

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-389</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/22/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ELEVATED FAMILY SERVICES, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>128 LAURA AVENUE WINSTON SALEM, NC 27105</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p><b>INITIAL COMMENTS</b></p> <p>A complaint and follow-up survey was completed on November 22, 2023. The complaint was substantiated (intake #NC00209830). Deficiencies were cited.</p> <p>This facility is licensed for the following service category : 10A NCAC 27G .1700-Residential Treatment Staff Secure for Children or Adolescents.</p> <p>This facility is licensed for 4 and currently has a census of 1. The survey sample consisted of audits of 1 current client and 2 former clients.</p>	V 000		
V 108	<p><b>27G .0202 (F-I) Personnel Requirements</b></p> <p>10A NCAC 27G .0202 PERSONNEL REQUIREMENTS</p> <p>(f) Continuing education shall be documented.</p> <p>(g) Employee training programs shall be provided and, at a minimum, shall consist of the following:</p> <p>(1) general organizational orientation;</p> <p>(2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B;</p> <p>(3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and</p> <p>(4) training in infectious diseases and bloodborne pathogens.</p> <p>(h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid</p>	V 108		

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-389</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/22/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ELEVATED FAMILY SERVICES, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>128 LAURA AVENUE</b> <b>WINSTON SALEM, NC 27105</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 108	<p>Continued From page 1</p> <p>techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction.</p> <p>(i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, it could not be determined that at least one staff member who was trained in basic first aid and cardiopulmonary resuscitation (CPR) techniques such as those provided by Red Cross, the American Heart Association or their equivalence was present in the facility when a client was present affecting 3 of 3 audited and current staff (Staff #1, Associate Professional (AP), and the Director/Qualified Professional (QP)), 3 out of 5 current staff (Staff #3, Staff #4, Staff #5) and 1 out of 1 former staff (FS #7). The findings are:</p> <p>Review on 11/20/23 of Staff #1's personnel record revealed: -Date of hire: 4/20/21. -Position: Paraprofessional. -Certification in First Aid and CPR expired on 4/18/23.</p> <p>Review on 11/20/23 of Staff #3's personnel record revealed: -Date of hire: 6/5/23. -Position: Paraprofessional. -No First Aid and CPR certification was provided.</p>	V 108		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-389</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/22/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ELEVATED FAMILY SERVICES, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>128 LAURA AVENUE WINSTON SALEM, NC 27105</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 108	<p>Continued From page 2</p> <p>Review on 11/20/23 of Staff #5's personnel record revealed: -Date of hire: 6/5/23. -Position: Paraprofessional. -Certificate from the American Safety Training Institute (ASTI) dated 12/29/22-12/29/24 included a statement that the "American Safety Training Institute is not associated, affiliated with, sponsored , or endorsed by American Safety and Health Institute (ASHI), American Heart Association (AHA), or the American Red Cross (ARC) ..."</p> <p>Review on 11/20/23 of FS #7's personnel record revealed: -Date of hire: 5/8/23. -Position: Paraprofessional. -Certification in First Aid and CPR was from the American Safety Training Institute (ASTI) dated 9/25/23.</p> <p>Review on 11/20/23 of the AP's personnel record revealed: -Date of hire: 8/17/23. -Position: Associate Professional -Certification in First Aid and CPR completed on 8/5/23 had the Director/Qualified Professional (QP) as her First Aid and CPR instructor.</p> <p>Review on 11/20/23 of the Director/QP's personnel record revealed: -Date of hire: 6/4/19. -Position: Director/Qualified Professional -An email dated 11/29/23 from an online health and safety organization sent to the Director/QP at 6:09 am informed the Director/QP her instructor authorization had expired more than 90 days prior.</p>	V 108		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-389</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/22/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ELEVATED FAMILY SERVICES, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>128 LAURA AVENUE WINSTON SALEM, NC 27105</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 108	<p>Continued From page 3</p> <p>Interview on 11/16/23 with Staff #1 revealed: -She had worked "on and off" for the facility since 2021. -She started back to work at the facility about 2 weeks ago. -The Director/QP notified her she was current on all her trainings which included First Aid and CPR.