STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED			
				R		
	MHL067-192	B. WING		01/31/2025		
NAME OF PROVIDER OR SUPPLIE	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
FAITH THERAPEUTIC SERVICES 1102 DUCHESS LANE HUBERT, NC 28539						
PREFIX (EACH DEFICIEN			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	E	
V 000 INITIAL COMMENTS		V 000				
on January 31, 20 The facility is lice 10A NCAC 27G Alternative Family This facility is lice census of 1. The						
10A NCAC 27G AREQUIREMENTS (c) Medication ad (1) Prescription of only be administed order of a person drugs. (2) Medications socients only when client's physician. (3) Medications, if administered only unlicensed person pharmacist or other privileged to prepentially drugs administication of all drugs administication of the privileged immediation of the privileged	census of 1. The survey sample consisted of audits of 1 current client. 27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (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. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (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. (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: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administering the					

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (V4), DROVIDER/SUBBLIED/CLIA		(Y2) MI II TIDI	E CONSTRUCTION	(X3) DATE	SLIDVEV	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
			B. WING		F	
		MHL067-192	B. WING		01/3	1/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EAITH TI	JED ADELITIC SEDVIC	1102 DUC	HESS LANE			
FAIIT II	HERAPEUTIC SERVIC	HUBERT,	NC 28539			
(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 SHOUL CROSS-REFERENCED TO THE APPROPERTIES OF T	D BE	(X5) COMPLETE DATE
				DEFICIENCY)		
V 118	Continued From pa	ge 1	V 118			
	checks shall be rec	for medication changes or orded and kept with the MAR appointment or consultation				
	failed to ensure the record was current The findings are:	view and interview the facility medication administration for one of one clients (#1).				
	Admitted 6/1/15.Diagnoses of seiz	of client #1's record revealed: ure disorder, cerebral palsy tellectual developmental				
	regimen revealed: - Levetiracetam 100 seizures) - Twice da - Baclofen 25mg (tr twice daily and 4ml - Lacosamide 10mg - Diazepam Rectal As needed for seizu - Cetirizine 1mg (tre - Polyethylene Glyc needed.	eats CP) - 2 millileters (ml) at night. g (treats seizures)- Twice daily. Gel 10mg (treats seizures) - ures lasting over 5 minutes. eats allergies) - Once daily. ol (treats constipation)- As				
	Review on 1/31/25 November 2024 MA					

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- Levetiracetam.

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			71. BOILDING.		F	₹
		MHL067-192	B. WING		01/31/2025	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
FAITH TI	FAITH THERAPEUTIC SERVICES 1102 DUCHESS LANE HUBERT, NC 28539					
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118 V 736	- Baclofen Diazepam Rectal Interview on 1/31/2 - Client #1 had rece ordered She may have file November 2024 M/ - Moving forward, s of the MAR were av Due to the failure to medication adminis determined if client as ordered by the p	Gel. 5 the Licensee stated: eived his medications as ed the last page of the AR in the wrong place. he would ensure that all pages vailable for review. D accurately document etration it could not be s received their medications	V 118			
	exterior requirements of throughout the living-stains were preserred.	d its grounds shall be te, clean, attractive and orderly te kept free from offensive et as evidenced by: tion and interview, the facility in a safe, clean, attractive r. The findings are: 1/25 at approximately debris were on the floor g room, and bathroom #1. ent on the front of the blash, upper and lower ent around the base of the				

6899

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1XRI11 If continuation sheet 3 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
			B. WING		R			
		MHL067-192	1		01/3	1/2025		
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1102 DUCHESS LANE							
FAITH TI	HERAPEUTIC SERVIC	: -	, NC 28539					
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE		
V 736	Continued From pa	ige 3	V 736					
	- Debris and small identified on the flo	particles of food were or in the kitchen.						
	- She had been wo	5 the Licensee stated: rking on getting things it she had just fallen behind. is concerns.						
	This deficiency con and must be correct	stitutes a re-cited deficiency cted within 30 days.						

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