

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL068-132 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED R 03/01/2024 |
|--|---|---|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER RSI-FERRELL ROAD | STREET ADDRESS, CITY, STATE, ZIP CODE 1543 FERRELL ROAD CHAPEL HILL, NC 27517 |
|---|---|

| (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>INITIAL COMMENTS</p> <p>An annual and follow up survey was completed on March 1, 2024. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>This facility is licensed for 6 and currently has a census of 5. The survey sample consisted of audits of 3 current clients.</p> | V 000 | | |
| V 114 | <p>27G .0207 Emergency Plans and Supplies</p> <p>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES</p> <p>(a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority.</p> <p>(b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.</p> <p>(c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies.</p> <p>(d) Each facility shall have basic first aid supplies accessible for use.</p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure fire and disaster drills were conducted quarterly and on each shift. The findings are:</p> <p>Review on 3/1/24 of the facility's fire and disaster</p> | V 114 | | |

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: MHL068-132 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED R 03/01/2024 |
|--|---|---|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER RSI-FERRELL ROAD | STREET ADDRESS, CITY, STATE, ZIP CODE 1543 FERRELL ROAD CHAPEL HILL, NC 27517 |
|---|---|

| (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 114 | <p>Continued From page 1</p> <p>drill log from March 2023-February 2024 revealed:</p> <ul style="list-style-type: none"> -The night shift did not conduct a fire drill for the 4th quarter (October, November, December) of 2023. -There were no fire drills conducted during the 3rd quarter (July, August, September) of 2023. -The night shift did not conduct a fire drill for the 2nd quarter (April, May, June) of 2023. -There were no disaster drills conducted during the 4th quarter (October, November, December) of 2023. -There were no disaster drills conducted during the 3rd quarter (July, August, September) of 2023. <p>Interview on 2/29/24 with client #1 revealed:</p> <ul style="list-style-type: none"> -They did fire drills with staff. -They walked over to the mailbox near the road for a fire drill. -They also did hurricane and tornado drills with staff. They went to different places in the facility for those drills and away from the windows. -She wasn't sure how often the fire and disaster drills were conducted. <p>Interview on 2/29/24 with client #2 revealed:</p> <ul style="list-style-type: none"> -They did fire drills and disaster drills. -They walked over to the mailbox for a fire drill. -They went into the laundry room or bathroom for a disaster drill. -She wasn't sure how often they did fire and disaster drills with staff. <p>Interview on 2/29/24 with client #3 revealed:</p> <ul style="list-style-type: none"> -They did fire and disaster drills with staff. -They walked over to the mailbox for the fire drill. -They went into the bathroom for hurricane and tornado drills. -They had not done a fire or disaster drill in | V 114 | | |

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL068-132 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED R 03/01/2024 |
|--|---|---|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER RSI-FERRELL ROAD | STREET ADDRESS, CITY, STATE, ZIP CODE 1543 FERRELL ROAD CHAPEL HILL, NC 27517 |
|---|---|

| (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 114 | <p>Continued From page 2</p> <p>"several" months.</p> <p>Interview on 2/29/24 with staff #1 revealed: -She generally didn't conduct fire and disaster drills. -She did one fire drill since being employed several months ago. -The fire and disaster drills were generally done by other staff.</p> <p>Interview on 3/1/24 with the Director of Supported-Independent Living Services revealed: -There were two separate staff shifts. -"We are trying to tighten up on the process for staff completing fire and disaster drills." -She thought the staff were just forgetting to complete the drills. -She confirmed the facility failed to ensure fire and disaster drills were conducted quarterly on each shift.</p> <p>This deficiency has been cited 2 times since the original cite on 1/31/22 and must be corrected within 30 days.</p> | V 114 | | |
| V 118 | <p>27G .0209 (C) Medication Requirements</p> <p>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</p> | V 118 | | |

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL068-132 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED R 03/01/2024 |
|--|---|---|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER RSI-FERRELL ROAD | STREET ADDRESS, CITY, STATE, ZIP CODE 1543 FERRELL ROAD CHAPEL HILL, NC 27517 |
|---|---|

| (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 3</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to keep the MARs current affecting three of three audited clients (#1, #2 and #3); failed to ensure medications for available for administration affecting two of three audited clients (#1 and #2) and failed to have a written physician's order to self administer medication affecting one of three audited clients (#3). The findings are:</p> <p>The following is evidence the facility failed to keep the MAR current.</p> <p>Reviews on 2/29/24 and 3/1/24 of client #1's</p> | V 118 | | |

