Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7 50.125101				
		MHL068-117	B. WING		04/1	1/2025	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
MAGGIE ALVIS WOMEN'S HALFWAY HOUSE 114 NEW STATESIDE DRIVE CHAPEL HILL, NC 27516							
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENTS		V 000				
	An annual survey v 2025. A deficiency	vas completed on April 11, was cited.					
	category: 10A NCA	sed for the following service C 27G .5600E Supervised th Substance Abuse					
		sed for 12 and has a current survey sample consisted of clients.					
V 118	8 27G .0209 (C) Medication Requirements		V 118				
	only be administered order of a person and drugs. (2) Medications shat clients only when a client's physician. (3) Medications, included and individual and instered only builties and instered only builties and instered persons pharmacist or other privileged to prepare (4) A Medication Acall drugs administed current. Medication recorded immediated MAR is to include the (A) client's name; (B) name, strength (C) instructions for (D) date and time the	ninistration: non-prescription drugs shall ed to a client on the written nuthorized by law to prescribe all be self-administered by nuthorized in writing by the cluding injections, shall be by licensed persons, or by se trained by a registered nurse, re legally qualified person and re and administer medications. dministration Record (MAR) of red to each client must be kep as administered shall be ely after administration. The					

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X2)			(X3) DATE SURVEY COMPLETED	
		MHL068-117	B. WING		04/	11/2025	
	PROVIDER OR SUPPLIER	I FWAY HOUSE 114 NEW	DRESS, CITY, S' STATESIDE D HILL, NC 275	DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
V 118	drug. (5) Client requests checks shall be rec	ge 1 for medication changes or corded and kept with the MAR appointment or consultation	V 118				
	This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to keep the MAR current affecting one of three audited clients (#2). The findings are: Observation on 4/10/25 at approximately 1:10 pm of client #1's medication bin revealed: -A packet of Amitriptyline 75 milligrams (mg)						
	(Depression). Review on 4/10/25 -Admission date of -Diagnoses of Opic and Attention Defice	of client #2's record revealed: 11/13/24. id Use Disorder, Depression it Hyperactivity Disorder. dated 12/17/24 for Amitriptyline					
	April 2025Amitriptyline 75 mg -Staff did not indica administered 4/1 th March 2025Amitriptyline 75 mg	of client #2's MARs revealed: g was not listed on the MAR. te the medication was ru 4/9. g was not listed on the MAR. te the medication was					

Division of Health Service Regulation

STATE FORM 6899 C5PW11 If continuation sheet 2 of 3

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		MHL068-117	B. WING		04/1	1/2025	
	NAME OF PROVIDER OR SUPPLIER MAGGIE ALVIS WOMEN'S HALFWAY HOUSE STREET ADDRESS, CITY, STATE, ZIP CODE 114 NEW STATESIDE DRIVE CHAPEL HILL, NC 27516						
(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)	LD BE	(X5) COMPLETE DATE	
V 118	-Staff did not indica administered 2/1 th Interview on 4/10/25 - "I am familiar with day." -She took her Amitr for the last few mor Interview on 4/10/25 - She was responsible all of the medication - Staff administered client #2 She was not sure volisted on the February - She confirmed the client 2. Interview on 4/10/25 confirmed:	ru 3/31. g was not listed on the MAR. te the medication was ru 2/28. 5 with client #2 revealed: the medication I take every iptyline medication every night	V 118				

6899

Division of Health Service Regulation STATE FORM

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