Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL092-461	B. WING			R 02/2024
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
SLHC R	ESIDENTIAL PROGRA	M FOR WOMEN	PRING DRIVE ER, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	rs	V 000			
	on October 2, 2024	w up survey was completed . Deficiencies were cited.				
	category: 10A NCA Recovery Programs	sed for the following service C 27G .4100 Residential s for Individuals with Disorders and Their Children				
	census of 15. The s	sed for 16 and has a current survey sample consisted of clients and 1 former client.				
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	only be administered order of a person a drugs. (2) Medications shat clients only when at client's physician. (3) Medications, included administered only bunlicensed persons pharmacist or other privileged to prepar (4) A Medication Adall drugs administer current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for	inistration: non-prescription drugs shall ad 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 a trained by a registered nurse legally qualified person and le and administer medication liministration Record (MAR) ared to each client must be ke and sadministered shall be lely after administration. The	se, l ns. of ept			

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

TITLE (X6) DATE

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL092-461		B. WING			R 02/2024
	PROVIDER OR SUPPLIER	AM FOR WOMEN	1952 SPR	DRESS, CITY, S RING DRIVE , NC 27529	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	drug. (5) Client requests checks shall be recifile followed up by a with a physician.	for medication chan corded and kept with appointment or cons	the MAR	V 118			
	interview, the facility medications on a w ensure medications	et as evidenced by: ions, record review a y failed to administe ritten order of a phy s were available in thited clients (#12). The	r sician and ne facility				
	revealed: - Admitted 2/21/2 - Diagnoses of Cuncomplicated, Dia Disorder, Anxiety & - Physician's ord medications: - 7/21/24: Glycer insert 1 suppository needed) (Constipat - 8/14/24: Vitami three times a day P - 9/10/24: Mirtazi 1 tablet (tab) PO (b (Insomnia)	Other Stimulant Depo betes, Posttraumati Depression ers for the following in Suppository 2.1 g rectally every day F ion) n B-6 50mg give 1/2	endence c Stress gram (gm) PRN (as 2 tab PO (mg) give t PRN				
	Observation at 12:4	12pm on 10/2/24 of	client #12's				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		MHL092-461		B. WING			R 02/2024
	PROVIDER OR SUPPLIER	AM FOR WOMEN	1952 SPR	DRESS, CITY, S ING DRIVE NC 27529	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	medication bin reversible. Glycerin Supports B-6 were not in the Interview on 10/2/2- Was not missing the self-adminition of the self-administer in Interview on 10/2/2- Client #12 was administered her owner of the self-administered her owner o	ealed: psitory, Mirtazapine & facility 4 client #12 reported: ng any medications istered her insulin injected: needed a physician's nsulin injections 4 staff #1 reported: a diabetic and she wn insulin injections I client #12 as she injections I client #12 as she injections I client #12 as she injections I client #12 is Glycected: I clients while administication or Vitamin B-6 is first was responsible for a staff was responsible edications and ensuring the staff was responsible	ections s order ected her etering ulin erin were checking dentify facility er for ion in her or	V 118			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
				A. BOILDING.	-		R
		MHL092-461		B. WING			02/2024
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SLHC RE	SIDENTIAL PROGRA	AM FOR WOMEN		ING DRIVE NC 27529			
(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 OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
V 118	were discontinued, physician's order - Couldn't recall Suppository in her - Believed there client #12 to self-ac	but she didn't have th	Glycerin Ier for	V 118			
V 120	10A NCAC 27G .02 REQUIREMENTS (e) Medication Stor (1) All medication s (A) in a securely lowell-lighted, ventila and 86 degrees Fa (B) in a refrigerator degrees and 46 de refrigerator is used shall be kept in a s or container; (C) separately for e (D) separately for e (E) in a secure man for a client to self-n (2) Each facility tha controlled substance registered under th Substances Act, G subsequent amend	rage: cked cabinet in a clea ted room between 59 hrenheit; r, if required, between grees Fahrenheit. If th for food items, medic eparate, locked comp each client; external and internal u nner if approved by a nedicate. at maintains stocks of ces shall be currently the North Carolina Con S. 90, Article 5, include ments.	an, degrees 36 ne cations partment use; physician	V 120			
	Based on observat	et as evidenced by: ion, record review and y failed to ensure all	d				

