Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.1.12 . 2.1.1	o. oo.u.2011o.u			A. BUILDING:				
	MHL092-678			B. WING		08/	08/28/2024	
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE BRU	JSON GROUP /NEW	BEGINNINGS HE	4513 FOX					
	Г			, NC 27616				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY I .SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 000	V 000 INITIAL COMMENTS			V 000				
	An annual survey v deficiency was cite	vas completed on 8/26 d.	8/24 . A					
	This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents.							
		sed for 6 and has a courvey sample consisted clients.						
V 118 27G .0209 (C) Medication Requirements		V 118						
	only be administered order of a person adrugs.  (2) Medications shat clients only when a client's physician.  (3) Medications, included administered only builties of persons pharmacist or othe privileged to prepare (4) A Medication Adall drugs administe current. Medication recorded immediat MAR is to include the (A) client's name;  (B) name, strength (C) instructions for (D) date and time the	ninistration: non-prescription drugged to a client on the wathorized by law to prove the self-administere authorized in writing by cluding injections, shappy licensed persons, or trained by a register regally qualified persone and administer medical ministration Record (ared to each client must administered shall lely after administration	ritten rescribe ed by / the all be or by ed nurse, son and dications. (MAR) of st be kept be on. The lrug; g; ed; and					

Division of Health Service Regulation 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/SUPPL IDENTIFICATION N			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL092-678		B. WING		08/	28/2024	
NAME OF PROVIDER OR SUPPLIER  THE BRUSON GROUP /NEW BEGINNINGS HEA  4513 FOX R				DDRESS, CITY, STATE, ZIP CODE ( ROAD I, NC 27616				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	DER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLE DATE		
V 118	(5) Client requests checks shall be rec	nge 1  for medication change orded and kept with appointment or constant	the MAR	V 118				
	failed to administer order of a physiciar findings are:  Review on 8/28/24 - admitted 12/29 - diagnoses: Sch Intellectual Develop Disorder - physician's order	oview and interview the medications on the medications on the medications on the medications of client #3's record /21 mizophrenia, Moderate mental Disorder and medicated: 6/17/24: Alternations of the medicated	written 63). The revealed: e d Anxiety					
	medications revealed - no Abilify  Review on 8/28/24  MAR revealed: - a blank space of documentation of sadministered  During interview on Professional (QP) residues	of client #3's August on 8/19/24 with no taff initials as the Ab	2024 ilify was Qualified					

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	MHL092-678		B. WING		08/28/2024	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE BRUSON GROUP /NEW BEGINNINGS HE 4513 FOX ROAD RALEIGH, NC 27616						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
V 118	injection on 8/19/24  During interview on - she did not adra Abilify injection  During interview on - "I have behavio - received an injemonth - the QP would a arm - "did not get the - "I hope she did  During interview on reported: - thought staff #3 Abilify injection this - "it could have be - "she (client #3) - the Abilify injection to her hearing work in the staff was a staff with the staff was a staff with the staff was a staff was	B administered the Abilify  8 8/28/24 staff #3 reported: minister client #3's monthly  8 8/28/24 client #3 reported: personal states and states are states and states are states	V 118			

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