Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		MHL024-122	B. WING		06/27/2025		
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE			
LCBHS-	591 SILVER SPOON F	ROAD	ER SPOON R EEN, NC 284				
(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 000	INITIAL COMMENTS		V 000				
	An annual survey w 2025. A deficiency	was completed on June 27, was cited.					
	This facility is licensed for the following service category: 10A NCAC 27G .5100 Community Respite Services for Individuals of all Disability Groups.						
		sed for 2 and currently has a urvey sample consisted of an ient.					
V 118	18 27G .0209 (C) Medication Requirements		V 118				
	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						

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:			3) DATE SURVEY COMPLETED	
		MHL024-122	B. WING		06/2	7/2025	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
LCBHS-	LCBHS-591 SILVER SPOON ROAD 591 SILVER SPOON ROAD EVERGREEN, NC 28438						
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ORRECTIVE ACTION SHOULD BE COMPLEFERENCED TO THE APPROPRIATE DAT		
V 118	checks shall be rec	ge 1 for medication changes or orded and kept with the MAR appointment or consultation	V 118				
	interview, the facility medications on the and failed to keep the of one former client.  Review on 6/26/25 - 16 year old female. Admission date of Discharge date of Diagnoses include.	view, observation, and y failed to administer written order of a physician he MARs current affecting one (FC) (#1). The findings are:  of FC#1's record revealed:					
	orders dated 5/30/2 - Mexiletine (treats milligram (mg) - 1 c - Atomoxetine (treat daily Propranolol (treats Take 2 capsules (12) Review on 6/26/25 2025 MARs revealer No documentation been administered	irregular heartbeats) 150 apsule three times daily. ts ADHD) 60mg - 1 capsule s irregular heartbeats) 60mg - 20mg) twice daily. of FC #1's May 2025 - June					

Division of Health Service Regulation

STATE FORM G899 QFVH11 If continuation sheet 2 of 3

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL024-122	B. WING		06/	27/2025
	PROVIDER OR SUPPLIER 591 SILVER SPOON R	OAD 591 SILVE	DRESS, CITY, S ER SPOON R EEN, NC 284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	been administered - No documentation been administered - The order printed MARs read to admi capsules by mouth Interview on 6/27/2 -The findings would moving forward.  Due to the failure to medication adminis	from 6/1/25 - 6/14/25 at 8pm. In that Atomoxetine 60mg had from 6/1/25 - 6/14/25 at 8am. In May 2025 and June 2025 inister Propranolol 60mg "2 daily." In the Supervisor stated: If the be reviewed and corrected of accurately document tration it could not be received their medications as	V 118			

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Division of Health Service Regulation STATE FORM

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