STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			B. WING		06/03/2021	
		MHL059-077			06/	
			DDRESS, CITY, ST TICE ROAD	ATE, ZIP CODE		
TAMEY	HOME 1		, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENT	rs	V 000			
	completed on June unsubstantiated (In Deficiencies were of This facility is licens category: 10A NCA	nt and follow up survey was 3, 2021. The complaint was take #NC00176930). sited. sed for the following service C 27G. 5600C Supervised h Developmental Disabilities.				
V 115	27G .0208 Client Se	ervices	V 115			
	 (a) Facilities that prassure that: (1) space and super the safety and welfative (2) activities are suited and treatment/habilies and treatment/habilies and treatment/habilies and treatment/habilies and treatment/habilies (3) clients participation (3) clients participation (3) clients participation (4) Facilities or program activities. (h) Facilities or program activities and these Rules as "2 available 24 hours are unless otherwise special clients shall ensure (2) When clients what are transported, the with secure adaptive (e) When two or more require special assist in a vehicle are transported and the secure adaptive (c) Statement (c) when two or more adaptive special assist in a vehicle are transported are transported are transported assisted as the secure adaptive (c) when two or more adaptive special assisted as the secure adaptive are transported are transported as the secure adaptive (c) when two or more adaptive as the secure adaptive (c) when two or more adaptive are transported as the secure adaptive active adaptive as the secure adaptive active adaptive active adaptive and the secure adaptive active active active active adaptive active adaptive active ac	itable for the ages, interests, litation needs of the clients te in planning or determining grams designated or described 24-hour" shall make services a day, every day in the year. becified in the rule. erve or prepare meals for that the meals are nutritious. no have a physical handicap e vehicle shall be equipped re equipment. ore preschool children who istance with boarding or riding asported in the same vehicle, adult, other than the driver, to				

STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL059-077	B. WING		06/	03/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S ⁻	TATE, ZIP CODE		
STAMEY	HOME 1		ICE ROAD NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
V 115	Continued From pa	ge 1	V 115			
	This Rule is not met as evidenced by: Based on observation and interview the facility failed to ensure meals were nutritious for 3 of 3 clients (Client #1, Client #2 and Client #3). The findings are: Observation of the facility at 9:00 am on 6-1-21 revealed: -The kitchen cabinet contained the following foods: 1/2 jar of peanut butter, 1/2 pack of hot dog buns, 1 container of Quick Oats, 1 1/2 containers of grits, 1 pack of Bisquick mix and a pack of blueberry muffin mix with a "best if used by" date of 5-26-18.					
	condiments: 1 carto white vinegar, 1/2 b bottles of vegetable packs of salt and po oil.	et contained the following on of beef stock, 2 bottles of oottle of red wine vinegar, 3 e oil, 8 packs of gravy mix, 2 epper, and a bottle of canola				
	locked bag of chop of cole slaw, a zip lo bag of carrots.	as empty except for a zip ped onions, a zip locked bag ocked bag of hot dogs and 1 ction of the refrigerator				
	cole slaw which had a pack of frozen bro 5-11-21.	n of ice cream, 1 bag of frozen d a use by date of 5-10-21 and occoli with a use by date of ntained 50 frozen individual pot				
	pies, 1 bag of pops unsealed pack of cl frozen vegetables v vegetables.	icles, 1 frozen turkey, 1 hicken nuggets, 1 large bag of vith approximately 1 handful of				
	-There was no othe facility. ealth Service Regulation	r food or beverages at the				

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	Qulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED	
		MHL059-077	B. WING		06/	03/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
STAMEY	HOME 1		ICE ROAD NC 28752			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 115	Continued From pa	ge 2	V 115			
	-He had a chicken s restaurant for break -Most meals were h Ramen Noodles. -Sometimes fruit wa Interview on 6-1-21 -He stated, "We har asked for other drin us and flavor packet water." -There were no gro days. -Staff #1 usually sp purchase food for th -Yesterday he had a local fast food resta -Clients rarely got a -Meals mostly cons and macaroni and o -Vegetables were u meals.	not dogs, chicken nuggets and as available for the clients. with Client #2 revealed: we too many sodas here. We ks. They buy water bottles for ets and we have running ceries in the house for 7-8 ent his own money to he clients from restaurants. a sandwich and a coke from a jurant. "home cooked" meal. isted of Hamburger Helper				
	-He stated "I'm a pi	ot casseroles and chili. cky eater." with Staff #1 revealed:				
	-Staff shopped for g week.	proceries 1-2 times every neals for the clients such as				
	hot dogs, hamburge cheese, corn and g	ers, french fries, macaroni and				

STATEMEN	of Health Service Re NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		MHL059-077	B. WING		06/	03/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
STAMEY	HOME 1		ICE ROAD NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
V 115		-	V 115			
	11:00 am today. -This grocery order delivered. -He stated, "I had e	-This grocery order took longer than normal to be				
	-Groceries were ord -Every time we get clean out the cabine -He stated, "We ord the order through th messed up and cau -He sent a new ord	with Staff #2 revealed: dered on a weekly basis. groceries, we completely ets and refrigerator. dered food two days ago, but he app (mobile application) got used a delay." er for groceries yesterday. e at the facility at 11:00 am				
	-Staff #2 and an un	-21 at 11:40 am revealed: known individual brought ceries into the facility.				
V 118	 10A NCAC 27G .02 REQUIREMENTS (c) Medication adm (1) Prescription or r only be administered order of a person a drugs. (2) Medications shat clients only when an client's physician. (3) Medications, inc administered only b unlicensed persons pharmacist or other 		V 118			

STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL059-077	B. WING		06/	03/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
STAMEY	HOME 1		ICE ROAD NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		V 118			
	interviews facility st physician's orders a (Medication Admini- affecting 2 of 3 clien The findings are: Review on 6-1-21 o	views, observation and aff failed to follow the and failed to keep the MAR stration Record) current nts (Client #2 and Client #3). of Client #2's record revealed:				
	Deficit/Hyperactivity Oppositional Defiar Abuse History in Ch Self-Harm. -Physicians' orders	tellectual Disability; illic Disorder; Attention				

STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		MHL059-077	B. WING		06/	6/03/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
STAMEY	HOME 1		TICE ROAD , NC 28752				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
V 118	Continued From pa	ige 5	V 118				
V 118	Continued From page 5 500 milligrams (mg) chew 1 tablet orally twice daily. -An order dated 5-12-21 for Depakote (divalproex sodium) 500 mg 2 tablets orally twice daily. Review on 6-1-21 of Client #2's June 2021 MAR revealed: -Transcription for Tums 500 mg chew 1/2 tablet orally twice daily. -There were no administration instructions for route, dose, or frequency of the Depakote. Review on 6-1-21 of Client #3's record revealed: -Date of Admission: 4-26-19. -Diagnoses: Autism Spectrum Disorder; Bipolar Disorder; ADHD; Anxiety Disorder; Depressive Disorder. -Physicians' orders for the following medications: -An order dated 1-25-21 with three 30-day supply refills for clindamycin phosphate (antibiotic) apply to affected areas 1-2 times per						
	revealed: -Transcription for cl topically to affected Observation on 6-1 -The clindamycin p not be located at th Interview on 6-1-21	with Client #3 revealed:					
	several months. Interview on 6-3-21 Professional (QP) r						

STATEMEN	of Health Service Re NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL059-077	B. WING		06/	03/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
STAMEY	HOME 1		TICE ROAD , NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118 V 736	-A Registered Nurs MAR's, but the posi-A new RN was goi oversight and revier basis. This deficiency con and must be correct 27G .0303(c) Facili 10A NCAC 27G .03 EXTERIOR REQUI	e (RN) used to review the ition was currently vacant. ng to be hired to provide w the MAR's on a regular stitutes a re-cited deficiency ted within 30 days. ty and Grounds Maintenance	V 118 V 736			
	maintained in a safe manner and shall b odor. This Rule is not me Based on observati maintain the facility orderly manner and	e, clean, attractive and orderly e kept free from offensive				
	6-1-21 at 9:00 am r -There was a strong and kitchen. -A locked doorway was not accessible -The basement/unc had a dirt floor with -Client #3's bedroor	g musty odor in the living room to enter the basement which				

				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		MHL059-077	B. WING		06/	03/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
STAMEY	HOME 1		NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 736	Continued From pa	ge 7	V 736			
	beverages laying on the floor. There was also trash scattered across the floor of the bedroom.					
	was usually damp. -There were plans to location within in the -Direct care staff we cleanliness of the fa- -Staff #1 resided at instructed Client #3 orderly manner. -She was responsite -She had not been COVID 19.	evealed: lerspace beneath the home to move the facility to a new e near future. ere responsible for maintaining acility. the facility and should have to keep his bedroom in an ole for oversight of the facility. on site at the facility due to stitutes a re-cited deficiency				
V 774	EQUIPMENT (d) Indoor space re- prior to October 1, ' square footage requireme. Unless otherwing residential facilities 1988 shall meet the requirements: (7) Minimum furnish include a separate	nimum Furnishings 04 FACILITY DESIGN AND quirements: Facilities licensed 1988 shall satisfy the minimum uirements in effect at that vise provided in these Rules, licensed after October 1, e following indoor space hings for client bedrooms shall bed, bedding, pillow, bedside for personal belongings for				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUB ID PLAN OF CORRECTION IDENTIFICATION				(X3) DATE SURVEY COMPLETED	
		MHL059-077	B. WING		06/	02/2024
					06/	03/2021
	ROVIDER OR SUPPLIER		DDRESS, CITY, ST TICE ROAD	ATE, ZIP CODE		
STAMEY	HOME 1		, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 774	Continued From pa	ge 8	V 774			
	This Rule is not met as evidenced by: Based on observation and interview, the facility failed to provide minimum furnishings affecting 2 of 3 clients (Client #1 and Client #2). The findings are: Observation on 6-1-21 at 9:00 am revealed: -Bedroom #2 was shared between Client #1 and Client #2. -There was only 1 nightstand in the bedroom. Interview on 6-3-21 with the Qualified Professional (QP) revealed: -She had not made any recent visits to the facility due to COVID 19. -She was not sure why there was only 1 nightstand in the bedroom. -She planned to follow up at the facility to ensure					
	that each client hac furniture.	I the required bedroom				