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL068-132 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED R 03/01/2024 |
|--|---|---|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER RSI-FERRELL ROAD | STREET ADDRESS, CITY, STATE, ZIP CODE 1543 FERRELL ROAD CHAPEL HILL, NC 27517 |
|---|---|

| (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 4</p> <p>record revealed:</p> <ul style="list-style-type: none"> -Admission date of 11/14/19. -Diagnoses of Mild Intellectual Disability, Histrionic Personality Disorder, Obesity, Major Depressive Disorder-single episode, Anxiety Disorder, Impulse Disorder, Obstructive Sleep Apnea, Myopia, Presbyopia, Essential Hypertension and Gastroesophageal Reflux Disease. <p>Reviews on 2/29/24 and 3/1/24 of client #1's physician's orders revealed:</p> <p>12/11/23:</p> <ul style="list-style-type: none"> -Olopatadine 0.1 % (Itchy Eyes), instill one drop into both eyes twice daily -Folic Acid 1 milligrams (mg) (Supplement), 5 tablets daily -Propranolol 20 mg (High Blood Pressure), one tablet twice daily <p>9/26/23:</p> <ul style="list-style-type: none"> -Triamcinolone Ointment 0.1% (Skin Disorders), use as directed 2 x daily -Clobetasol Solution 0.05% (Psoriasis), spread topically to itchy red scaly plaques of psoriasis on the scalp twice daily <p>Review on 2/29/24 of MARs for client #1 revealed:</p> <p>February 2024-No staff initials as administered or treatment completed for the following medications:</p> <ul style="list-style-type: none"> -Folic Acid 1 mg on 2/11 -Clobetasol Solution 0.05% on 2/17 and 2/18 am; 2/4, 2/18, 2/25 and 2/26 pm <p>January 2024-No staff initials as administered or treatment completed for the following</p> | V 118 | | |

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL068-132 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED R 03/01/2024 |
|--|---|---|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER RSI-FERRELL ROAD | STREET ADDRESS, CITY, STATE, ZIP CODE 1543 FERRELL ROAD CHAPEL HILL, NC 27517 |
|---|---|

| (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>medications: -Olopatadine 0.1 % on 1/6 pm -Clobetasol Solution 0.05% on 1/6, 1/9 and 1/21 am; 1/6, 1/9, 1/14 and 1/20 pm</p> <p>December 2023-No staff initials as administered or treatment completed for the following medications: -Olopatadine 0.1 % on 12/22, 12/24, 12/25 and 12/27 am/pm -Propranolol 20 mg on 12/22, 12/24 and 12/25 -Triamcinolone Ointment 0.1% on 12/10, 12/22, 12/24 and 12/25 pm -Clobetasol Solution 0.05% on 12/11 am; 12/3, 12/22 thru 12/25 pm</p> <p>Reviews on 2/29/24 and 3/1/24 of client #2's record revealed: -Admission date of 11/24/14. -Diagnoses of Mild Intellectual Disability, Spastic Diplegic Cerebral Palsy, Essential Hypertension, Lymphedema, Edema, Prediabetes, Tinea Unguium, Tinea Pedis and Morbid Obesity.</p> <p>Reviews on 2/29/24 and 3/1/24 of client #2's physician's orders revealed:</p> <p>12/22/23: -Chlorthalidone 25 mg (High Blood Pressure), 1 and ½ tablet in morning -Nystatin Cream 100000 units (Antifungal), apply to area under breasts twice daily</p> <p>12/13/23: -Vitamin E (Supplement), one tablet in evening -Xerac-AC Solution 6.25% (Excessive sweating), apply topically to affected area twice daily -Triamcinolone cream 0.1 %, apply to affected area twice daily -Miconazorb Powder AF 2% (Fungus), apply to</p> | V 118 | | |

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL068-132 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED R 03/01/2024 |
|--|---|---|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER RSI-FERRELL ROAD | STREET ADDRESS, CITY, STATE, ZIP CODE 1543 FERRELL ROAD CHAPEL HILL, NC 27517 |
|---|---|

