		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL059-077	B. WING			I-C <b>31/2021</b>	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE			
STAMEY	HOME 1		TICE ROAD				
		MARION	, 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) COMPLETE DATE	
V 000	INITIAL COMMENT	rs	V 000				
	on August 31, 2021 substantiated (Intak Deficiencies were of This facility is licens category: 10ANCA0	sed for the following service C 27G.5600C Supervised					
V 118		h Developmental Disabilities.  ication Requirements	V 118				
	only be administered order of a person a drugs.  (2) Medications shat clients only when at client's physician.  (3) Medications, included and individual drugs administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Adall drugs administer current. Medication recorded immediate MAR is to include the (A) client's name;  (B) name, strength, (C) instructions for (D) date and time the (E) name or initials drug.  (5) Client requests	inistration: non-prescription drugs shall ad to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by trained by a registered nurse, regally qualified person and re and administer medications. Iministration Record (MAR) of red to each client must be kept administered shall be ely after administration. The					

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL059-077	B. WING			-C <b>31/2021</b>	
STAMEY HOME 1 180 JUST		DDRESS, CITY, S FICE ROAD NC 28752	STATE, ZIP CODE				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
V 118	Continued From pa file followed up by a with a physician.	ge 1 appointment or consultation	V 118				
	facility failed to adm ordered by a physic (Client #3 and #4) a	et as evidenced by: views and interviews, the ninister medications as cian affecting 2 of 3 clients and failed to keep the MAR ents (Client #4). The findings					
	-Date of Admission:	of Client #3's record revealed: : 7/21/18. c Disorder; Moderate Mental					
	for Client #3 revealer-An order dated 6/7 microgram (mcg)/s nostril twice dailyAn order dated 8/1	of signed physician's orders ed: /21 fluticasone nasal 50 pray, instill 1 spray in each 9/21 Jardiance 25 milligram ablet by mouth every morning.					
	-There were no inst often to administer -Fluticasone nasal s given during the en	of Client #3's MAR revealed: cructions on the MAR for how the fluticasone nasal spray. spray was not initialed as tire month of August 2021. initialed as given for 8/19/21					
	Review on 8/31/21 -Date of Admission:	of Client #4's record revealed: 7/1/21.					

Division of Health Service Regulation

STATE FORM 6899 FLBA11 If continuation sheet 2 of 7

	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		71. 501251110.		R-	c
	MHL059-077	B. WING	<u> </u>		1/2021
NAME OF PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
STAMEY HOME 1		ICE ROAD NC 28752			
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	T BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
Client #4 revealed: -An order dated 8/24/21 following medications: Of Lexapro 5 mg" -An order dated 8/16/21 tablet by mouth four time days.  Review on 8/30/21 of Clitoneprazole 20 mg had and was initialed as admitialed as administ 8/30/21Lexapro 5 mg had not be was initialed as administ 8/30/21Penicillin 500 mg four time handwritten onto the MA name of the client, or the was administered.  Interview on 8/30/21 with the recently received refered medication administration. He noticed the order for nasal spray was incomplemental to the mouth of the client, or the was administered.	a, Unspecified; Disorder; Borderline Mild Cognitive matic Brain Injury.  gned physician's order for to" discontinue the Disorder 20 mg, for penicillin 500 mg 1 es per day for seven  ient #4's MAR revealed: I not been discontinued hinistered 8/25/21 through been discontinued and tered 8/25/21 through mes per day was aR and did not list the e times the medication  and Staff #1 revealed: fresher training in on. The Client #3's fluticasone lete on the MAR. Totify the Registered she never returned his enicillin on Client #4's end because the pharmacy the part of the staff was a serious continued his enicillin on Client #4's end because the pharmacy to per month.	V 118			

