STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL096-034	A. BUILDING: _____ B. WING _____	R 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCI-MT OLIVE	600 WEST JOHN STREET MOUNT OLIVE, NC 28365

(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 An annual and follow up survey was completed on May 1, 2024. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 6 and has a current census of 6. The survey sample consisted of audits of 3 current clients.	V 000		
V 117	27G .0209 (B) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa center), and the name of the dispensing	V 117	RECEIVED MAY 23 2024 DHSR-MH Licensure Sect RECEIVED MAY 23 2024 DHSR-MH Licensure Sect	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Leslie Rayfield — TITLE: Chief Operations Officer — (X6) DATE: 5/16/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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V 117	Continued From page 1 practitioner. This Rule is not met as evidenced by: Based on record reviews, observations and interviews, the facility failed to ensure that medications for administration at the facility were labeled as required. The findings are: Review on 5/1/24 of client #5's record revealed: - 59 year old male admitted 3/12/06. - Diagnoses of Intellectual Developmental Disability-Moderate, Impulse Control, Rheumatoid Arthritis, Osteoporosis, Tobacco Use, cand Chronic Obstructive Pulmonary Disease. -FL2 signed and dated 9/7/23- Spiriva Handihaler 18mcg, Inhale 1 capsule daily. Observation on 5/1/24 of client #5's medication revealed 20 Spiriva capsules in silver packaging with no label. Interview on 5/1/24 client #5 stated he staff assisted him with taking his medications daily. Interview on 5/1/23 the Group Home Director stated she did not know what happened to the label. Interview on 5/1/24 the Vice President of Operations stated she understood the facility was required to have the packaging label on all medications.	V 117	V117 A label will be obtained from the pharmacy for Client # 5's medication. In the future, all client prescription medication will be properly labeled with all required elements. Medication will not be removed from the pharmacy packaging and labeling. Medication will be monitored monthly to assure proper labeling and storage by the Group Home Director or the Direct Care Administrator. The VP of Operations (Corporate Office) will monitor medication storage and labeling once quarterly during routine facility visits. Any issues will be immediately corrected.	6-30-2024