

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL054-156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/18/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ADVANCE BEHAVIORAL HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2840 LISA LANE KINSTON, NC 28502
---	--

(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	<p>INITIAL COMMENTS</p> <p>An annual, complaint and follow up survey was completed on December 18, 2024. The complaint was substantiated (intake #NC00224042). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>This facility is licensed for 5 and has a current census of 5. The survey sample consisted of audits of 3 current clients.</p>	V 000		
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>	V 118		

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/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL054-156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/18/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ADVANCE BEHAVIORAL HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2840 LISA LANE KINSTON, NC 28502
---	--

(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 118	<p>Continued From page 1</p> <p>(E) name or initials of person administering the drug. (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> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to administer medications as ordered by the physician and maintain an accurate MAR affecting 3 of 3 current clients (#1, #2, #4). The findings are:</p> <p>Finding #1 Review on 12/18/24 of client #1's record revealed: -Admitted 2/15/15. -Diagnoses of Moderate Intellectual Disability, Seizure Disorder, Mild Scoliosis, Hypertension and Osteoarthritis.</p> <p>Review on 12/18/24 of client #1's signed physician orders dated 9/17/24 revealed: -Irbesartan 300 milligram (mg) at bedtime. (Hypertension) -Rosuvastatin 40 mg at bedtime. (Cholesterol) -Metoprolol Tartrate 50 mg 1/2 tablet twice daily. (Hypertension)</p> <p>Review on 12/18/24 of client #1's MARs from 10/1/24 - 12/18/24 revealed the following medications were not documented as administered:</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL054-156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/18/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ADVANCE BEHAVIORAL HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2840 LISA LANE KINSTON, NC 28502
---	--

(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 118	<p>Continued From page 2</p> <ul style="list-style-type: none"> -Irbesartan 300 mg on 12/15/24. -Rosuvastatin 40 mg on 12/5/24. -Metoprolol Tartrate 50 mg 10/11/24 (PM). <p>Interview on 12/18/24 client #1 stated she received her medications daily.</p> <p>Finding #2 Review on 12/18/24 of client #2's record revealed: -Admitted 3/1/11. -Diagnoses of Severe Intellectual Disability, Anxiety Disorder, Hyperlipidemia and Essential Hypertension.</p> <p>Review on 12/18/24 of client #2's signed physician orders dated 8/14/24 revealed: -Furosemide 40 mg daily. (Hyperlipidemia) -Arthritis Pain Relief 4 times daily. -KCL (Potassium) 10 mg 2 tablets twice daily. (Supplement)</p> <p>Review on 12/18/24 of client #2's MARs from 10/1/24 - 12/18/24 revealed: -Furosemide 40 mg was not documented as administered on 12/12/24. -Arthritis Pain Relief was not documented as administered on 12/8/24 at 4pm. -KCL (Potassium) 10 mg was transcribed/administered as 1 tablet twice daily from 12/1/24 - 12/17/24.</p> <p>Attempted interview on 12/18/24 with client #2 revealed her speech was limited.</p> <p>Finding #3 Review on 12/18/24 of client #4's record revealed: -Admitted 4/1/24. -Diagnoses of Mood Disorder due to known</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL054-156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/18/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ADVANCE BEHAVIORAL HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2840 LISA LANE KINSTON, NC 28502
---	--

(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 118	<p>Continued From page 3</p> <p>physiological condition, Dependent personality disorder and Mild Intellectual Disability.</p> <p>Review on 12/18/24 of client #4's signed physician orders revealed: 7/10/24 Fluticasone-Vilanterol one inhalation daily. (Wheezing) Cetirizine 10 mg every evening. (Allergy) Docusate 100 mg daily. (Stool Softener) Therapeutic-M daily. (Vitamin Deficiency) 6/25/24 Quetiapine 25 mg every morning, at 2pm and at 8pm. (Schizophrenia)</p> <p>Review on 12/18/24 of client #4's MARs from 10/1/24 - 12/18/24 revealed the following medications were not documented as administered: -Fluticasone-Vilanterol on 11/5/24, 12/5/24. -Cetirizine 10 mg on 10/23/24, 10/24/24 and 11/7/24. -Docusate 100 mg on 12/1/24 - 12/3/24, 12/5/24, 12/7/24 and 12/12/24. -Therapeutic-M on 11/11/24, 11/27/24 and 12/1/24. -Quetiapine 25 mg at 2pm on 12/12/24 and 12/13/24.</p> <p>Interview on 12/18/24 client #4 stated: -She received her medications daily. -She had not missed any medications.</p> <p>Interview on 12/18/24 staff #5 stated: -The clients' received their medications as ordered. -Blanks on the MAR were from a client being on a home visit or a medication prescribed as needed. -Client #2 received KCL (Potassium) 10 mg, 1 tab twice daily.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL054-156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/18/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ADVANCE BEHAVIORAL HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2840 LISA LANE KINSTON, NC 28502
---	--

(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 118	Continued From page 4 Interview on 12/18/24 the Qualified Professional #1 stated; -The clients' received their medications as ordered. -Client #2 had not had a change in her KCL (Potassium) 10 mg. -Client #2's KCL (Potassium) 10 mg was ordered as 2 tablets twice daily. -She would ensure the MARs was updated to reflex client #2's physician order.	V 118		
V 736	27G .0303(c) Facility and Grounds Maintenance 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 record review, observations and interviews the facility was not maintained in a safe, clean and attractive manner and free from offensive odors. The findings are: Observation on 12/18/24 at approximately 10am a tour of the facility revealed: -Client #1's bedroom had a hanging ceiling panel near the exit door. -The half bathroom in client #1's bedroom had a reverse door lock. -The kitchen's refrigerator had brownish liquid stains at the bottom of the refrigerator. -The ceiling fan in the sitting area had one of four lights not working. -The bathroom sink stopper, in client #2 and client #4's bedroom, was broken and was not	V 736		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL054-156	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/18/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ADVANCE BEHAVIORAL HEALTH SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 2840 LISA LANE KINSTON, NC 28502
---	--

(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 736	<p>Continued From page 5</p> <p>lifted and retained water in the sink.</p> <p>Interview on 12/18/24 the Qualified Professional #1 stated:</p> <ul style="list-style-type: none"> -The facility recently had the floors replaced in client #1's bedroom. -She believed client #1's bathroom door lock was reversed when the floors were replaced. -She scheduled their facility maintenance person for the following day. <p>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.</p>	V 736		