</p> <p>Interview on 11/20/23 with Staff #4 revealed: -She started work as a paraprofessional at the facility in September (2023). -She had no training in First Aid and CPR.</p> <p>Interview on 11/20/23 with FS #7 revealed: -She worked at the facility as a direct support professional from 3/1/23 until she was terminated from her job around 10/16/23. -She obtained her First Aid and CPR certification online while working 3rd shift at the facility. -She worked with different staff (Staff #1, #2 and #4) while on duty.</p> <p>Interview on 11/15/23 with the AP revealed: -She was hired in August (2023) as an AP. -She was up to date on all her required trainings which included First Aid and CPR. -The Director/QP was the First Aid and CPR instructor.</p> <p>Interviews on 11/20/23 and 11/22/23 with the Director/QP revealed: -She completed her renewal for First Aid and CPR instructor online. -She tried to access her instructor training portal online and learned that her access had expired more than 90 days ago. -She understood she could be re-qualified as a First Aid and CPR instructor online. -Some of her staff brought their First Aid and CPR certifications from their previous jobs and</p>	V 108		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-389</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/22/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ELEVATED FAMILY SERVICES, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>128 LAURA AVENUE WINSTON SALEM, NC 27105</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 108	Continued From page 4  she thought their certifications were "good" (valid). -She planned to schedule mandatory training for all staff to have them First Aid and CPR certified as required.	V 108		
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 (E) name or initials of person administering the drug. (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.	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-389</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/22/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ELEVATED FAMILY SERVICES, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>128 LAURA AVENUE WINSTON SALEM, NC 27105</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 5</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure medications were administered on a written order of a person authorized by law to prescribe medications and failed to keep current the MAR for all drugs administered affecting 1 of 1 current clients (Client #1) and 1 of 2 audited former clients (FC #3) . The findings are:</p> <p>Review on 11/16/23 of Client #1's record revealed: -Date of admission: 1/5/22. -Diagnoses: Generalized Anxiety Disorder (GAD) and Attention-Deficit Hyperactivity Disorder (ADHD). -Physician-ordered medications: -6/20/23, Sertraline 100 milligrams (mg)- one tablet daily (depression) and Vyvanse 40 mg-one tablet daily (ADHD). -11/8/23, Fluticasone Propionate Nasal Spray-50 micrograms (mcg)- Two sprays by nasal route daily (allergies). -10/2023 Mupirocin 2% ointment-apply to infected area 3 times a day for 10 days (ingrown toenail). -No physician order for Melatonin 10 mg (sleep).</p> <p>Review on 11/16/23 of Client #1's September 2023 MAR, October 2023 MAR and November 2023 MAR revealed: -Fluticasone Propionate Nasal Spray was identified as a PRN (as needed) medication. -Fluticasone Propionate Nasal Spray was blank</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-389</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/22/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ELEVATED FAMILY SERVICES, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>128 LAURA AVENUE WINSTON SALEM, NC 27105</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 6</p> <p>on 9/16/23, 9/30/23, 10/4/23, 10/29/23, 11/4/23, 11/5/23, 11/11/23 and 11/12/23 at the 7:30 am (morning) dose time with no staff initials circled or charting codes that explained the blanks.</p> <p>-No documentation of administration for a 3rd dose of Mupirocin 2% ointment on October 2023's MAR during a 10-day application period from 10/18/23 to 10/28/23.</p> <p>-Sertraline and Vyvanse was blank on 11/5/23 at the 7:30 am dose time with no staff initials circled or charting codes that explained the blanks.</p> <p>-Staff signatures documented for administration of Melatonin on 9/4/23 at 9:30, 9/6/23 at 9:15, 9/7/23 at 8:25 pm (evening), 9/10/23 at 7:30 pm, 9/11/23 at 7:30, 9/13/23 at 7:30, 9/14/23 at 11:00, 9/19/23 at 7:30, 9/24/23 at 8:30, 10/3/23 at 7:30, 10/4/23 at 7:30, 10/5/23 at 7:30, 10/6/23 at 7:30, 10/7/23 at 8:30 pm, 10/8/23 at 8:30 pm, 11/5/23 at 8:00 pm, 11/6/23 at 7:30, 11/7/23 at 7:30, 11/8/23 at 7:30, 11/9/23 at 7:30, and 11/10/23 at 7:30.</p> <p>Interview on 11/15/23 with Client #1 revealed:</p> <p>-She took Vyvanse 40 mg and Zoloft 10 mg every morning for her ADHD and anxiety.</p> <p>-Staff were responsible for giving her her medications.</p> <p>Review on 11/16/23 of FC #3's record revealed:</p> <p>-Date of Admission: 2/17/23.