Division of Health Service Regulation

	AND DI AN OF CORRECTION \ \ \ IDENTIFICATION NUMBER: \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		` '	(2) MULTIPLE CONSTRUCTION BUILDING:		(X3) DATE SURVEY COMPLETED	
					R		
		MHL040-009	B. WING		11/1	2/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
FAIR FA	x		HWAY 903 SO LL, NC 2858				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
V 000	00 INITIAL COMMENTS		V 000				
	completed on Nove was unsubstantiate Deficiencies were complete. This facility is licens category: 10A NCA	nt and follow up survey was mber 12, 2021. The complaint d (intake # NC00181683). ited. sed for the following service C 27G .5600C, Supervised h Developmental Disabilities.					
V 118		ication Requirements	V 118				
	only be administered order of a person and drugs. (2) Medications shad clients only when a client's physician. (3) Medications, incomplete administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Administer current. Medications recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for a (D) date and time the (E) name or initials drug. (5) Client requests the client's name (C) instructions for a (C) client requests the condensation of t	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 y licensed persons, or by trained by a registered nurse, legally qualified person and e and administer medications. Ininistration Record (MAR) of led to each client must be kept administered shall be lely after administration. The					

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:		R	
		MHL040-009	B. WING			2/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FAIR FA	X		HWAY 903 S			
040.15	CLIMMA DV CTA		LL, NC 2858		ION	0.(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y 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	age 1	V 118			
	file followed up by a with a physician.	appointment or consultation				
	Based on record re interviews, the facil medications on the and failed to keep t 3 clients audited (#Finding #1:	et as evidenced by: eviews, observations, and ity failed to administer written order of a physician the MARs current affecting 3 of 1, #2, #3). The findings are: and 11/12/21 of client #1's				
	disorder (ADHD), o (ODD), intellectual moderate (IDD), ex hearing impairment -Order dated 8/1/2' mg (milligrams) at the -Order dated 8/1/2'	ed attention deficit hyperactive appositional defiant disorder and developmental disability - expressive language disorder, t, and cerebral palsy. 1 and 9/30/21 for Clonidine 0.1 noon. (ADHD) 1 and 9/30/21 for Concerta ER 36 mg daily. (ADHD)				
	August, 2021 - Nov -On 8/10/21 Clonid "Med (medication) documented by the -Concerta ER 36 m the August 2021 M.	and 11/12/21 of client #1's rember, 2021 MARS revealed: ine 0.1 mg was documented, not delivered on time" Medical Coordinator. Mas printed in duplicate on AR and documented as given 4/21, 8/6/21, 8/7/21, and				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED	
	-		A. BUILDING:		R	
		MHL040-009	B. WING			2/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FAIR FA	x		-lWAY 903 S L, NC 2858			
(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 SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 118	Continued From page 2		V 118			
	-11/8/21 Concerta ER 36 mg was documented as not given because it was not available.					
	record revealed: -23 year-old male -Admission date of -Diagnoses includedisorder (PTSD), hyschizoaffective disormildOrder dated 7/21/2 be administered we -No signed physicial-100mg every even. Review on 11/9/21 November, 2021 M There was no reconsidered. Observation at approficient #2's medical-blister pack for Tracevery evening and owere hand-written sempty Trazadone - dated from 10/06 - No vitamin D3 50, Interview on 11/9/21 - He took medication - He did not miss and - His medications we Finding #3:	d posttraumatic stress /pothyroidism, hyperlipidemia, rder - bipolar type, and IDD - 21 for vitamin D3 50,000 IU to ekly. In's order for Trazadone ing. of client #2's August, 2021 - ARS revealed: ord of Trazadone 100mg being roximately 4:00pm on 11/9/12 ations revealed: Izadone - 100mg by mouth dispensed on 6/28/21. There etaff initials, corresponding to 100mg blister pack slots, 11/08. 11/08. 12 client #2 stated: 13 client #2 stated: 14 client #2 stated: 15 client #2 stated: 16 client #2 stated: 17 client #2 stated: 18 client #2 stated:				

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STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		MHL040-009	B. WING		F 11/1	2/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FAIR FA	x		HWAY 903 S			
.,			L, NC 2858			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
V 118	Continued From page 3		V 118			
	- Admission date of - Diagnoses included developmental disa depressive disorder diabetes, gastroeso (GERD), hypertrophy obstruction, and paragraphy of the control of the c	de intellectual and bility - moderate (IDD), major r - unspecified, type II ophageal reflux disease by benign prostate with urinary ritial leg amputation, for Tylenol 650 mg 3 times at 1 for Ferrous Gluconate 324 th meals for supplement. If for Polyethylene Glycol I capful, 17 gms (grams), in 8 juice and take on Monday, riday constipation.				
