PRINTED: 11/12/2024

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING \_ MHL078-337 10/28/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **465 LONNIE FARM ROAD** 

SOUTHE	ASTERN INTEGRATED CARE, LLC PEMBRON	KE, NC 283	72	
(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	V 000		
	An annual and complaint survey was completed on October 28, 2024. The complaint was unsubstantiated (intake #NC00222820). Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment Facilities for Children & Adolescents  This facility is licensed for 6 and has a current census of 6. The survey sample consisted of audits of 3 current clients.			
V 111	27G .0205 (A-B) Assessment/Treatment/Habilitation Plan  10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN  (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to:  (1) the client's presenting problem;  (2) the client's needs and strengths;  (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission;  (4) a pertinent social, family, and medical history; and  (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and	V 111	Residential leadership team and residential care staff receive in-person MAR training. Residential staff has recieved code of conduct training on medication and the responsibility of administering medication.  To prevent this error leadership has implemented a check in sheet at the beginning of each staff shift to ensure their knowledge of all residents medication that needs to be given that day. As well leadership reviewing camera footage at administering times to ensure cleints are receiving their medication. This will be mointored by the Residnetial House Manager daily and weekly.  QA team will condcut quarterly audits to ensure compliance.	
	vocational, as appropriate to the client's needs.  (b) When services are provided prior to the establishment and implementation of the treatment/habilitation or service plan, hereafter ealth Service Regulation			

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

TITLE

(X6) DATE

**QA** Director

11/22/2024

Division of Health Service Regulation

DIVIDION	Of Fleatill Service IN	guiation				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		MHL078-337	B. WING		10/2	8/2024
NAME OF		CTDEET AD		STATE ZID CODE		
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
SOUTHE	ASTERN INTEGRATE	D CARE LLC	IIE FARM RO			
		PEMBRO	KE, NC 283	/2		
(X4) ID		TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
V 111	Continued From pa	go 1	V 111			
V 111	•		VIII			
		olan," strategies to address the				
	client's presenting p	problem shall be documented.				
				Accoment recourse CAFAS was		12/24/24
	This Rule is not me	et as evidenced by:		Asessment resource, CAFAS was purchased in 9/2024 to conduct within		
		view and interviews the facility		30 days of clients admission. A		
		cumentation that an admission		CASFAS has been condcuted for all current clients on or before 12/1/2024.		
		ompleted prior to the delivery		current clients on or before 12/1/2024.		
		3 audited clients (#1). The		Opertaional guideline has been create	d	
	findings are:	,		and implemented that all new clients w	vill	
				recieve the CAFAS within 7 days of admissions. This will be monitored by		
	Review on 10/25/24	fof client #3's record		the Clinical Director to ensure		
	revealed:			compliance within 4 days everytime a	new	
	-14 year old male.			client is admitted.		
	-Admitted on 5/16/2					
		Traumatic Stress Disorder				
		t Hyperactivity Disorder.				
		of an admission assessment				
		enting problems, client needs isional or admitting diagnosis,				
	social, family and m	ieuloai History.				
	Interview on 10/24/	24 the Quality Director stated:				
		t completed admission				
	assessments.					
	-The facility used th	e the client Clinical				
		sessment (CCA) to create the				
	treatment plan.	(2 2. 1) 10 2. 2.1.2 110				
		pdate the CCA or use the				
	CCA provided prior					

Division of Health Service Regulation

STATE FORM 6899 ORBI11 If continuation sheet 2 of 9

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	l` ´com	E SURVEY PLETED	
7.110 1 27.11	is contract to the state of the		A. BUILDING		
		MHL078-337	B. WING		28/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE	
SOUTHE	ASTERN INTEGRATE	FD CARE, LLC	NNIE FARM R OKE, NC 283		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 111	Continued From pa	ige 2	V 111		
	Interview on 10/24/24 the Operations Director stated: -There was no admission assessment for client #3.				
V 114	27G .0207 Emerge	ncy Plans and Supplies	V 114		
	114 27G .0207 Emergency Plans and Supplies  10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES  (a) Each facility shall develop a written fire plan and a disaster plan and shall make a copy of these plans available to the county emergency services agencies upon request. The plans shall include evacuation procedures and routes.  (b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.  (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift.  Drills shall be conducted under conditions that simulate the facility's response to fire emergencies.  (d) Each facility shall have a first aid kit accessible for use.				
	facility failed to ens	et as evidenced by: eview and interviews, the ure fire and disaster drills we rly and repeated on each shif		QA Director has re-trained all leadership staff to ensure fire and dieasater drill competency. To ensure correction that drills are being condcuted quarterly, all leadership will abide by the annual drill schedule. Once drills are condcuted leadership will upload anaylsis to the internal shared drive. QA will monitor monthly to ensure compliance	12/24/24

