Division of Health Service Regulation								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		MHL001-132	B. WING		R <b>08/02/2024</b>			
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE				
DEE & G	ENRICHMENT CENTER #	# 3	STIN STREET IGTON, NC 27217					
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE			
V 000	INITIAL COMMENTS		V 000					
	An annual and follow up survey was completed on August 2, 2024. A deficiency was cited.							
		d for the following service 27G .5600A Supervised Mental Illness.						
		d for 3 and has a current vey sample consisted of ents.						
V 121	27G .0209 (F) Medica	ation Requirements	V 121					
	governing body or op for obtaining a review regimen at least ever shall be to be perforn physician. The on-site the client's physician the review when med	es psychotropic drugs, the erator shall be responsible of each client's drug y six months. The review ned by a pharmacist or e manager shall assure that is informed of the results of lical intervention is indicated. e drug regimen review shall ent record along with						
	facility failed to obtain months for three of the who received psycho	as evidenced by: views and interview the n drug reviews every six nree clients (#1, #2 and #3) tropic drugs. The finding are: Client #1's record revealed:						
	olth Service Pegulation		,		<u> </u>			

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:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
AND PLAN OF CORRECTION		IDENTIFICATION NOWBER.	A. BUILDING: _		COMPLETED				
					R				
MHL001-132		B. WING		08/02/2024					
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE					
	321 AUSTIN STREET								
DEE & G	ENRICHMENT CENTER #	BURLING	TON, NC 27217	•					
(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 CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE				
V 121	21 Continued From page 1  -Admission date of 10/3/22Diagnoses of Congenital Deafness, Diabetes, Hypothyroidism, Encephalitis, Schizoaffective Disorder, Hyperlipidemia, GERD, PVD and Urinary IncontinencePhysicians' order dated 10/12/23: -Clozapine 100 milligrams (mg)-Take 2 tablets by mouth every morning and 3 tablets at bedtime and used for anxietyRisperidone 3mg-Take 1 tablet by mouth twice daily and used to treat schizophreniaSertraline 100mg-Take 1 tablet by mouth once daily at bedtime and used for depressionThe last six months of 2024 Medication Administration Record (MAR) revealed client #1 was administered the above medications dailyThere was no evidence of a psychotropic drug review for client #1's medications in the last six months.		V 121						
	-Admission date of 6/ -Diagnoses of Seizur Hypertension, Hyperl Retardation, InsomniPhysician's orders d -Aripiprazole 15mg- and used to treat sch -Clonazepam 1mg- bedtime and used for -Mirtazapine 15mg- bedtime and used for -Quetiapine 400mg bedtime and used for -Trazodone 100mg bedtime used for dep -The last six months of #2 was administered -There was no evider	e Disorder, Diabetes Type II, ipidemia, Psychosis, Mental a, Renal Insufficiency ated 10/30/23: -Take 1 tablet by mouth daily izophrenia. Take 1 tablet by mouth at panic disordersTake 1 tablet by mouth at depressionTake 1 tablet by mouth at insomnia.							

Division of Health Service Regulation

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
		MHL001-132	B. WING		R 08/02/2024				
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE. ZIP CODE	1 00/0	2/2024			
DEE & G ENRICHMENT CENTER # 3									
		BURLINGT	ON, NC 27217	7					
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE			
V 121	Continued From page 2		V 121						
	months.								
	Review on 8/2/24 of Client #3's record revealed: -Admission date of 8/26/11Diagnoses of Mental Retardation, Paranoid Schizophrenia, Bipolar affective Disorder, Insomnia, Constipation, and PrediabetesPhysician's orders dated 11/10/23: -Divalproex 500mg-Take 1 tablet by mouth twice daily and used for seizuresLorazepam 0.5mg-Take 1 tablet by mouth three time daily and used for insomnia and anxietyQuetiapine 400mg-Take 1 tablet by mouth at bedtime and used for insomniaThe last six months of 2024 MAR revealed client #3 was administered the above medications dailyThere was no evidence of a psychotropic drug review for client #3's medications in the last six months.								
	-"I was having trouble scheduling a date to a control of the scheduling a date to a control of the scheduling a date to a control of the scheduling and my scheduling to the scheduling review rescheduling to the scheduling schedulin	review the medications." It was doing my facility had facility didn't get rescheduled ist." In oharmacist in the office and ne." If the pharmacy and the date for psychotropic lied." If the pharmacy and the date for psychotropic lied." If the pharmacy and the date for psychotropic lied."							

Division of Health Service Regulation

STATE FORM 6899 L68S11 If continuation sheet 3 of 3