 came in	V 118			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE	SURVEY
,	0. 00.11.120.10.1		A. BUILDING:			
		MHL001-132	B. WING		09/1	18/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DEE & G	ENRICHMENT CENT	FR#3	TIN STREET STON, NC 27	217		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 118	Continued From pa	nge 7	V 118			
	-It was unknown at been without the m	this time how long client had edication.				
	medication adminis medication available	o accurately document stration and not having a le it could not be determined if her medications as ordered by				
V 121	27G .0209 (F) Med	ication Requirements	V 121			
	governing body or of for obtaining a review regimen at least evident shall be to be performed by the client's physician. The ones the client's physician the review when more (2) The findings of the control of the client's physician the review when more than the client's physician the review when more than the client's physician than the	ew: bives psychotropic drugs, the operator shall be responsible ew of each client's drug ery six months. The review ormed by a pharmacist or site manager shall assure that an is informed of the results of edical intervention is indicated, the drug regimen review shall client record along with				
	facility failed to obta months for three of	et as evidenced by: reviews and interview the ain drug reviews every six three clients (#1, #2 and #3) notropic drugs. The findings				
	Review on 9/18/23 -Admission date of	of Client #1's record revealed: 10/3/22.				

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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	
		MHL001-132	B. WING		09/1	8/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		321 AUST	IN STREET			
DEE & G	ENRICHMENT CENT	ER#3 BURLING	TON, NC 27	217		
(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 APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 121	Continued From pa	ge 8	V 121			
V 12.1	-Diagnoses of Schir Congenital Deafnes Hypothyroidism Enereflux disease (GEF HypertensionPhysician's order of Clozapine 100 tablets by mouth exbedtimeRisperidone 3 twice dailySertraline 100 once daily at bedtimeClonazepam 0 once daily as needed -Haloperidol 5nevery 6 hours as nepsychosis/agitation hoursThe July, August a Medication Administrevealed Client #1 medications dailyThere was no evid review for Client #1 months. Review on 9/18/23 -Admission date of -Diagnoses of Psychypertension, Epile Insomnia, Renal Insi-Physician's orders	zoaffective Disorder; ss; Diabetes Mellitus; cephalitis; Gastroesophageal RD); Hyperlipidemia; dated 10/19/22: milligrams (mg)- Take 2 very morning and 3 tablets at mg-Take 1 tablet by mouth mg- Take 1 tablet by mouth ed. 1.5 mg- Take 1 tablet by mouth ed. 1.5 mg- Take 1 tablet by mouth ed. 1.5 mg- Take 1 tablet by mouth ed. 1.6 mg- Take 1 tablet by mouth eded for severe not to exceed 4 tablets/24 and September 2023 stration Record (MAR) was administered the above ence of a psychotropic drug 's medications in the last six of Client #2's record revealed: 6/4/11. chosis; Diabetes Type II, epsy, Seizure Disorder, sufficiency.	V 121			
	daily.	mg- Take 1 tablet by mouth at				
	bedtime.	mg- Take 1 tablet by mouth				

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-Quetiapine 400 mg- Take 2 tablets by mouth

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	MHL001-132	B. WING		09/1	8/2023
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
DEE & G ENRICHMENT CENTE	FR#3	TIN STREET STON, NC 27	217		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOU (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
at bedtime. -The July, August at Medication Administ revealed Client #2 with medications daily. -There was no evide review for Client #2 with months. Review on 9/18/23 of a constitution of the constituti	o mg- Take 1 tablet by mouth and September 2023 tration Record (MAR) was administered the above ence of a psychotropic drug is medications in the last six of Client #3's record revealed: 6/14/11. ar Affective Disorder; Mental bid Schizophrenia; ania; Prediabetes. dated 11/7/22: mg- Take 1 tablet by mouth of mg- Take 1 tablet by mg- Take 1	V 121			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING	S:		
		MHL001-132	B. WING		09/	18/2023
NAME OF PROVID	ER OR SUPPLIER	STI	REET ADDRESS, CITY,	STATE, ZIP CODE		
DEE & G ENRIG	CHMENT CENT	I F R # 4	1 AUSTIN STREET JRLINGTON, NC 2			
(X4) ID PREFIX TAG R	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULI LSC IDENTIFYING INFORMATION	ID - PREFIX	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
	inued From pa	age 10	V 121			

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