| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|----------------------------|---|----------|-------------------------------|--|
| | | | A. BUILDING: | | | _ | |
| | | MHL001-275 | B. WING | | | २ 2 <mark>7/2024</mark> | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | | |
| CREATIV | ELY RENEWED LIVIN | NG | HMOND AVE STON, NC 27 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) | IOULD BE | (X5) COMPLETE DATE | |
| V 000 | INITIAL COMMENTS | | V 000 | | | | |
| | on August 27, 2024 This facility is licens category: 10A NCA | w up survey was completed . A deficiency was cited. sed for the following service C 27G Supervised Living for | | | | | |
| | Adults with Mental Illness. This facility is licensed for 6 and has a current census of 5. The survey sample consisted of audits of 3 current clients. | | | | | | |
| V 118 | 27G .0209 (C) Med 10A NCAC 27G .02 | lication Requirements | V 118 | | | | |
| | 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; | | | | | | |
| | (C) instructions for (D) date and time the | and quantity of the drug; administering the drug; ne drug is administered; and of person administering the | | | | | |

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

(X6) DATE TITLE

| OTATEMENT OF REFIGIENCIES (V4) PROVIDER/OURRING | | (VO) MULTIPL | E CONOTRIUCTION | LOVON DATE | OLIDVEN. | |
|---|---|--|--|--|-------------------------------|----------|
| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
| | | | A. BUILDING: | | | |
| | | | | | F | |
| | | MHL001-275 | B. WING | | 08/2 | 7/2024 |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| | | 1006 RIC | HMOND AVE | NUE | | |
| CREATI | ELY RENEWED LIVIN | NG | TON, NC 27 | | | |
| (V4) ID | SLIMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| (X4) ID PREFIX | | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOUL | | COMPLETE |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPRO DEFICIENCY) | PRIATE | DATE |
| | | | | BEHOLINGTY | | |
| V 118 | Continued From page 1 | | V 118 | | | |
| | (5) Client requests for medication changes or | | | | | |
| | | orded and kept with the MAR | | | | |
| | | appointment or consultation | | | | |
| | with a physician. | | | | | |
| | | | | | | |
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| | | | | | | |
| | This Puls, is not met as avidenced by: | | | | | |
| This Rule is not met as evidenced by: Based on observation, records reviews | | | | | | |
| | interview, the facility failed to keep the MAR current affecting one of three audited clients (#1). The findings are: | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | of Client #1's record revealed: | | | | |
| | -Admission date of | | | | | |
| | -Diagnoses Intellectual and Developmental | | | | | |
| | Disabilities Unspecified; Schizophrenia; | | | | | |
| | Constipation; Chronic Hepatitis; Tachycardia; Amblyopia (Right) Eye. | | | | | |
| | | ated 2/22/24 for the following | | | | |
| | medications: | ated 2/22/21 for the following | | | | |
| | | milligrams (mg)- take one | | | | |
| | tablet twice daily ale | ong with 100 mg. | | | | |
| | |) mg- take one tablet twice | | | | |
| | daily. | | | | | |
| | · · | 5 mg- take one tablet twice | | | | |
| | daily. | mg- take one tablet twice | | | | |
| | daily. | mg- take one tablet twice | | | | |
| | | mg- take one tablet twice | | | | |
| | daily along with 200 | | | | | |
| | , | 3 | | | | |
| | Observation on 8/2 | 3/24 at about 11:50 am of | | | | |
| | Client #1's medicat | | | | | |
| | | orementioned were available in | | | | |
| | the form of "bubble | packs." | | | | |

Division of Health Service Regulation

STATE FORM 6899 3O5C11 If continuation sheet 2 of 4

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|---|--|--|-------------------------------|--------------------------|--|
| | MHL001-275 | | B. WING | | | R 08/27/2024 | |
| | PROVIDER OR SUPPLIER | NG 1006 RICH | DRESS, CITY, ST HMOND AVEN TON, NC 272 | IUE | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY) | OULD BE | (X5) COMPLETE DATE | |
| V 118 | V 118 Continued From page 2 | | V 118 | | | | |
| | 1, 2024 through Au- -August: -Clozapine 200 medication as giver pm; 8/23 @ 8 am. -Bupropion 150 medication as giver pm; 8/23 @ 8 am. -Benztropine 0. medication as giver pm; 8/23 @ 8 am. -Metoprolol 25 medication as giver pm; 8/23 @ 8 am. -Clozapine 100 | of Client #1's MARs for June gust 23, 2024 revealed: mg- Staff did not initial the n from 8/1-8/22 @ 8am and 8 mg- Staff did not initial the n from 8/1-8/22 @ 8am and 8 5 mg- Staff did not initial the n from 8/1-8/22 @ 8am and 8 mg- Staff did not initial the n from 8/1-8/22 @ 8am and 8 mg- Staff did not initial the n from 8/1-8/22 @ 8am and 8 | | | | | |
| | -Clozapine was a ty for the treatment of schizophreniaBupropion was an -Benztropine was a effects from other n-Metoprolol was a r pressure. Interview on 8/1324 revealed: -She was not aware been initialing the n the beginning of the -She could assure to medications because bubble packsShe acknowledged | with the the Administrator e she and other staff had not nedications on the MAR since | | | | | |

Division of Health Service Regulation

STATE FORM 6899 3O5C11 If continuation sheet 3 of 4

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE COMI | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--|--|---------------------------------|----------------------------|--|
| | | MHL001-275 | B. WING | | | R 27/2024 | |
| | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S CHMOND AVE GTON, NC 27 | | · | | |
| (X4) ID PREFIX TAG | EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | HOULD BE COMPLETE | |
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Division of Health Service Regulation