	-Order dated 6/21/21 for Temazepam 15mg at bedtime for insomnia. Review on 11/9/21 and 11/12/21 of client #3's August, 2021 - November, 2021 MARS revealed: -8/15/21, 8 pm dose of Tylenol 650 mg was not given, "Med not available." -8/1/21 - 8/11/21 Temazepam 15mg at bedtime was not given, "Med not available." -11/8/21, 2 pm dose of Tylenol 650 mg was blank11/8/21, 12 pm dose of Ferrous Gluconate 324 mg was blank10/6/21 - 10/25/21 Polyethylene Glycol 3350 Powder was not administered, a total of 9 consecutively scheduled doses, because the medication was not available. Unable to interview client #3 on 11/9/21 because he had been admitted to the hospital that morning from his doctor's office. Interview on 11/09/21 staff #1 stated: - He had been employed with the agency for					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	' '	E CONSTRUCTION		B) DATE SURVEY COMPLETED	
, , , , , , , , , , , , , , , , , , , ,	or contraction	IBERTIN TO ATTOMBET.	A. BUILDING:				
		MHL040-009	B. WING		R 11/12/	/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
FAIR FA	x		HWAY 903 S				
			L, NC 2858				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
V 118	Continued From pa	ige 4	V 118				
	clients He notified his management team when a client would "run out" of medications and they (management) would reorder.						
	Interview on 11/09/21 staff #4 stated: - She had been employed with the facility for approximately 1 month Medications were always available for the clients There had been no concerns with medications.						
	stated: -There had been see Pharmacy after it of facility had experier -The delivery proble -If a medication wa notified the Medica the pharmacy to ha -Client #1 had dupl his primary care ph medication, then de order. This resulted August 2021 MARShe believed the of mg documented in documentation erro have been enough given 2 doses for the Due to the failure to medication administ determined if client as ordered by the p	s not available and staff I Coordinator, she contacted ave it delivered. icate Concerta orders because sysician had been ordering the ecided his psychiatrist should don duplicate entries on the I louble doses of Concerta 36 August 2021 for client #1 were ors because there would not medication on hand to have nese days. Description of the could not be served their medications only sician.					
		been cited 3 times since be corrected within 30 days.					

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL040-009		B. WING		R 2/2021
					11/1	2/2021
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
FAIR FAX	X		HWAY 903 S LL, NC 2858			
240.15	CLIMMA DV CTA		·		DNI .	(2/5)
(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 APPROF	D BE	(X5) COMPLETE DATE
V 123	Continued From page 5		V 123			
V 123	27G .0209 (H) Med	ication Requirements	V 123			
	and significant adverse reported immediate pharmacist. An entrand the drug reaction	rs. Drug administration errors erse drug reactions shall be				
	facility failed to notific immediately of mediately of mediately of mediately of mediately of mediated (#1, #2, #3). Finding #1: Review on 11/9/21 record revealed: -21 year-old maleAdmission date of -Diagnoses include disorder (ADHD), or (ODD), intellectual moderate (IDD), exhearing impairment -Order dated 8/1/21 mg (milligrams) at re-Order dated 8/1/21	views and interviews, the fy the physician or pharmacist lication errors and ls affecting 3 of 3 clients. The findings are: and 11/12/21 of client #1's 3/3/15. d attention deficit hyperactive ppositional defiant disorder and developmental disability - pressive language disorder, and cerebral palsy. and 9/30/21 for Clonidine 0.1				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			R	
		MHL040-009	B. WING			< 2/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