</p> <p>-Diagnoses: Conduct Disorder, Unspecified Trauma and Stress Disorder, Oppositional Defiant Disorder.</p> <p>-Physician-ordered medications:</p> <p>-7/5/23, Metronidazole .75% topical cream- Apply twice daily (Rosacea).</p> <p>-9/5/23, Sertraline 50 mg- One tablet-50 mg daily (depression).</p> <p>-No physician order for Sertraline 25 mg- ½ pill for 7 days, on 9/13/23, give 50 mg.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-389</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/22/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ELEVATED FAMILY SERVICES, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>128 LAURA AVENUE WINSTON SALEM, NC 27105</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 7</p> <p>-No physician order for Melatonin 10 mg (sleep).</p> <p>Review on 11/16/23 of FC #3's September 2023 MAR, October 2023 MAR and November 2023 MAR revealed:</p> <p>-September 2023 MAR included a handwritten note for Sertraline- ½ pill 7 days, give 25 mg.</p> <p>-Metronidazole topical cream was blank on 10/2/23 and 10/3/23 at 7:30 pm dose time with no staff initials circled or charting codes that explained the blanks.</p> <p>-Staff signatures documented for administration of Melatonin 10 mg on on 9/1/23 at 2:00 am, 9/2/23 at 7:30 pm, 9/3/23 at 7:30 pm, 9/4/23 at 7:30 pm, 9/6/23 at 7:30 pm and at 9:18, 9/7/23 at 8:00 pm, 9/8/23 at 7:30 pm, 9/9/23 at 7:30 pm, 9/10/23 at 7:30 pm, 9/11/23 at 7:30 pm, 9/12/23 at 7:30 pm, 9/24/23 at 8:45 pm, 9/26/23 at 8:00 pm, 9/28/23 at 7:55 pm, 9/29/23 at 9 pm, 10/1/23 at 9:30 pm, 10/3/23 at 7:30, 10/6/23 at 7:30, 10/7/23 at 1:15 am, and 10/8/23 at 8:30.</p> <p>Interview on 11/20/23 with FC #3's guardian revealed:</p> <p>-The Director/Qualified Professional (QP) was attentive to FC #3's needs while placed at the facility.</p> <p>-FC #3 was believed to be living with family after she went AWOL (away without leave) from school in August (2023).</p> <p>Interview on 11/16/23 with the Director/QP revealed:</p> <p>-Client #1's Fluticasone used to be a PRN medication. She acknowledged the label on the Fluticasone said the nasal spray was to be used every day.</p> <p>-She did not know the reason for the 11/5/23 blanks on Client #1's Sertraline and Vyvanse.</p> <p>-She did not provide a physician's order for FC</p>	V 118		



Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-389</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/22/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ELEVATED FAMILY SERVICES, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>128 LAURA AVENUE WINSTON SALEM, NC 27105</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 8  #3's Sertraline 25 mg., 1/2 pill for 7 days. -The Melatonin 10 mg for Client #1 and FC #3 was a standing order signed by the client's guardian and was not not signed by a physician or person authorized to prescribe medications. -The Associate Professional (AP) wrote the client medications on their MARs. -She would have staff retrained in Medication Administration. -She planned to take back the oversight of the medication management responsibilities.	V 118		
V 119	27G .0209 (D) Medication Requirements  10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining	V 119		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-389</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/22/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ELEVATED FAMILY SERVICES, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>128 LAURA AVENUE WINSTON SALEM, NC 27105</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 119	<p>Continued From page 9</p> <p>drug supply shall not be held for more than 30 calendar days after the date of discharge.</p> <p>This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure all prescription medication was disposed of in a manner that guarded against diversion. The findings are:</p> <p>Review on 11/16/23 of Client #1's record revealed: -Date of admission: 1/5/22. -Diagnoses: Generalized Anxiety Disorder (GAD) and Attention-Deficit Hyperactivity Disorder (ADHD).</p> <p>Review on 11/16/23 of Client #1's October 2023 MAR revealed: -Mupirocin 2% ointment was administered from 10/18/23 at 7:30 pm to 10/28/23 at 7:30 am.</p> <p>Observation on 11/16/23 at 11:51 am of Client #1's medications revealed: -Mupirocin 2% ointment had a pharmacy label that the ointment was dispensed on 10/18/23 with instructions to administer this medication for 10 days. -The Mupirocin was present in a clear plastic bag and included with Client #1's current medications.</p> <p>Interview on 11/16/23 with the Director/Qualified Professional revealed: -She needed to destroy the Mupirocin. She planned to squeeze the ointment into a paper</p>	V 119		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL034-389</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/22/2023</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>ELEVATED FAMILY SERVICES, LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>128 LAURA AVENUE</b> <b>WINSTON SALEM, NC 27105</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 119	Continued From page 10 towel and throw it away.	V 119		