Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		X3) DATE SURVEY COMPLETED	
		A. BOILDING	A. BUILDING.				
	MHL023-171		B. WING		07/	25/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CLEVELA	ND CRISIS AND RECOV	ERY CENTER	RTH WASHINGTO Y, NC 28150	N STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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 000	INITIAL COMMENTS		V 000				
	An annual survey was deficiency was cited.	s completed on 7/25/24. A					
	This facility is licensed for the following service categories: 10A NCAC 27G.1100 Partial Hospitalization for Individuals who are acutely Mentally III, 10A NCAC 27G.3300 Outpatient Detoxification for Substance Abuse, 10A NCAC 27G.5000 Facility Based Crisis Service for Individuals of all Disability Groups. This facility is licensed for 16 and has a current census of 9. The survey sample consisted of audits of 3 current clients.						
V 118	27G .0209 (C) Medica	ation Requirements	V 118				
	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;						

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

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL023-171		B. WING		0.	7/25/2024
	ROVIDER OR SUPPLIER	ERY CENTER		DRESS, CITY, STA H WASHINGTO NC 28150	,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
V 118	Continued From page 1 (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			
	This Rule is not met Based on observatior interview, the facility is kept current affecting and #3). The findings Review on 7/24/24 of admission date of 7/-diagnoses of Amphe Disorder severe, Cocand Other Stimulant Is Methamphetamine sero/20/24 physician's of HCL (Hydrochloride) 2 times a day. Review on 7/25/24 of 7/19/24 through 7/25/-Buspirone HCL 10 meno entry and time en medication was admit dose and 7/22/24 model.	n, record review, and failed to ensure MAI 3 of 3 clients (Clients are: Client #1's record r	Rs were hts #1, #2 revealed: nnce Use severe nxiety) - 1 tablet om a day. e evening				

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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		
		MHL023-171		B. WING		0.	7/25/2024
NAME OF F	PROVIDER OR SUPPLIER			RESS, CITY, STA			
CLEVELA	AND CRISIS AND RECOV	ERY CENTER	609 NORTH SHELBY, N	I WASHINGTO C 28150	N STREET		
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETE DATE
V 118	-admission date of 7/diagnoses of Stimula Methamphetamine tyl Bipolar Type, Post-Tr. (PTSD), and Insomnia -7/18/24 physician's of (Schizophrenia) 10 m and Mirtazapine (Dep bedtime. Review on 7/25/24 of 7/18/24 through 7/25/Aripiprazole 10 mg - entry and time entere was administered on -Mirtazapine 15 mg - entry and time entere was administered at the Review on 7/24/24 of -admission date of 7/diagnoses of Cocaine Uncomplicated, Alcoh Uncomplicated, PTSD Disorder (MDD)7/19/24 physician's of HCL 50 mg - 1 tablet Trazodone (MDD) 50 Review on 7/25/24 of 7/18/24 through 7/25/Sertraline HCL 50 mg no entry and time entered to in administered at bedting the service of the service	nt Use Disorder pe, Schizoaffective Disorder pe, Schizoaffective Disorder pe, Schizoaffective Disorder pe, Schizoaffective Disorder per a. orders - Aripiprazole g - 1 tablet in the morning ression) 15 mg - 1 tablet Client #2's MAR from 24 revealed: 1 tablet in the morning d to indicate the medicate the morning of 7/22/24. 1 tablet at bedtime - no d to indicate the medicate the morning of 7/21/24. Client #3's record rever 18/24. The Dependence of and Major Depressive orders - Sertraline (MDE orders - Sertraline (M	er ing et at - no ation ation aled: - o g of entry was	V 118			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL023-171	B. WING		0:	7/25/2024
			<u> </u>		1 0	720/2024
NAME OF P	ROVIDER OR SUPPLIER		REET ADDRESS, CITY, ST			
CLEVELA	ND CRISIS AND RECOV	ERY CENTER	9 NORTH WASHINGT	ON STREET		
	T		IELBY, NC 28150			T
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	e 3	V 118			
	revealed: -administered medica missed any day or ev	ntions daily and had not ening medications.				
	Interview on 7/25/24 with the facility Registered Nurse (RN) revealed: -worked Monday through Friday, 9:00 a.m. to 5:00 p.m. and administered medications to clientsworked on 7/22/24 and administered Client #1, #2 and #3's medications as orderedhad an electronic system for medication administration which was the same system used for client records"Anybody can get into the MAR and anyone can change (entries) it" in the MAR"meds (medications) get entered (for administration) and for some reason or another					
	it's (entry) goneever (electronic system) st re-enter it (again) and -reported this to the C (CEO) (date unknown	n if re-do it (the entry) it ill throws it outtry to it still is not taking" Chief Operations Officer in). It is unable to enter dates on administration.				
	Crisis Services revea -was aware the electr adequate do docume administration3/18/24 was when "f with a local pharmacy however this pharmac was needednot aware of any act clients not receiving t -5/16/24 able to locat	ronic MAR system was not nt medication irst started conversations" about changing systems, by could not provide what ual medication errors or of				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		/CLIA BER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMF	X3) DATE SURVEY COMPLETED	
		MHL023-171		B. WING		07	/25/2024
	ROVIDER OR SUPPLIER	ERY CENTER	609 NORTH	RESS, CITY, STA			
(X4) ID PREFIX TAG	4) ID SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 118	wantedlast met with the sele	ected pharmacy in June stem was expected to l		V 118			

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