FAIR FA	x		HWAY 903 S LL, NC 2858				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y 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 123	-There was no door the client's physicial immediately when a missed. Review on 11/9/21 August, 2021 - Nov-On 8/10/21 Clonid not delivered on time Medical Coordinated -11/8/21 Concerta Inot given because Finding #2: Review on 11/9/21 record revealed: -23 year-old male -Admission date of -Diagnoses included disorder (PTSD), his schizoaffective disording wildOrder dated 7/21/2 take 1 capsule everorder dated 7/21/2 patch - apply 1 patch - ap	umentation a pharmacist or in had been notified a medication had been and 11/12/21 of client #1's wember, 2021 MARS revealed: ine 0.1 mg, "Med (medication) ne" documented by the or. ER 36 mg was documented as it was not available. and 11/12/21 of client 2's 6/14/21 of client 2's 6/14/21 of client 2's 6/14/21 of posttraumatic stress ypothyroidism, hyperlipidemia, order - bipolar type, and IDD - 21 for Vitamin D3 50,000IU - 21 for Nicotine 21 mg/24 hr ch every 24 hours. 6/21 for Divalproex extended g - take 3 tablets (1500mg) ility. 21 for Quetiapine 50mg - take 21 for Prazosin 2mg - take 1	V 123				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	0. 00.1.1.20.10.1		A. BUILDING:			
		MHL040-009	B. WING			R 1 2/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
FAIR FA	x		HWAY 903 S LL, NC 2858			
	OLIMANA DV. OTA		T		TOTION	0.17
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
V 123	Continued From pa	nge 7	V 123			
	-Nicotine 21 mg/24 hr patch - 10/16/21 at 8am -Divalproex ER - 10/20/21, 10/21/21, 10/22/21, 10/25/21 at 8am -Prazosin - 8/27/21, 8/30/21, 8/31/21 at 8pm. -Quetiapine - 10/20/21 at 8am.					
	Review on 11/9/21 of client #2's September, 2021 MAR revealed medications were refused and no documentation a physician or pharmacist was notified on the following dates and times: -Nicotine 21 mg/24 hr patch - 9/9/21 at 8am.					
	Interview on 11/9/21 client #2 stated: -He took medications dailyHe did not miss any medicationsHis medications were always available.					
	record revealed: -59 year-old maleAdmission date of -Diagnoses include developmental disa depressive disorde diabetes, gastroeso (GERD), hypertropl obstruction, and pa -Order dated 6/1/2 daily for painOrder dated 6/21/2 mg 3 times daily wi -Order dated 8/18/2 3350 Powder, mix ounces of water or Wednesday, and F -Order dated 6/21/2 bedtime for insomn -There was no doc	ed intellectual and ability - moderate (IDD), major r - unspecified, type II ophageal reflux disease hy benign prostate with urinary urtial leg amputation, 1 for Tylenol 650 mg 3 times 21 for Ferrous Gluconate 324 th meals for supplement. 21 for Polyethylene Glycol 1 capful, 17 gms (grams), in 8 juice and take on Monday, riday constipation. 21 for Temazepam 15mg at				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		DATE SURVEY COMPLETED	
					F	2	
		MHL040-009	B. WING		11/1	2/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
FAIR FAX	<		HWAY 903 S				
(V4) ID	STIMMADV STA		LL, NC 2858		NI.	(VE)	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE	
V 123	Continued From pa	ge 8	V 123				
	immediately when a missed.	a medication had been					
	August, 2021 - Nov -8/15/21, 8 pm dose given; "Med not ava -8/1/21 - 8/11/21 Te was not given; "Mee -10/6/21 - 10/25/21 Powder was not ad consecutively schemedication was not Interview on 11/09/2 - He had been emp approximately 6-7 relif he did not have a due to be administed computer entry and would notify the pha	mazepam 15mg at bedtime d not available." Polyethylene Glycol 3350 ministered, a total of 9 duled doses, because the available. 21 staff #1 stated: loyed with the agency for months. a medication on hand that was ered he would make a the Medical Coordinator					
	did not have a need Interview on 11/9/2						
	Pharmacy after it of facility had experier -If a medication was notified the Medical the pharmacy to ha	everal meetings with the nanged ownership and the need problems with delivery. It is not available and staff a Coordinator, she contacted we it delivered. The physician if a client missed					
V 139	27G .0404 (F-L) Op Period	perations During Licensed	V 139				
	10A NCAC 27G 04	.04 OPERATIONS					

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Division	Division of Health Service Regulation					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL040-009	B. WING		R 11/12/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			HWAY 903 S			
FAIR FAX	(LL, NC 2858			
(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 APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 139	Continued From page 9		V 139			
