Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		MHL063-081	B. WING		R 11/28	/2023	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
PORT HI	PORT HEALTH SERVICES - ABERDEEN 204 B PINE STREET ABERDEEN, NC 28315						
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENT	rs .	V 000				
	on November 28, 2	w-up survey was completed 023. Deficiencies were cited.					
	category: 10A NCA	sed for the following service C 27G .5600D Supervised th Substance Abuse					
	census of 2. The su	sed for 9 and currently has a urvey sample consisted of clients and 1 former client.					
V 118	27G .0209 (C) Med	ication Requirements	V 118				
	only be administered order of a person a drugs. (2) Medications shat clients only when at client's physician. (3) Medications, included administered only bunlicensed persons pharmacist or other privileged to prepar (4) A Medication Adall drugs administer current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the	inistration: non-prescription drugs shall ad to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be all licensed persons, or by a trained by a registered nurse, a legally qualified person and a and administer medications. Iministration Record (MAR) of a the document of the control of the contr					

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				A. BUILDING.			R
		MHL06	3-081	B. WING			28/2023
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
PORT HI	EALTH SERVICES - A	BERDEEN		E STREET EN, NC 2831	5		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 118	drug. (5) Client requests checks shall be rec file followed up by a with a physician.	for medication corded and ke appointment c	pt with the MAR or consultation	V 118			
	This Rule is not m Based on observat interview, the facilit were administered physician affecting (#1). The findings a	ion, record rev y failed to ens on the written one of three a	view and sure medications order of a				
	Review on 11/28/23 -Admission date of -Diagnoses of Can Inhalant Use Disord Remission; Alcoho Traumatic Stress D	11/20/23. nabis Use Dis der, Moderate I Use Disorde	sorder, Severe; e, in Early				
	There were no writ -Fluoxetine 20 milli in the morningGuanfacine 2 mg, and 2 tablets at bee -Melatonin 3 mg, Ti -Trazodone 50 mg,	grams (mg), Take 1 tablet dtime. ake 1 tablet a	Take one capsule in the morning t bedtime.				
	Observation on 11/ #1's medications re -The aforemention	evealed:					
	Review on 11/28/23 November 2023 re		MARs for				

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DIVISION OF FIGURE OF PERIODE AND		()(0) 1:	F CONCERNATION	0.00 - :==	OLIDA (EX.			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
DENTIFICATION IDENTIFICATION NUMBER.		A. BUILDING:		COMPLETED				
					F			
		MHL063-081	B. WING		11/2	8/2023		
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
	204 B PINE STREET							
PORT HE	PORT HEALTH SERVICES - ABERDEEN ABERDEEN, NC 28315							
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)		
PRÉFIX	•	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE		
				,				
V 118	Continued From pa	ge 2	V 118					
	-The following medi	ications were given daily from						
		gh November 28, 2023:						
	-Fluoxetine 20 mg.							
	-Guanfacine 2 mg.							
	-Melatonin 3 mg.							
	-Trazodone 50 mg.							
	Paviou on 11/29/22	of webmd.com revealed:						
		ed to treat depression,						
		ive disorder, some eating						
	disorders, and pani							
		sed as part of a treatment						
		symptoms of attention deficit						
	hyperactivity disord							
		ed as a sleeping aid.						
		ed as a sleeping aid and as an						
	anti depressant me	dication.						
	Interview on 11/28/	23 with Client #1 revealed:						
	-He took medication							
	-Facility gave him th							
	, ,							
ı		23 with the Qualified						
	Professional/Case I							
		ally got the physician orders						
	had been out on me							
		came to the program. He was neir own psychiatrist soon and						
		e new medication scripts from						
	their doctor.	c new medication scripts from						
		ility failed to have physician's						
	orders for client #1's							
		stitutes a re-cited deficiency						
	and must be correc	eted within 30 days.						
V 736	27G .0303(c) Facilit	ty and Grounds Maintenance	V 736					
	10A NCAC 27G .03	303 LOCATION AND						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
					l l	R	
		MHL063-081	B. WING		11/2	28/2023	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
PORT H	EALTH SERVICES - A	BERDEEN 204 B PIN ABERDEE	5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 736	Continued From pa	ige 3	V 736				
	EXTERIOR REQU (c) Each facility and maintained in a saf manner and shall b odor.	IREMENTS d its grounds shall be e, clean, attractive and orderly be kept free from offensive					
	Based on observat failed to ensure fac	et as evidenced by: ion and interview, the facility iility grounds were maintained ractive and orderly manner.					
	am revealed: -Girl's Bathroom: T looking substance of the tiles inside the si -Boy's Bathroom: T looking substance of with a tub. The ligh working properly.	28/23 at approximately 11:53 here was a black mold/mildew on the wall and floor between shower. There was a black mold/mildew on the floor inside the shower t on top of sink was not resser had writings on top and					
	Professional/Case -She did not know the showersShe acknowledged looked like mold/m -Facility was plannithe bedrooms, The would be removedA work order had be lighting in the boy's -She confirmed the grounds were main attractive manner.	what was the substance inside d there was something that ildew inside the showers. ng to replace the furniture in old dresser with writings been completed to fix the					

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PRINTED: 11/30/2023

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 B. WING _ MHL063-081 11/28/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **204 B PINE STREET PORT HEALTH SERVICES - ABERDEEN** ABERDEEN, NC 28315 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY)

V 736	Continued From page 4	V 736	
	and must be corrected within 30 days.		
	alli Osmis Damista		

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