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AND DIAN OF CORRECTION \ \ \ IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
				71. 501251110.			R
		MHL092-461		B. WING		l l	02/2024
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SLHC RE	ESIDENTIAL PROGRA	AM FOR WOMEN		NC 27529			
(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 OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 120	medications were saudited clients (#12 Review on 10/2/24 revealed: - Admitted 2/21/ Diagnoses of Cuncomplicated, Dia Disorder, Anxiety 8 - Physician's ord medications: - 7/9/24: Nicotine piece by mouth (PC hour (Smoking Cestronia) - 7/12/24: Human subcutaneously two snacks (Diabetes) - 8/14/24: Polyef 1 capful of powder daily (Constipation) - No physician's medication separated to the properties of the	stored securely affection and content #12's record 24 Other Stimulant Dependents, Posttraumatic Depression and park under lip of sation) are displayed as needed with the sation and library or 10/2/24 of cleated; in her apartment 42pm on 10/2/24 of cleated; medications were not in the sation of client #12's July, A MARs revealed; medications had "w (won the MARs:	ew 1 every 1 10 units with r dissolve nd give store ient #12's in the	V 120			
	Interview on 10/2/2	4 client #12 reported:					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL092-461	B. WING		10/0	R 02/2024
	PROVIDER OR SUPPLIER	AM FOR WOMEN 1952 SPR	DRESS, CITY, S RING DRIVE , NC 27529	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 120	- Was granted pormedications in her and a second results of the se	ermission to keep some apartment , Nicotine & Polyethylene	V 120			
V 263	Operations 10A NCAC 27G .41 (a) Admissions: (1) Admission decision of the desithe provider of residue) (2) The indivitor at least one presexcept for an emery (b) Coordination O Children In The Face	n to the facility shall be a joint gnated qualified professional, dential care, and the individual. dual shall have the opportunity admission visit to the facility	V 263			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL092-461		B. WING			R 02/2024
	PROVIDER OR SUPPLIER ESIDENTIAL PROGRA	AM FOR WOMEN	1952 SPR	DRESS, CITY, S RING DRIVE , NC 27529	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 263	(1) The approached a child shall be cooplan. (2) Each child primary health care (3) Each child immunizations as so (4) Each child age, shall receive a developmental screecive a multi-disc professionals for easervices. Parents son services that the to receive at screer (5) Each child shall receive a behad evelopmental screevaluated for child abuse disorder(s) becomes (6) Each child shall receive substated	ppriate education prordinated with his/her dishall receive prevents services. It shall have required pecified by G.S. 130 dt, birth through four a behavioral health a pening, and if appropropriate appropriate to the provided inference of the provided inference and evaluation. It is eligible for a pening, and if appropriate appropriate the provided inference and evaluation. It is eligible for a pening, and if appropriate appropriate the provided inference and the professed three years of age ance abuse preventice at-risk factors assets.	entive and d DA-152. years of nd oriate, by qualified ention or entitled and over, oriate, be ubstance sional(s). and over, on	V 263			
	failed to ensure each over received a behinder developmental screen Professional (QP) f (clients #2A & #2B) child 3 years of age abuse prevention s	view and interview, ch child five years of	age and l ldren e each substance at- risk				

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		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					R	
		MHL092-461	B. WING		10/0	2/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SLHC RI	ESIDENTIAL PROGRA	AM FOR WOMEN	NC 27529			
(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 (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
V 263	Continued From pa	age 7	V 263			
	family 2 of 2 audite The findings are:	d children (clients #2A & #2B).				
	revealed:	of client #2A's record				
	 admitted 1/8/24 no documentat 	4 ion of a behavioral health and				
	developmental scre	eening				
		ion of substance abuse s to address at- risk factors				
	revealed:	of client #2B's record				
		ion of a behavioral health and				
	developmental scre	eening ion of substance abuse				
		s to address at- risk factors				
	reported:	10/2/24 the clinical therapist				
		as contracted with another the behavioral and ening				
	- she reached ou	ut a couple of months ago to				
		at the contracted agency about had not heard back				
		substance abuse prevention				
	services had to be provided for children 3 years old or older					
	- she would look further into these prevention					
	services					
	_	10/2/24 the Program Director				
	reported: - all staff were re	esponsible for ensuring the				
		elopmental screening were				
		ign one staff to ensure the ompleted				

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	(X3) DATE SURVEY COMPLETED	
MHL092-461 R B. WING 10/02/	/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
SLHC RESIDENTIAL PROGRAM FOR WOMEN 1952 SPRING DRIVE GARNER, NC 27529		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
V 736 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview the facility was not maintained in a clean, attractive and orderly manner. The findings are: Observation on 10/2/24 at 10:12am of the facility's apartments (apt) revealed the following: - apt #1958: - a bug crawled up the wall - apt #1848: - a roach in the sink along with ants - apt 1846 downstairs area: - had 2 boxes of paper towels - 2 large boxes up against the wall - the kitchen sink water had a strong smell - upstairs storage closet had a hole size of a basketball - apt #118D: - a single high-pitched chirp every 60 seconds originating from a smoke detector in the kitchen bi-fold bedroom closet door off it's track - apt 12CC: - 2 linoleum floor planks taped down using clear packing tape During interview on 10/2/24 the Operational Manager reported: - the apartments were exterminated monthly - had reached out to someone to exterminate apt #1958 & apt #1848 - apt #1848 was used as a storage for the last		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
					R	
	MHL092-461	B. WING		10/0	02/2024	
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE			
SLHC RESIDENTIAL PROGRA	IM FOR WOMEN	RING DRIVE , NC 27529				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
 the water in apt they had the way were reported 	age items in the staff's office t 1846 smelled "like sulfur" ater tested and no concerns stitutes a re-cited deficiency	V 736				

6899

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