		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		MHL013-086	B. WING		R 05/15/2019	
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		169 SPF	ING STREET	,		
ABARRU	IS COUNTY GROUP HO	ME #4 CONCO	RD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENTS	;	V 000			
	An annual and follow on 5/15/19. Deficience	up survey was completed ies were cited.				
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disabilities.				
V 118	27G .0209 (C) Medic	ation Requirements	V 118			
	 only be administered order of a person aut drugs. (2) Medications shall clients only when aut client's physician. (3) Medications, inclu administered only by unlicensed persons to pharmacist or other le privileged to prepare medications. (4) A Medication Adm all drugs administered kept current. Medication recorded immediately MAR is to include the (A) client's name; (B) name, strength, au (C) instructions for aco (D) date and time the 	istration: n-prescription drugs shall to a client on the written horized by law to prescribe be self-administered by horized in writing by the ding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer hinistration Record (MAR) of d to each client must be ions administered shall be y after administration. The e following: nd quantity of the drug;				

LRV911

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NUMBER: A. BUILDING:		- (X3) DATE SURVEY COMPLETED R 05/15/2019	
		MHL013-086				
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
CABARRI	JS COUNTY GROUP HO	MF #4	RING STREET DRD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pag	e 1	V 118			
	file followed up by ap with a physician.	opointment or consultation				
	interviews, the facility were kept current an were recorded imme	as evidenced by: view, observations and y failed to ensure MARS d medications administered diately after administration is (#3). The findings are:				
	-admission date of 6 Major Depressive Di Anxiety Disorder;	f client #3's record revealed: /3/13 with diagnoses of sorder and Generalized ted 2/6/19 for Head and use daily at 7pm.				
	medications on site r	/19 at 3:10pm of client #3's evealed Head and present at the facility.				
	3/1/19 until 5/15/19 r 4/1-4/30 left blank fo	f client #3's MARS from evealed the dosing dates of r Head and Shoulders at 7pm with no explanation				
	Interview on 5/15/19 -used her shampoo -never had to go with -always have it.					
		with staff #1 revealed: without her shampoo;				

STATEMEN	of Health Service Regu FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			R
		MHL013-086			05	5/15/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
CABARRI	JS COUNTY GROUP HO	MF #4	RING STREET RD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pag	e 2	V 118			
	revealed: -she reviewed all the them;	with Administrative Staff MARS after staff completed e blank dosing dates for the r.				
V 289	27G .5601 Supervise	ed Living - Scope	V 289			
	provides residential s home environment w these services is the rehabilitation of indiv illness, a developmen or a substance abuse supervision when in (b) A supervised livin the facility serves eith (1) one or mor (2) two or mor (2) to a supervised licensed to serve a s designated below: (1) "A" designates serves adults whose illness but may also	g is a 24-hour facility which services to individuals in a where the primary purpose of care, habilitation or iduals who have a mental ntal disability or disabilities, e disorder, and who require the residence. ng facility shall be licensed if her: e minor clients; or e adult clients. ts shall not reside in the living facility shall be				

Division of Health Service Regulation STATE FORM

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
					R
		MHL013-086			05/15/2019
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	
ABARRI	JS COUNTY GROUP HO	ME #4 169 SPR	ING STREET		
		CONCO	RD, NC 28025		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
V 289	Continued From page	e 3	V 289		
	developmental disab diagnoses; (3) "C" designa serves adults whose developmental disab diagnoses; (4) "D" designa serves minors whose substance abuse dep other diagnoses; (5) "E" designa serves adults whose substance abuse dep other diagnoses; or (6) "F" designa private residence, wh three adult clients wh mental illness but ma disabilities, or three a clients whose primary developmental disab other disabilities who family provides the se exempt from the follo .0201 (a)(1),(2),(3),(4 (A),(B),(E),(F),(G),(H (18) and (b); 10A NCAC 27 27G .0208 (b),(e); 10 non-prescription med (1)(A),(D),(E);(f);(g); a (b)(2),(d)(4). This fac	bendency but may also have ation means a facility in a nich serves no more than hose primary diagnoses is ay also have other adult clients or three minor y diagnoses is ilities but may also have o live with a family and the ervice. This facility shall be owing rules: 10A NCAC 27G			

STATEMENT	of Health Service Regu	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL013-086	B. WING		05	R / 15/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
CABARRI	JS COUNTY GROUP HO	MF #4	RING STREET RD, NC 28025			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 289	Continued From page	9 4	V 289			
	affecting 2 of 3 clients Review on 5/15/19 of -admission date of 8/. OCD, IDD-Moderate, Hypokalemia, Vitamir Kidney Disease, Seiz Hyperlipidemia and H -3/18/19 client #1 wer knee pain, X-ray com sprain; -3/22/19 client #1 sav who checked his left -3/29/19 client #1 wer for pain in the left knee diagnoses with a spra -4/4/19 seen by Ortho	view, observation and failed to operate 24 hours is (#1, #2). The findings are: client #1's record revealed: 22/07 with diagnosis of Allergies, Sleep Apnea, on D Deficiency, Chronic cure Disorder, Hypertension, lemochromatosis; on to Urgent Care with left pleted, diagnosed with a whis primary care physician knee, no issues found; on to the Emergency Room				
	Observation on 5/15/	19 at 10:30am revealed air at the facility's parent				
	-admission date of 2/	derate, Schizophrenia, High				
	revealed the following -10:00am client #1 ar couches at the facility	nd client #2 sitting on v's parent agency office; nd client #2 continue to be				

STATEMENT	of Health Service Regu	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED R	
		MHL013-086	B. WING			/15/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
CABARRI	JS COUNTY GROUP HO	MF #4	RING STREET RD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIEN(TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 289	Continued From page	e 5	V 289			
	-1:16pm client #1 and the facility's parent ag	d client #2 continue to be at gency office; d client #2 continue to be at				
		•				
	unsuccessful as he d	client #2 on 5/15/19 with lid not respond to questions to the questions asked.				
	workshop; -the Local Manageme funds for the worksho freeze on new admis -client #2's paperwork then the freeze happe	d: g on placement at the local ent Entity are evaluating the op and the workshop has a sions; k was almost completed and				
	Interview on 5/15/19 -client #1 not in the w -ready to go to the wo -talked about it a lot.					
	revealed: -client #1 comes to th not have his PT, he is	with Administrative Staff ne office on days he does s recovering from his injury; ne office because he is not hop because of the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		R	
		MHL013-086	B. WING		05	к 5/15/2019
AME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
ABARRU	IS COUNTY GROUP HO	DME #4	RING STREET			
		CONCO	RD, NC 28025			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 289	Continued From pag	e 6	V 289			
	the facility if client #2 -live-in staff get off a at 2:30pm;	a lot of overtime to staff at 2 remained at the facility; t 9:30am and return to work of clients at the office.				