| (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>feet twice a day as directed</p> <p>6/28/23: -Norethindron 0.35 mg (Birth Control), one tablet daily -Compression stockings and wraps. Morning black pair and evening white pair</p> <p>Review on 2/29/24 of MARs for client #2 revealed:</p> <p>February 2024-No staff initials as administered or treatment completed for the following medications: -Chlorthalidone 25 mg on 2/3 and 2/24 -Nystatin Cream 100000 units on 2/25 -Vitamin E on 2/25 -Xerac-AC Solution 6.25% on 2/25 pm -Triamcinolone cream 0.1 % on 2/25 pm -Miconazorb Powder AF 2% on 2/3, 2/4, 2/17 and 2/18 am; 2/4, 2/18 and 2/25 pm -Compression stockings and wraps on 2/4, 2/7 and 2/25 pm</p> <p>January 2024-No staff initials as administered or treatment completed for the following medications: -Chlorthalidone 25 mg on 1/15 -Xerac-AC Solution 6.25% on 1/7, 1/9 and 1/28 pm -Triamcinolone cream 0.1 % on 1/28 -Miconazorb Powder AF 2% on 1/21 am; 1/20 and 1/28 pm -Compression stockings and wraps on 1/2, 1/7 and 1/28 pm</p> <p>December 2023-No staff initials as administered or treatment completed for the following medications: -Vitamin E on 12/18</p> | V 118 | | |

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL068-132 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED R 03/01/2024 |
|--|---|---|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER RSI-FERRELL ROAD | STREET ADDRESS, CITY, STATE, ZIP CODE 1543 FERRELL ROAD CHAPEL HILL, NC 27517 |
|---|---|

| (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> <ul style="list-style-type: none"> -Miconazorb Powder AF 2% on 12/24 am/pm -Norethindron 0.35 mg on 12/11 -Compression stockings and wraps 12/24 am/pm <p>Reviews on 2/29/24 and 3/1/24 of client #3's record revealed:</p> <ul style="list-style-type: none"> -Admission date of 11/24/14. -Diagnoses of Mild Intellectual Disability, Down Syndrome, Celiac Disease, Ventricular Septal Defect Patent Ductus, Patent Ductus Arteriosus, Hidradenitis-Recurrent boils, Blepharitis, Hypotension, Hypothyroidism and Dermatitis. <p>Reviews on 2/29/24 and 3/1/24 of client #3's physician's orders revealed:</p> <p>12/20/23:</p> <ul style="list-style-type: none"> -Polyethylene Glycol Powder 238 grams (gm) (Constipation), mix 17 gm into suitable liquid -Mineral Oil (Ear Wax), instill 3 drops into ears three times a week -Zinc Oxide Ointment 20% (Skin Treatment), apply to areas of friction on inner thighs daily -Minerin Cream (Skin Treatment), apply topically to skin once daily -Ketoconazole 2% cream 60 gm (Skin Infection), apply once daily under the breast and on legs/inner thighs that itch <p>9/26/23:</p> <ul style="list-style-type: none"> -Clobetasol Sol 0.05%, apply topically to scaly patches on scalp once daily <p>7/11/23:</p> <ul style="list-style-type: none"> -Hydrocortisone 2.5 % cream (Skin Treatment), apply top to boils in groin, itchy spots on left arm and back on Sundays and Thursdays for itching -Clindamycin Gel 1% (Skin Infection), apply once daily | V 118 | | |

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL068-132 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED R 03/01/2024 |
|--|---|---|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER RSI-FERRELL ROAD | STREET ADDRESS, CITY, STATE, ZIP CODE 1543 FERRELL ROAD CHAPEL HILL, NC 27517 |
|---|---|

| (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 8</p> <p>Review on 2/29/24 of MARs for client #3 revealed:</p> <p>February 2024-No staff initials as administered or treatment completed for the following medications: -Polyethylene Glycol Powder on 2/4, 2/17 and 2/24 -Zinc Oxide Ointment 20% on 2/10 and 2/11 -Minerin Cream on 2/4 -Ketoconazole 2% on 2/24 -Hydrocortisone 2.5 % cream on 2/4, 2/11, 2/18 and 2/25</p> <p>January 2024-No staff initials as administered or treatment completed for the following medications: -Minerin Cream on 1/7, 1/15 and 1/29 -Hydrocortisone 2.5 % cream on 1/7, 1/14 and 1/21</p> <p>December 2023-No staff initials as administered or treatment completed for the following medications: -Polyethylene Glycol Powder on 12/3, 12/4, 12/10, 12/22, 12/24 and 12/25 -Mineral Oil on 12/11 -Zinc Oxide Ointment 20% on 12/11 -Minerin Cream on 12/22, 12/24 and 12/25 -Clobetasol Sol 0.05% on 12/11 and 12/17 -Hydrocortisone 2.5 % cream on 12/10 -Clindamycin Gel 1% on 12/11</p> <p>Interview on 2/29/24 with staff #1 revealed: -She "obsessively" checked the MAR to ensure she was putting her initials whenever she administered medications. -She wasn't sure why there were blanks on the MARs. -She thought other staff possibly forgot to put</p> | V 118 | | |

