STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. BOILDING.		 F	₹
		MHL065-269	B. WING		1	4/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PROJEC	T TRANSITION-WILM	IINGTON	TOR'S CIRC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 000	INITIAL COMMEN	ΓS	V 000			
	on August 14, 2024	low up survey was completed The complaint was take #NC00219733). A d.				
	category: 10 A NC	sed for the following service AC 27 G .1100 Partial ndividuals Who Are Acutely				
		urrent census of 31. The sisted of audits of 2 current r client.				
V 118	27G .0209 (C) Med	lication Requirements	V 118			
	only be administered order of a person a drugs. (2) Medications shat clients only when a client's physician. (3) Medications, included administered only builties administered only builties administered only builties administered or other privileged to prepare (4) A Medication Acall drugs administer current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength.	inistration: non-prescription drugs shall ed to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by to trained by a registered nurse, regally qualified person and ee and administer medications. Iministration Record (MAR) of red to each client must be kept s administered shall be elely after administration. The				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

	(X3) DATE SURVEY COMPLETED					
	R 08/14/2024					
MHL065-269 B. WING 08/14/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
.E 01						
PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE COMPLETE					
_	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPROPRIES OF THE					

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER	⊃ .	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	A. BOILDING.	A. BUILDING:		R		
MHL065-269	B. WING		08/14/202	24		
NAME OF PROVIDER OR SUPPLIER STF	REET ADDRESS, CITY, ST	TATE, ZIP CODE				
PROJECT TRANSITION-WILMINGTON 1514 DOCTOR'S CIRCLE WILMINGTON, NC 28401						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE CON	(X5) MPLETE DATE		
twice daily. Review on 8/14/24 of client #1's June 2024 August 2024 MARs revealed the following b Clozapine 150 mg - 6/01/24 - 6/03/24, 6/08 6/09/24, 6/15/24, 6/16/24, 6/22/24, 6/23/24, 6/29/24, 6/30/24, 7/15/24, 7/12/24, 8/12/24, 8/13/24 at 8pm. Omeprazole 20 mg - 6/01/24, 6/02/24, 6/02/24, 6/09/24, 6/11/24, 6/15/24, 6/16/24, 6/22/24, 6/23/24, 6/23/24, and 6/30/24 at 9am. Oxcarbazepine 600 mg - 6/01/24, 6/02/24, 6/08/24, 6/09/24, 6/15/24, 6/16/24, 6/22/24, 6/23/24, 6/30/24, 7/28/24, 8/07/24, 8/08/24, 8/09/24 and 8/13/24 at 9am. Rexulti 3 mg - 6/01/24, 6/02/24, 6/08/24, 6/09/24, 6/15/24, 6/16/24, 6/22/24, 6/30/24, 7/28/24, 8/07/24, 8/08/24, 8/09/24 and 8/13/24 at 9am. Rexulti 3 mg - 6/01/24, 6/02/24, 6/08/24, 6/09/24, 6/15/24, 6/16/24, 6/22/24, 6/30/24, 7/28/24, 8/07/24, 8/08/24, 8/09/24, 8/13/24 at 9am. Interview on 8/14/24 client #1 stated: She had resided at the facility for 2 -3 mon She received her medications daily from standard she received her medications from the received her medications daily from standard she received her medications from the received her for the received her for the received her for the received her for the recei	planks: 3/24, and 08/24, and oths. taff. ealed: ne use ol use use rders e	DELIGITION 1				

Division of Health Service Regulation

STATE FORM 6899 SO2Q11 If continuation sheet 3 of 5

Division	of Health Service Re	egulation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL065-269	B. WING		R 08/14/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
PROJEC	T TRANSITION-WILM	INGTON	TOR'S CIRC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 118	Continued From page 3		V 118			
	- Melatonin (treats sleep disturbance) 3 mg - Take in the evening.					
	August 2024 MARs - Sertraline 50 mg - 6/09/24, 6/10/24, 6/6/23/24, 6/29/24, 6/8/01/24, 8/02/24, and 8/13/2 - Straterra 40 mg - 7/30/24, 7/31/24, 8/8/07/24, 8/08/24, 6/08/24, 6/09/24, 6/6/23/24, 6/29/24, 6/7/31/24, 8/01/24 - 8	7/23/23, 7/24/24, 7/28/24, 01/24, 8/02/24, 8/06/24, 09/24, and 8/13/24 at 9am. 6/01/24, 6/02/24, 6/03/24, 15/24, 6/16/24, 6/22/24, 30/24, 7/04/24, 7/11/24 - /11/24 at 8pm.				
	months He received his m - He had not misse	edications daily from staff. d any medications.				
	Admission date of of 8/02/24.Diagnoses include	of FC #3's record revealed: 12/20/22 and discharge date ed PTSD, attention-deficit ectrum disorder, and bipolar				
	dated 7/16/24 revea - Abilify (antipsychology evening. - Trazadone (for sleevery evening for sleevery)	tic) 5 mg - Take every ep disturbance) 50 mg - Take				

STATE FORM 6899 If continuation sheet 4 of 5 SO2Q11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					F	2
		MHL065-269	B. WING		08/1	4/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
PROJEC	T TRANSITION-WILM	IINGTON	TOR'S CIRC TON, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	nge 4	V 118			
V 118	Review on 8/14/24 2024 MARs reveale - Abilify 5 mg - 6/01 6/15/24, 6/16/24, 6/ 6/30/24, 7/04/24, 7/ - Trazadone 50 mg 6/08/24, 6/15/24, 6/ 6/29/24, 6/30/24, 7/ 8pm Lamictal 50 mg - 6 6/08/24, and 6/09/2 Interview on 8/14/2 No clients had mis - They had one stafinitials on the MAR medications The staff that did was no longer emplement of the staff that did was no longer emplement	of FC #3's June 2024 - August ed the following blanks: 1/24, 6/02/24, 6/03/24, 6/08/24, 1/22/24, 6/23/24, 6/29/24, 1/5/24, and 7/22/24 at 8pm 6/01/24, 6/02/24, 6/03/24, 1/6/24, 6/22/24, 6/23/24, 1/04/24, 7/15/24, and 7/22/24 at 6/01/24, 6/02/24, 6/03/24, 1/24 at 8pm. 4 the Program Director stated: ssed any medications. If who had not filled out their after assisting with the facility. The would ensure staff eations on the MAR properly. In accurately document stration it could not be s received their medications.	V 118			

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