Division of Health Service Regulation

STATE FORM 6899 FLBA11 If continuation sheet 3 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	` ´COMP		SURVEY LETED
		MHL059-077	B. WING		R- <b>08/3</b>	-C 3 <b>1/2021</b>
STAMEY HOME 1 180 JUSTI		DRESS, CITY, SICE ROAD NC 28752	STATE, ZIP CODE			
(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	Continued From pa	ge 3	V 118			
	revealed: -A RN was recently medications.  Interview on 8/31/2 revealed: -She initially worked (QP) and in June 20 full time RNHer job responsibil MAR's, providing sutraining staff in medication of the planned to protraining to Staff #1 are She also planned to	1 with the Owner of the facility hired to provide oversight for 1 with the Registered Nurse 2 as a Qualified Professional 321 she fulfilled the role as the 321 she fulfilled the role as the 321 she fulfilled reviewing the 321 upport with medical needs and 321 dication administration. Sovide additional medication and the Owner of the facility. The facility of a more der to provide increased				
	medication adminis -A staff member fro assist in mentoring compliance with me	ed: tly been retrained on tration. m a sister facility was going to Staff #1 to improve edication administration. stitutes a re-cited deficiency				
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736			
	EXTERIOR REQUI (c) Each facility and maintained in a safe	03 LOCATION AND REMENTS I its grounds shall be e, clean, attractive and orderly e kept free from offensive				

Division of Health Service Regulation

STATE FORM 6899 FLBA11 If continuation sheet 4 of 7

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MUI 050 077	B. WING		R-C <b>08/31/2021</b>	
		MHL059-077	D. WO		08/3	31/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
STAME	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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 736	Continued From pa	ge 4	V 736			
	was not maintained and orderly manner of Clie approximately 10:4. The bed was not mitems were laying obox of pizza with sli appeared to have betemperature for sevin which the pasta a stuck to the bowl; a contained a wilted scolor; a grocery bag plastic water bottles some of which were and numerous bags. A dish with red colositting on a table nether three large disposarestaurant with liquid bottle of Pepsi; 3 er bottles and 1 opened A small side table of food; 1 large empty sized bags of chew amount of tobacco and 1/2 bag of potal. There was a 2 liter disposable underwere	on and interviews, the facility in a safe, clean, attractive in a safe, clean, attractive in the findings are:  Int #4's bedroom on 8/30/21 at 5 am revealed: Inade and the following food in top of the bed: a cardboard ces of pizza inside of it which een left sitting at room reral hours; a bowl of spaghetti and sauce were dried up and styrofoam food tray which salad which was dark brown in gwith 5 empty disposable is; several bags of potato chips, e laying opened on the bed is of candies.  In the fact was a server of the bed in the be				

6899

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			71. Boilesinto.		R-C	
	MHL059-077		B. WING			1/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
STAMEY	HOME 1		ICE ROAD			
	-	<u>`</u>	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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
V 736	Continued From pa	ge 5	V 736			
	Interview on 8/30/2 -He was responsible cleanHe stated, "If I ask he becomes upset allow me to clean the working to mitigate -Client #4 was new	1 with Staff #1 revealed: e for keeping clients' rooms [Client #4] to clean his room and refuses to clean and won't ne room eitherWe are his behaviors."				
	revealed: -Staff #1 was responsed to their rooms clean -Client #4 would try was asked to clean -If staff attempted to would become compart -He stated, "Since to cleanliness to the godo it. [Client #4] is a and hasn't been ad yetwe are working	to fight with staff whenever he college to clean the room, Client #4 shative. The last visit, we stress uys and set a time for them to an exception, he is fairly new justed on his medications just gon making things right."				
	placement and progoral prain injury (TBI).  -The TBI caused C unregulated emotion cleanliness.  -Client #4 needed to the staff #1 was being training to assist in rules with hygiene.  -She stated, "We assixty days to see if the staff with the staf					

Division of Health Service Regulation

STATE FORM 6899 FLBA11 If continuation sheet 6 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE COM		SURVEY LETED
				R-C		
		MHL059-077	B. WING			1/2021
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
STAMEY	HOME 1		ICE 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 736	Continued From pa	ge 6	V 736			
	work."					
		stitutes a re-cited deficiency sted within 30 days.				

Division of Health Service Regulation