

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-694	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 04/17/2024
--------------------------------------------------	-----------------------------------------------------------------------------	------------------------------------------------------------------------	------------------------------------------------------------


NAME OF PROVIDER OR SUPPLIER UNITED RESIDENTIAL SERVICES OF NORTH C	STREET ADDRESS, CITY, STATE, ZIP CODE 6503 KEMPER COURT FAYETTEVILLE, NC 28303
-----------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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	INITIAL COMMENTS A complaint and follow up survey was completed on April 17, 2024. The complaint was unsubstantiated (intake #NC00214892). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 4 current clients.	V 000		
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	V 118		

RECEIVED
AUG 13 2024
DHSR-MH Licensure Sect

RECEIVED
AUG 14 2024
DHSR-MH Licensure Sect

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE _____ (X6) DATE 4/27/24

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-694	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/17/2024
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNITED RESIDENTIAL SERVICES OF NORTH C	STREET ADDRESS, CITY, STATE, ZIP CODE 6503 KEMPER COURT FAYETTEVILLE, NC 28303
-----------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 1</p> <p>(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 record reviews and interviews, the facility failed to administer medications as ordered by the physician and maintain an accurate MAR affecting 2 of 4 current clients (#1, #4). The findings are:</p> <p>Finding #1 Review on 4/17/24 of client #1's record revealed: -34 year old male. -Admitted on 12/9/11. -Diagnoses of Autism Spectrum Disorder, Bipolar 1 Disorder and Borderline Intellectual Functioning.</p> <p>Review on 4/17/24 of signed physician orders for client #1 revealed: -2/8/24 - Hydroxyzine HCL 50 milligram (mg) at bedtime. -2/22/24 - Ondansetron 4 mg 2 tablets 3 times daily as needed for nausea and vomiting.</p> <p>Review on 4/17/24 of client #1's MARs from 2/1/24 - 4/17/24 revealed: -Hydroxyzine HCL 50 was not given from 2/1/24-3/4/24, 3/9/24-3/31/24. -Ondansetron 4 mg was not documented on the</p>	V 118		
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-694	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/17/2024
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNITED RESIDENTIAL SERVICES OF NORTH (STREET ADDRESS, CITY, STATE, ZIP CODE 6503 KEMPER COURT FAYETTEVILLE, NC 28303
-----------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 2</p> <p>MAR as administered.</p> <p>Interview on 4/17/24 client #1 stated: -He received his medications daily.</p> <p>Finding #2 Review on 4/17/24 of client #4's record revealed: -30 year old male. -Admitted on 12/20/11. -Diagnoses of Bipolar Disorder II, Intellectual Disability Developmental Disorder moderate, Obsessive-Compulsive Disorder (OCD) and Intermittent Explosive Disorder.</p> <p>Review on 4/17/24 of client #4's signed physicians orders revealed: -6/1/23 - Risperidone 1 mg three times daily. (Bipolar)</p> <p>Review on 4/17/24 of client #4's MARs from 2/1/24 - 4/17/24 revealed: -Risperidone 1 mg was not administered 3/1/24 - 3/31/24 at 7am and 7pm. -Risperidone 1 mg was not administered 4/1/24 - 4/16/24 at 7am and 2pm.</p> <p>Interview on 4/17/24 client #4 stated: -He received his medications every morning, afternoon and night.</p> <p>Interview on 4/17/24 the Program Manager stated: -Client #1's Hydroxyzine HCL was prescribed as needed. -Client #1 would request the Hydroxyzine HCL. -She would get clarification on client #1's Hydroxyzine HCL. -Client #1 was seen at a local urgent care and prescribed Ondansetron 4 mg. -Client #2's Risperidone was administered as</p>	V 118		
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-694	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/17/2024
NAME OF PROVIDER OR SUPPLIER UNITED RESIDENTIAL SERVICES OF NORTH C		STREET ADDRESS, CITY, STATE, ZIP CODE 6503 KEMPER COURT FAYETTEVILLE, NC 28303		