6899

Division of Health Service Regulation STATE FORM

ORBI11 If continuation sheet 3 of 9

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE S		
AND FLAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:	BUILDING:		
		MHL078-337	B. WING		10/2	8/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SOUTHE	ASTERN INTEGRATE	FD CARE, LLC	IIE FARM RO KE, NC 2837			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 114	Continued From pa	ige 3	V 114			
V 440	and disaster drills r -No fire drill held or of 2024 (April - Jun -No disaster drill he the 2nd quarterNo fire drill held or quarter of 2024 (Ju -No disaster drill he the 3rd quarter.  Interview on 10/24/ stated: -The facility began -The shifts at the fa 2nd shift 3pm - 11p	n 2nd shift during the 2 quarter e). eld on 2nd or 3rd shift during in 3rd shift during the 3rd ly - September). eld on 2nd or 3rd shift during 24 the Operations Director serving clients in April 2024. ecility were 1st shift 7am - 3pm, im and 3rd shift 11pm - 7am.	V440			
V 118	10A NCAC 27G .02 REQUIREMENTS (c) Medication adm (1) Prescription or ronly be administered order of a person adrugs. (2) Medications shadlients only when a client's physician. (3) Medications, incline administered only builticensed persons pharmacist or other privileged to prepar (4) A Medication Adall drugs administered current. Medication		V 118			

Division of Health Service Regulation

STATE FORM 6899 ORBI11 If continuation sheet 4 of 9

Division of Health Service Regulation

Division of Health Service Regulation						
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	·	COMPLETED	
	MHL078-337		B. WING		10/2	8/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
		465 I ON	NIE FARM RO			
SOUTHE	ASTERN INTEGRATE	DCARFIIC	KE, NC 283			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES		DATE
				DEFICIENCY)		
V 118	Continued From pa	ae 4	V 118			
	-					
	MAR is to include the	ne following:				
	(A) client's name;	and quantity of the drug;				
		administering the drug;				
		ne drug is administered; and				
		of person administering the				
	drug.	•				
		for medication changes or				
		orded and kept with the MAR				
	with a physician.	appointment or consultation				
	with a physician.					
	This Dule is not my	at an evidenced by				
	This Rule is not me	views and interviews, the		Residential leadership team and resid	ential	12/24/24
		ninister medications on the		care staff will receive in-person MAR re-training. Residential staff has recieve	ed a code	,
		hysician and failed to keep the		of conduct training on medication and	the	,
		ting three of three audited		responsiblity of administering medicat	ion.	
	clients (#3, #4, #6).	The findings are:		To prevent this error leadership has		
				implemented a check in sheet at the b		
	Finding #1	4 - f - li - u t #0l - u u d		of each staff's shift to ensure their kno of all residents medication that needs		
	revealed:	4 of client #3's record		given that day. As well leadership revi	ewing	
	-14 year old male.			camera footage at administering times ensure clients are receiving their med	s to ication	
-Admitted on 5/16/24Diagnoses of Post Traumatic		24.		This will be mointored by the Residner	tial	
				House Manager daily and weekly.		
		it Hyperactivity Disorder		QA team will condcut quarterly audits	to ensure	
	(ADHD).			compliance.		
		an orders for Smarty Pants				
		mies daily (Supplement) and				
		mies daily (Supplement) and				
	Melatonin 3 milligra	iiii (iiig <i>)</i> .				
	Review on 10/24/24	4 and 10/25/24 of client #3's				
	signed physician or					

