

Division of Health Service Regulation

|   |   |  |  |  |
|---|---|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>MHL092-582</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/10/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>Varsity Crest #3</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1503 CREST ROAD APT. 103<br/>RALEIGH, NC 27606</b> |  |  |
| (X4) ID<br>PREFIX<br>TAG                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE   |
| V 000   | <p><b>INITIAL COMMENTS</b></p> <p>An annual and follow up survey was completed on 12/10/24. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness.</p> <p>This facility is licensed for 2 and has a current census of 2. The survey sample consisted of audits of 2 current clients.</p>   | V 000  |  |  |
| V 114   | <p><b>27G .0207 Emergency Plans and Supplies</b></p> <p><b>10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES</b></p> <p>(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.</p> <p>(b) The plans shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.</p> <p>(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.</p> <p>(d) Each facility shall have a first aid kit accessible for use.</p> | V 114  |  |  |

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<br>AND PLAN OF CORRECTION         |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>MHL092-582</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/10/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>Varsity Crest #3</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1503 CREST ROAD APT. 103<br/>RALEIGH, NC 27606</b> |  |  |
| (X4) ID<br>PREFIX<br>TAG                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE   |
| V 114   | <p>Continued From page 1</p> <p>This Rule is not met as evidenced by:<br/>Based on record review and interview the facility failed to ensure fire and disaster drills were completed on each shift. The findings are:</p> <p>Review on 12/6/24 of the facility's fire and disaster drill revealed:</p> <ul style="list-style-type: none"> <li>- 1 fire and 2 disaster drills completed this 2024 year</li> </ul> <p>During interview on 12/6/24 the Program Director reported:</p> <ul style="list-style-type: none"> <li>- staff work shifts: 8am - 4pm, 4pm - 12am &amp; 12am - 8am</li> </ul> <p>During interview on 12/5/24 client #1 reported:</p> <ul style="list-style-type: none"> <li>- fire and disaster drills were not practiced</li> <li>- staff gave them handouts on fire and disaster drills</li> <li>- fire: go outside to the dumpster</li> <li>- tornado: bathroom or hallway and get down</li> </ul> <p>During interview on 12/6/24 staff #1 reported:</p> <ul style="list-style-type: none"> <li>- staff practiced fire and disaster drills with each individual client</li> <li>- clients went to the dumpster for fire drills</li> <li>- tornado drills were practiced in the bathroom</li> </ul> <p>During interview on 12/6/24 staff #2 reported:</p> <ul style="list-style-type: none"> <li>- clients were given handouts regarding fire and disaster drills</li> <li>- clients did not practice fire and disaster drills</li> </ul> <p>During interview on 12/6/24 the Program Director reported:</p> <ul style="list-style-type: none"> <li>- he was responsible for ensuring fire and disaster drills were completed</li> <li>- will ensure fire and disaster drills were completed</li> </ul> | V 114  |  |  |

Division of Health Service Regulation

|   |  |  |  |  |
|---|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>MHL092-582</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/10/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>Varsity Crest #3</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1503 CREST ROAD APT. 103<br/>RALEIGH, NC 27606</b> |  |  |
| (X4) ID<br>PREFIX<br>TAG                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE   |
| V 118   | Continued From page 2  | V 118  |  |  |
| V 118   | <p>27G .0209 (C) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS</p> <p>(c) Medication administration:</p> <p>(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.</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(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.</p> <p>(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:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p> <p>(D) date and time the drug is administered; and</p> <p>(E) name or initials of person administering the drug.</p> <p>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> | V 118  |  |  |

Division of Health Service Regulation

|   |  |  |  |  |
|---|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>MHL092-582</b>                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/10/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>Varsity Crest #3</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1503 CREST ROAD APT. 103<br/>RALEIGH, NC 27606</b> |  |  |
| (X4) ID<br>PREFIX<br>TAG                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE   |
| V 118   | Continued From page 3<br><br>This Rule is not met as evidenced by:<br>Based on record review and interview the facility failed to ensure 1 of 2 clients (#1) medications were administered on the written order of a physician. The findings are:<br><br>Review on 12/5/24 of client #1's record revealed:<br>- admitted 6/17/24<br>- diagnosis: Schizophrenia<br>- no physician's order for Rosuvastatin 20mg (milligram) bedtime (Cholesterol)<br><br>Review on 12/5/24 of client #1's November 2024 and December 2024 MARs revealed:<br>- staff signed the MARs as administered for Rosuvastatin<br><br>During interview on 12/5/24 the facility's nurse reported:<br>- the facility's staff taught clients to be independent<br>- clients went to the physician's office without staff<br>- clients were responsible for getting physician's information to bring back to the facility | V 118  |  |  |
| V 121   | 27G .0209 (F) Medication Requirements<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(f) Medication review:<br>(1) If the client receives psychotropic drugs, the governing body or operator shall be responsible for obtaining a review of each client's drug regimen at least every six months. The review shall be to be performed by a pharmacist or physician. The on-site manager shall assure that the client's physician is informed of the results of the review when medical intervention is indicated.  | V 121  |  |  |

Division of Health Service Regulation

|   |   |  |  |  |
|---|---|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION         |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>MHL092-582</b>                       | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>R</b><br><b>12/10/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>VARSITY CREST #3</b> |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1503 CREST ROAD APT. 103</b><br><b>RALEIGH, NC 27606</b> |  |  |
| (X4) ID<br>PREFIX<br>TAG                                    | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE   |
| V 121   | <p>Continued From page 4</p> <p>(2) The findings of the drug regimen review shall be recorded in the client record along with corrective action, if applicable.</p> <p>This Rule is not met as evidenced by:<br/>Based on record review and interview the facility failed to ensure a psychotropic drug regimen was completed for 1 of 3 clients (#2). The findings are:</p> <p>Review on 12/5/24 of client #1's record revealed:</p> <ul style="list-style-type: none"> <li>- admitted 1/17/24</li> <li>- diagnoses: Schizophrenia, Hypertension, Prediabetes, Dyslipidemia and Intellectual Developmental Disorder</li> <li>- a FL2 dated 6/27/23:</li> <li>- Clozapine 200mg (milligram) bedtime (Schizophrenia)</li> <li>- Clozapine 25mg morning</li> <li>- Escitalopram 10mg every day (depression)</li> <li>- no documentation of a psychotropic drug regimen review</li> </ul> <p>During interview on 12/6/24 the Program Director reported:</p> <ul style="list-style-type: none"> <li>- was not aware psychotropic drug regimen review had to be completed</li> <li>- will work with local pharmacy to complete the psychotropic drug regimen review</li> </ul> | V 121  |  |  |