(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 3 ordered. Staff did not document correctly. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 121	27G .0209 (F) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (f) Medication review: (1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated. (2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to obtain drug regimen reviews for 3 of 4 audited clients (#1, #3, #4) who received psychotropic medications. The findings are: Finding #1 Review on 4/17/24 of client #1's record revealed: -34 year old male. -Admitted on 12/9/11. -Diagnoses of Autism Spectrum Disorder, Bipolar 1 Disorder and Borderline Intellectual Functioning.	V 121		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-694	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/17/2024
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNITED RESIDENTIAL SERVICES OF NORTH C	STREET ADDRESS, CITY, STATE, ZIP CODE 6503 KEMPER COURT FAYETTEVILLE, NC 28303
-----------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 121	<p>Continued From page 4</p> <p>-No drug regimen review documented in the past 6 months.</p> <p>Review on 4/17/24 of signed physician orders for client #1 dated 2/8/24 revealed:</p> <ul style="list-style-type: none"> -Bupropion hydrochloride (HCL) extended release (ER) 300 milligram (mg) daily (Depression). -Cetirizine HCL 10 mg daily for allergies. -Fluticasone Propionate 50 microgram daily. (allergies) -Hydroxyzine HCL 50 mg at bedtime for sleep. -Lithium ER 300 mg every morning. (Bipolar) -Lithium ER 450 mg 2 tablets at bedtime. (Bipolar) -Melatonin 3 mg 2 tablets at bedtime. (sleep) -Quetiapine ER 400 mg at bedtime. (Bipolar) <p>Finding #2 Review on 4/17/24 of client #3's record revealed:</p> <ul style="list-style-type: none"> -36 year old male. -Admitted on 3/16/20. -Diagnoses of Autism Spectrum, Turret ' s Disorder, Intermittent Explosive Disorder, Severe Intellectual Disability, Bipolar Disorder II with disassociate personality episodes, Functional Neurological Symptom Disorder, Conversion Disorder. -No drug regimen review documented in the past 6 months. <p>Review on 4/17/24 of signed physician orders for client #1 revealed: FL2 dated 8/7/23</p> <ul style="list-style-type: none"> -Haloperidol 10 mg twice daily as needed for agitation. -Aspirin EC 81 mg daily. (Preventive) -Benztropine 1 mg three times daily. (side effects) -Buspirone HCL 15 mg twice daily for anxiety. -Divalproex SOD DR 500 mg 2 tablets twice daily for mood stabilization. 	V 121		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-694	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/17/2024
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNITED RESIDENTIAL SERVICES OF NORTH C	STREET ADDRESS, CITY, STATE, ZIP CODE 6503 KEMPER COURT FAYETTEVILLE, NC 28303
-----------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 121	<p>Continued From page 5</p> <ul style="list-style-type: none"> -Ferrous Sulfate 325 mg daily. (anemia) -Haloperidol Dec 100 mg/ml every 4 weeks. (mental) -Invega Sustenna 234 mg monthly. (Schizophrenia) -Lisinopril 5 mg daily. (blood pressure) -Melatonin 5 mg at bedtime. (Sleep) -Paliperidone ER 6 mg daily at 2pm for psychosis. -Xarelto 20 mg daily. (blood thinner) -Clonazepam 1 mg twice daily. (Anxiety) 9/25/23 - Quetiapine Fumarate 400 mg twice daily. (mental) <p>Finding #3 Review on 4/17/24 of client #4's record revealed:</p> <ul style="list-style-type: none"> -30 year old male. -Admitted on 12/20/11. -Diagnoses of Bipolar Disorder II, Intellectual Disability Developmental Disorder moderate, Obsessive-Compulsive Disorder (OCD) and Intermittent Explosive Disorder. -No drug regimen review documented in the past 6 months. <p>Review on 4/17/24 of client #4's signed physicians orders revealed:</p> <ul style="list-style-type: none"> -6/1/23 - Risperidone 1 mg three times daily. (Bipolar) -7/26/23 - Atorvastatin 40 mg daily. (Cholesterol) <ul style="list-style-type: none"> - Lisinopril 2.5 mg daily. (blood pressure) - Omeprazole DR 20 mg daily. (heartburn) -7/19/23 - Docusate Sodium 100 mg twice. (Stool) -8/28/23 - Metformin HCL 500 mg twice daily. (Blood Glucose) -10/3/23 - Fluvoxamine Maleate 50 mg at bedtime updated 3/28/24 twice daily. (OCD) <ul style="list-style-type: none"> - Oxcarbazepine 600 mg twice daily. (Seizures) 	V 121		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL026-694	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 04/17/2024
--------------------------------------------------	-----------------------------------------------------------------------------	-----------------------------------------------------------------------	-------------------------------------------------------------

