| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|--|--|-------------------------------|--------------------------|--|
| | | MHL092-864 | B. WING | | R 08/31/2023 | | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | | |
| TERRY'S | TERRY'S SAFE HAVEN 2720 CASHLIN DRIVE RALEIGH, NC 27616 | | | | | | |
| (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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE | |
| V 000 | INITIAL COMMENT | -S | V 000 | | | | |
| | on August 31, 2023 This facility is licens | w up survey was completed . Deficiencies were cited. sed for the following service C 27G .5600F Supervised e Family Living. | | | | | |
| | census of 3. The su | | | | | | |
| V 118 | census of 3. The survey sample consisted of audits of 3 current clients. V 118 27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (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 drugs. (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 | | V 118 | | | | |
| | recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the | ely after administration. The ne following: and quantity of the drug; administering the drug; | | | | | |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING: | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|------------------------------|---|--------|-------------------------------|--|
| | | MHL092-864 | B. WING 08 | | | R / 31/2023 | |
| | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2720 CASHLIN DRIVE RALEIGH, NC 27616 | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPROFICIENCY) | JLD BE | (X5) COMPLETE DATE | |
| V 118 | (5) Client requests to checks shall be rec | ge 1 for medication changes or orded and kept with the MAR appointment or consultation | V 118 | | | | |
| | failed to have a writ clients (#1 & #2) to medication. The fine Review on 8/31/23 - Admitted 7/7/22 - Diagnoses of M Disability (IDD), Schunspecified, Blindre bilateral, Genetic Schund Diabetes Mellit Complications - Physician's order Lantus Solostar subcutaneously at the Novolog Flexpes subcutaneously throuse correlation scale elevated pre-meal grands injections - She was a diablin sulin | view and interview, the facility ten physician's order for 2 of 3 administer their own dings are: of client #1's record revealed: liid Intellectual Developmental nizoaffective Disorder, ess, both eyes, Hearing Loss, usceptibility to Other Disease, us with Other Specified er dated 8/28/23: 100 units (U) inject 14U | | | | | |

Division of Health Service Regulation STATE FORM

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--|--|-----------------------------------|-------------------------------|--|
| | | MHL092-864 | B. WING | | | R 08/31/2023 | |
| | PROVIDER OR SUPPLIER | 2720 CAS | SHLIN DRIVE | TATE, ZIP CODE | | | |
| | T | | I, NC 27616 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE | |
| V 118 | Continued From pa | ge 2 | V 118 | | | | |
| | - Admitted 9/1/15 - Diagnoses of M Disorder, Mature-O Type 5, and Recurr Features - Physician's ord Solostar 100U inject daily (Diabetes) - Physician's ord Flexpen Syringe injutimes daily before in 150=2U, 151-200=3 (greater than) 300 | hild IDD, Major Depressive nset Diabetes of the Young ent Episode with Psychotic er dated 1/30/23: Lantus et 10U subcutaneously once er dated 2/9/23: Novolog ect subcutaneously three neals per sliding scales (100-3U, 201-250=4U, 251-300=5U, | | | | | |
| | She was a diab insulinShe self-admin the stomach everyor | 8/30/23 client #2 reported: etic and she was prescribed istered her insulin injection in lay her while she administered | | | | | |
| | - Clients #1 and a prescribed insulin - Neither client has self-administer their - She "dialed" the insulin pen and she they self-administer - Both client #1 a administer their own injecting themselve into the facility - Neither client hadministering their self-administering their self-administer their self-ad | e dosage of clients #1 and #2's monitored the clients while red the injections and #2 were capable to n injections and they had been s since they were admitted ad any problems with | | | | | |

Division of Health Service Regulation

STATE FORM 6899 HN1911 If continuation sheet 3 of 4

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|--|--|-------|-------------------------------|--|
| | | MHL092-864 | B. WING | | | R 31/2023 | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2720 CASHLIN DRIVE RALEIGH, NC 27616 | | | | | | | |
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| V 118 | in her orientation traclients could admin During interview on reported: - Insulin injection staff or clients - Client #1 and # and "dialed" - Neither client # order to self-adminiculation a self-administer not a self-administer not measuring the count of the county and medicine cup and medicine in their medicine | insulin, because she learned aining that only nurses or the ister injections 8/30/23 the Licensee s could be administered by 2's insulin was "pre-dosed" 1 nor #2 had a physician's ster their insulin injections ting themselves with insulin) is the because they (clients) are dosage" te themselves "pre-dosed" tike staff putting medicine in the client putting the | V 118 | | | | |

6899

Division of Health Service Regulation STATE FORM