Division of Health Service Regulation

STATE FORM 6899 ORBI11 If continuation sheet 5 of 9

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
			A. BUILDING:			
		MHL078-337	B. WING		10/2	28/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
SOUTHE	SOUTHEASTERN INTEGRATED CARE, LLC PEMBRO					
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 118	Continued From pa	age 5	V 118			
	8/13/24 - Melatonir	n 10 mg at bedtime (sleep).				
	Review on 10/24/24 re-Smarty Pants Multidaily from 8/10/24 re-Multivitamins Gumfrom 9/12/24 - 10/9 review.  Interview on 10/25/2 revealed: -15 year old maleAdmitted on 7/19/9 review.  Review on 10/25/2 revealed: -15 year old maleAdmitted on 7/19/9 review.  Review on 10/25/2 revealed: -15 year old maleAdmitted on 7/19/9 review.  Review on 10/24/2 revealed: -10 year old maleAdmitted on 7/19/9 review.  Review on 10/24/2 revealed: -10 year old maleAdmitted on 7/19/9 review.	4 of client #3's MARs from evealed: tivitamin was administered - 9/12/24. miles was administered daily 0/24. as documented as 9/1/24 - 9/30/24. 24/24 at 3:55pm of client #3's ed: was not available onsite for 24 client #3 stated: edications twice daily. 4 of client #4's record 24. ositional Defiant Disorder Mild, Depression Disorder. an orders for Smarty Pants mies daily (Supplement) and mies daily (Supplement). 4 and 10/25/24 of client #4's recers revealed: g every morning.				
	8/22/24 -Amoxicillin 500 mg 9/16/24	g 3 times daily for 10 days.				
		milliliter 4 times daily for 10				

Division of Health Service Regulation

STATE FORM 6899 ORBI11 If continuation sheet 6 of 9

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			X3) DATE SURVEY COMPLETED	
MHL078-337		B. WING		10/2	8/2024	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
SOUTHE	ASTERN INTEGRATE	D CARE, LLC	IIE FARM RO KE, NC 2837			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 6	V 118			
	8/1/24 - 10/24/24 re-Smarty Pants Multivitamins Gum from 9/17/24 - 10/9 - Bupropion 150 mg administered on 9/2 - Clonidine 0.1 mg vadministered on 9/2 - Amoxicillin 500 mg administered 4 time - Nystatin 100000 wadministered once 9/22/24 and 9/24/24 and twice on 9/23/2 - Clotrimazole was radministered on 9/2 - He received his me-He took Amoxicillir - He was taking a m to get it prescribed  Finding #3 Review on 10/25/24 revealed: -13 year old male Admitted on 7/24/2 - Diagnoses of Bipo Disorder, Oppositio - No signed physicia Multivitamin 4 gum Multivitamins Gumr Penicillin 500 mg 4 (antibiotic) and Chlorometric part of the signed physicial formula in the signe	ivitamin was administered 9/9/24. Imies was administered daily /24. Iwas not documented as 10/24 and 9/11/24. Iwas not documented as 25/24 and 9/26/24. Iwas documented as 25/24 and 9/26/24, 9/19/24 - 4 - 9/26/24, 3 times on 9/18/24 and documented as 27/24, 9/28/24(PM).  24 client #4 stated: edications daily. In a while ago. I while ago.				

