		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		07/09/2021	
		MHL041-689				
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
1 & M SPI	ECIAL SERVICES		SBORO, NC 27403			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENTS	3	V 000			
	An annual and follow on July 9, 2021. A de	up survey was completed ficiency was cited.				
	category: 10A NCAC	d for the following service 27G .5600C Supervised se Primary Diagnosis is a bility.				
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 la privileged to prepare (4) A Medication Adm all drugs administere current. Medications recorded immediately MAR is to include the (A) client's name; (B) name, strength, at (C) instructions for ac (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be record 	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 uding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. hinistration Record (MAR) of d to each client must be kept administered shall be y after administration. The e following: and quantity of the drug;				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-689			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
		MHL041-689	B. WING		07/09/2021	
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	ECIAL SERVICES	2621 GR	IMSLEY STREET			
1 & 11 3P	ECIAL SERVICES	GREENS	SBORO, NC 27403			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From page	e 1	V 118			
	with a physician.					
	This Rule is not met as evidenced by:					
	Based on record reviews and interviews, the					
	facility failed to maintain a current MAR for 1 of 2					
	clients (#2). The findings are:					
	Review on 7/8/21 of client #2's record revealed: -An admission date of 8/1/2007 -Diagnoses of Moderate Intellectual Disabilities. Diabetes, Schizophrenia, Undifferentiated Type,					
	High Blood Pressure	, COPD, Congestive Heart e (Unspecified),Emphysema,				
	Gout, Obesity, Acute	Respiratory Failure with blic Congestive Heart Failure,				
	Post-Traumatic Oste	oarthritis of Right Knee, c Kidney Disease, State III				
	(Moderate) and Nico	tine Addiction				
	-An assessment date supervision is essent	tial to avert falls or injuries				
		end one of his legs, needs				
	-	cked 3 times a day, needs ake healthier choices, is able				
	to communicate his p	point of view, enjoys art and				
		ne with his family, wants to				
		n his independence, quit 0, usually eats his food to				
		y of bedwetting and needs to				
	take medication as p	rescribed and his leg was				
	-	34 years old due to being hit				
	•	ng the street and walks with				
	a limp."					
	-A lieannen man ma	ated 3/1/21 noting "will be				

VOVG11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL041-689	B. WING		07	7/09/2021
IAME OF PRO	OVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
/I & M SPE			RIMSLEY STREET SBORO, NC 27403			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
V 118	Continued From pag	e 2	V 118			
	PROVIDER OR SUPPLIER STREET ADD PECIAL SERVICES 2621 GRIM GREENSB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)					

STATE FORM

VOVG11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
	MHL041-689		B. WING		07	/09/2021
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	, ZIP CODE		
M & M SP	ECIAL SERVICES		SBORO, NC 27403			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pag	e 3	V 118			
	when blood sugars w	vere above 200				
	1, 2021 to July 8, 202 -On 5/7, 5/8, 5/11, 5/ to 5/31, 6/1, 6/12, 6/ ² to 7/8 only morning b -On 5/19 and 6/3, no	client #2's calendar from May 21 revealed: 14 to 5/18, 5/20 to 5/25, 5/29 17 to 6/19, 6/24 and 6/25, 7/1 blood sugars were recorded blood sugars were recorded ly evening blood sugars were				
	from May 1, 2021 to -Blood sugars were r 263, 5/9 343, 5/12 35 267, 6/2 275, 6/4/ 41 357, 6/22 433, 6/24 4 -No documentation of	8/21 of client #2's calendar July 8, 2021, revealed: recorded over 200 on 5/5 51, 5/24 260, 5/28 225, 6/1 7, 6/11 370, 6/19 523, 6/20 433, 7/2 228 and 7/3 239 of Novolin 70/30 units was a sugars were over 200				
	-Stated he administe as checking his blood -Stated when his BS (Insulin) and if it is to	vith client #2 revealed: red his own Insulin as well d sugars 2 times a day are too high, "I bring it down o low, I bring it up. Today my g) was 176. I exercise by with [staff #2]"				
	Professional (L/QP) i -Regarding blood sug client #2 was to check as giving himself the -Client #2 recorded h calendar in his room. -"He knows when it (and too low. We allow on his calendar. He c	gar checks, the L/QP stated k them 2 times a day as well insulin shots. his blood sugars on his				

STATE FORM

VOVG11

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	(X3) DATI COM	(X3) DATE SURVEY COMPLETED	
		MHL041-689	B. WING		07/09/2021	
AME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		07	//09/2021
				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
1 & M SP	ECIAL SERVICES		SBORO, NC 27403			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R 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	ge 4	V 118			
	evening to ensure h also record when he his blood sugars are					
	This is a re-cited sta must be corrected v	andard level deficiency and vithin 30 days.				
ion of Hea	alth Service Regulation		r			1