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL068-132 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED R 03/01/2024 |
|--|---|---|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER RSI-FERRELL ROAD | STREET ADDRESS, CITY, STATE, ZIP CODE 1543 FERRELL ROAD CHAPEL HILL, NC 27517 |
|---|---|

| (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 9</p> <p>their initials to indicate medications were administered. -Clients got their medications daily.</p> <p>Interview on 2/29/24 with the Director of Supported-Independent Living Services revealed: -There were no issues with clients getting their prescribed medications. -Staff were possibly forgetting to put their initials on the MARs. -She confirmed the MARs were not kept current for clients #1, #2 and #3.</p> <p>The following is the evidence the facility failed to ensure medications were available for administration.</p> <p>Review on 2/29/24 of MARs for client #1 revealed:</p> <p>February 2024-There were 0's for the following medication: -Olopatadine 0.1 % on 2/14 thru 2/29 am/pm</p> <p>December 2023-There were 0's for the following medications: -Olopatadine 0.1 % on 12/27 thru 12/29 am; 12/21 and 12/26 pm -Triamcinolone Ointment 0.1% on 12/13 thru 12/22 am; 12/13 thru 12/21 pm</p> <p>Observation on 2/29/24 at approximately 12:40 pm revealed: -The Olopatadine 0.1 % eye drops was not available for client #1.</p> <p>Review on 2/29/24 of MARs for client #2 revealed:</p> <p>February 2024-There were 0's for the following</p> | V 118 | | |

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL068-132 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED R 03/01/2024 |
|--|---|---|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER RSI-FERRELL ROAD | STREET ADDRESS, CITY, STATE, ZIP CODE 1543 FERRELL ROAD CHAPEL HILL, NC 27517 |
|---|---|

| (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 10</p> <p>medication: -Nystatin Cream 100000 units on 2/9 thru 2/29 am; 2/9 thru 2/24 pm</p> <p>January 2024-No staff initials as administered for the following medication: -Norethindron 0.35 mg on 1/1 thru 1/3</p> <p>December 2023-No staff initials as administered for the following medication: -Norethindron 0.35 mg on 12/28 thru 12/31</p> <p>Observation on 2/29/24 at approximately 2:21 pm revealed: -The Nystatin Cream 100000 units cream was not available for client #2.</p> <p>Interview on 2/29/24 with staff #1 revealed: -If clients MARs had 0's that meant the medication was not available and/or on back order.</p> <p>Interview on 2/29/24 with the Director of Supported-Independent Living Services revealed: -The 0's were on clients #1's and #2's MARs because the medication was on back order or they were waiting a new prescription from the physician. -She confirmed those medications were not available for administration for clients #1 and #2.</p> <p>The following is evidence the facility failed to have written physician's orders to self administer medication.</p> <p>Reviews on 2/29/24 and 3/1/24 of client #3's record revealed: -There were no written physician's orders for client #3 to self administer the medications below.</p> | V 118 | | |

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL068-132 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED R 03/01/2024 |
|--|---|---|---|

| | |
|---|---|
| NAME OF PROVIDER OR SUPPLIER RSI-FERRELL ROAD | STREET ADDRESS, CITY, STATE, ZIP CODE 1543 FERRELL ROAD CHAPEL HILL, NC 27517 |
|---|---|

| (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 11</p> <p>Reviews on 2/29/24 and 3/1/24 of client #3's physician's orders revealed:</p> <p>2/27/24: -Omeprazole 20 mg, one cap daily -Levothyroxine 100 mcg, one tab daily</p> <p>12/20/23: -Multivitamin, one tablet daily -Citrucel 500 mg, one tablet in the morning -Aranelle, one tablet at night -Loratadine 10 mg, one tab daily</p> <p>Review on 2/29/24 of December 2023, January and February 2024 MARs for client #3 revealed: -Staff had written self administers in the grids for the above medications.</p> <p>Interview on 1/29/24 with client #3 revealed: -She self-administered some of her medication daily.</p> <p>Interview on 2/29/24 with staff #1 revealed: -Client #3 could self-administer some of her medication. -Staff administered the other medication for client #3.</p> <p>Interview on 3/1/24 with the Director of Supported-Independent Living Services confirmed: -Client #3 had no written physician's orders to self administer her medication.</p> | V 118 | | |