Division of Health Service Regulation

STATE FORM 6899 ORBI11 If continuation sheet 7 of 9

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  465 LONNIE FARM ROAD PEMBROKE, NC 28372  [M4] ID PREFIX TAG  [MA   ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  V118  Continued From page 7  V118  Continued From page 7  V118  Review on 10/24/24 and 10/25/24 of client #6's signed physician orders revealed: 7/24/24 -Divalproex Extended Release 250 mg twice daily from 3/11/24 - 10/34/24 revealed: -Smarty Pants Multivitamin was administered daily from 8/11/24 - 10/8/24Divalproex Extended Release 250 mg was documented as administered on 10/11/24 - 10/14/24Divalproex Extended Release 250 mg was documented as administered on 10/11/24 - 10/14/24Divalproex Extended Release 250 mg was documented as administered on 10/11/24 - 10/14/24Pivalproex Extended Release 250 mg was documented as administered on 10/11/24 - 10/14/24Pivalproex Extended Release 250 mg was documented as administered on 10/11/24 - 10/14/24Pivalproex Extended Release 250 mg was documented as administered on 10/11/24 - 10/14/24Proficilin 500 mg was documented as administered on 10/11/24 - 10/14/24Proficilin 500 mg was documented as administered on 10/19/24 - 10/24/24Chlorhex/dine 0.12% Oral Rinse was documented as administered wice daily from 10/19/24 - 10/23/24Interview on 10/25/24 client #6 stated: -He received his medications at school.  Interview on 10/25/24 staff #1 stated: -Client #3's Melatonin 10mg was ordered and	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
SOUTHEASTERN INTEGRATED CARE, LLC   465 LONNIE FARM ROAD PEMBROKE, NC 28372	MHL078-337		B. WING		10/28/2024		
CALID   CARE   CARE   LIC   PEMBROKE, NC 28372     CALID   CARE   CARE	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES   ID   PREFIX   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   TAG   PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX   TAG   CROSS-REFERENCE OT OT HE APPROPRIATE DATE   DATE	SOUTHE	A STEDNINTECDATE	ED CARE LLC 465 LONI	NIE FARM RO	DAD		
PRÉFIX TAG    CACH DEFICIENCY MIST BE PRECEDED BY FULL TAG   CROSS-REFERNICE TO THE APPROPRIATE   CACH CONSTRUCTIVE ACTION SHOULD BE CROSS-REFERNICE TO THE APPROPRIATE	PEMBRO			KE, NC 2837	72		
Review on 10/24/24 and 10/25/24 of client #6's signed physician orders revealed: 7/24/24 -Divalproex Extended Release 250 mg twice daily. 9/10/24 -Concerta 36 mg daily.  Review on 10/24/24 of client #6's MARs from 8/1/24 - 10/24/24 revealed: -Smarty Pants Multivitamin was administered daily from 8/10/24 - 9/9/24Multivitamins Gummies was administered daily from 9/11/24 - 10/8/24Divalproex Extended Release 250 mg was documented as administered daily from 8/1/24Divalproex Extended Release 250 mg was documented as administered on 10/11/24 - 10/14/24Penicillin 500 mg was documented as administered on 10/11/24 - 10/24/24Penicillin 500 mg was documented as administered on 10/19/24 - 10/24/24Chlorhexidine 0.12% Oral Rinse was documented as administered wice daily from 10/19/24 - 10/23/24.  Interview on 10/25/24 client #6 stated: -He received his medications at school.  Interview on 10/25/24 staff #1 stated:	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	COMPLETE
signed physician orders revealed: 7/24/24 -Divalproex Extended Release 250 mg twice daily. 9/10/24 -Concerta 36 mg daily.  Review on 10/24/24 of client #6's MARs from 8/1/24 - 10/24/24 revealed: -Smarty Pants Multivitamin was administered daily from 8/10/24 - 9/9/24Multivitamins Gummies was administered daily from 9/11/24 - 10/8/24Divalproex Extended Release 250 mg was documented as administered daily from 8/1/24 - 8/31/24Concerta 36 mg was not documented as administered on 10/11/24 - 10/14/24Penicillin 500 mg was documented as administered on 10/19/24 - 10/24/24Chlorhexidine 0.12% Oral Rinse was documented as administered twice daily from 10/19/24 - 10/23/24.  Interview on 10/25/24 client #6 stated: -He received his medications dailyHe received some medications at school.  Interview on 10/25/24 staff #1 stated:	V 118	Continued From pa	age 7	V 118			
waiting to be delivered by the pharmacyShe believed the client's received their medications as orderedThe blanks were from staff documentation errors.  Interview on 10/24/24 and 10/25/24 the		signed physician or 7/24/24 -Divalproex Extend daily. 9/10/24 -Concerta 36 mg daily. 8/1/24 - 10/24/24 re-Smarty Pants Multidaily from 8/10/24 - Multivitamins Gumfrom 9/11/24 - 10/8 -Divalproex Extend documented as adil 8/31/24Concerta 36 mg wadministered on 10 -Penicillin 500 mg wadministered on 10 -Chlorhexidine 0.12 documented as adil 10/19/24 - 10/23/24 Interview on 10/25/-He received his manual received some Interview on 10/25/-Client #3's Melator waiting to be delived she believed the comedications as ord -The blanks were freerrors.	rders revealed:  ed Release 250 mg twice  aily.  4 of client #6's MARs from evealed: divitamin was administered 9/9/24. ed Release 250 mg was ministered daily from 8/1/24 -  ras not documented as 1/11/24 - 10/14/24. was documented as 1/11/24 - 10/24/24. 2% Oral Rinse was ministered twice daily from 4.  24 client #6 stated: edications daily. medications at school.  24 staff #1 stated: nin 10mg was ordered and red by the pharmacy. slient's received their ered. rom staff documentation				

Division of Health Service Regulation

STATE FORM 6899 ORBI11 If continuation sheet 8 of 9

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
MHL078-337		B. WING		10/2	28/2024	
NAME OF	PROVIDER OR SUPPLIER	•	DRESS, CITY,	STATE, ZIP CODE	,	
SOUTHE	EASTERN INTEGRATI	-I)(:ARF II(:	NIE FARM RO KE, NC 283			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 118	-All the clients were MultivitaminThe Multivitamin was prescription was	e taken a non prescribed vas discontinued after learning needed. t always received physician	V 118			

Division of Health Service Regulation STATE FORM

ORBI11 If continuation sheet 9 of 9