NAME OF PROVIDER OR SUPPLIER UNITED RESIDENTIAL SERVICES OF NORTH C	STREET ADDRESS, CITY, STATE, ZIP CODE 6503 KEMPER COURT FAYETTEVILLE, NC 28303
-----------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------

(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 121	<p>Continued From page 6</p> <p>- Clonazepam 1 mg three times daily.</p> <p>Interview on 4/17/24 the Qualified Professional stated: -The facility had a contract with a local pharmacy for the drug reviews. -The drug reviews had not been completed due to the remodel at the facility. -He scheduled the drug regimen review with the pharmacy.</p> <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 121		

United Residential Services of North Carolina, Inc

Plan of Correction	
<p>United Residential Services of NC, Inc. United Residential Services of NC#2 6503 Kemper Court Fayetteville, NC 28303</p>	<p>Submitted to: NC Division of Health Service Regulation</p>
<p>Provider Name: United Residential Services</p> <p>Provider Contact: Jessie James, President/CEO</p> <p>Person for follow-up: Gerald Nickelberry, QP</p> <p>Address: 6503 Kemper Court Fayetteville, NC 28303</p>	<p>Phone: (910)584-6268</p> <p>Fax:</p> <p>Email: Unitedresidentialservicesinc@yahoo.com</p>
Finding	Corrective/Preventive Action Steps/Risk Management
<p>10A NCAC 27G .0209 Medication requirements. V118 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to administer medications as ordered by the physician and maintain an accurate MAR affecting 2 of 4 current clients.</p>	<ul style="list-style-type: none"> • Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.). • Indicate what measures will be put in place to prevent the problem from occurring again. • Indicate who will monitor the situation to ensure it will not occur again. • Indicate how often the monitoring will take place. • Sign and date at the bottom of the first page of the State Form. <p>What corrective action(s) will be accomplished in those areas of the facility found to have been affected by the deficient practice. Medication administration documentation procedures were reviewed with staff by the qualified professional and facility director to staff persons at the Kemper House facility. QP and facility director re-trained the staff on proper documentation on the MAR to include proper documentation of PRN medications. The Qualified Professional and or the Facility Director shall review/monitor the MARs regularly for accuracy and provide ongoing supervision with staff. The RN shall continue to train the Medication Administration Class annually for all staff.</p>
Responsible Party	Timeline
<p>For all deficiencies: The facility director, Risk Mgmt., QA/QI shall be responsible for the implementation and monitoring of all corrective action.</p>	<p>Projected Completion Date: 4/24/2024</p>

10A NCAC 27G .209

Medication Requirements

V121

Based on record reviews and interviews the facility failed to obtain drug regimen reviews for 3 of 3 audited clients (#1,#2,#4) who received psychotropic medications.

What corrective action(s) will be accomplished in those areas of the facility found to have been affected by the deficient practice:

Medication reviews by the psychiatrist shall continue to occur every 6 months as per rule.

The medication reviews shall be scheduled by QP with Pharmacy staff.

The qualified professional shall be responsible for working closely with the Pharmacist to schedule and ensure that medication reviews for all medications are occurring every 6 months.

Medication review shall be maintained in the client record.

4/24/2024