	DURING LICENSE (f) DHSR shall conwithout advance not (g) Licenses for factory any clients during the not be renewed. (h) DHSR shall consumption of 24-hour facilities and months, to occur not July 1, 2007. (i) Written requests a minimum of 30 data changes: (1) Construct renovation of an ex (2) Increase of program service type (3) Change in (4) Change in (5) Written not to DHSR a minimum the following change in partnersh (2) Change in change in partnersh (3) When a licensed discontinue a service days in advance sh affected clients, and legally responsible This notice shall ad clients in the facility (I) Licenses shall e DHSR for an addition expiration of a licent to DHSR the follows (1) Annual February (1) Annual February (1) Annual February (2) Change in the facility (1) Annual February (1) Annual February (1) Annual February (1) Annual February (2) Annual February (3) Annual February (4) Annual February (5) Annual February (6) Annual February (7) Annual February (8) Annual February (1) Annua	D PERIOD duct inspections of facilities stice. cilities that have not served ne previous 12 months shall induct inspections of all naverage of once every 12 collater than 15 months as of shall be submitted to DHSR ays prior to any of the following cion of a new facility or any isting facility; or decrease in capacity by oe; in program service; or in location of facility. otification must be submitted m of 30 days prior to any of es: in ownership including any nip; or in name of facility. ee plans to close a facility or oe, written notice at least 30 all be provided to DHSR, to all d when applicable, to the persons of all affected clients. dress continuity of services to of expire unless renewed by onal period. Prior to the use, the licensee shall submit ing information: ee;				
	(2) Description	ee; on of any changes in the of written potification was				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					F	
		MHL040-009	B. WING		11/1	2/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FAIR FAX	(HWAY 903 S			
	OLIMANA DV. OTA		LL, NC 2858		N	0.50
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
V 139	Continued From pa	ge 10	V 139			
	submitted;					
	•	rent fire inspection report;				
		anitation inspection report, with				
		day/night or periodic service e food for which a sanitation				
	inspection report is					
	\ /	es of individuals who are				
	owner, partners or shareholders holding an ownership or controlling interest of 5% or more of the applicant entity.					
	This Rule is not me	at as evidenced by:				
		views and interviews, the				
		plete the required emergency				
		on to DHSR, or submit written 30 days prior to renovations.				
	The findings are:	ou days prior to removations.				
	· ·	24 444045 (1 5)				
	Interviews on 11/9/2 Operations stated:	21 - 11/12/15 the Director of				
		ated from facility in December				
		erns with facility floors.				
	 He considered the emergency relocation 	e facility relocation an				
		on. -opened in June - 2021.				
	- There were no sat	fety concerns with the facility				
	at present He had not notified DHSR of the emergency					
		in December 2020 or facility				
	renovations in 2021	because he was unaware of				
	these requirements	S.				
V 366	27G .0603 Incident	Response Requirments	V 366			
	10A NCAC 27G 06	603 INCIDENT				

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	or realth Service IN		()(0) 14111 TIBL	F CONSTRUCTION	()(0) DATE	01101/51/
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COIVIE	LLILD
					F	2
		MHL040-009	B. WING			` 2/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
FAIR FAX	K	2535 HIGH	HWAY 903 S	OUTH		
SNOW H			L, NC 2858	30		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATURY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
				,		
V 366	Continued From pa	ge 11	V 366			
	RESPONSE REQU	JIREMENTS FOR				
	CATEGORY A AND	B PROVIDERS				
	(a) Category A and	B providers shall develop and				
	implement written p	oolicies governing their				
	response to level I,	II or III incidents. The policies				
		ovider to respond by:				
	` '	to the health and safety needs				
	of individuals involv					
	(2) determining the cause of the incident;					
	(3) developing and implementing corrective					
		g to provider specified				
	timeframes not to e					
		g and implementing measures				
		cidents according to provider				
		es not to exceed 45 days;				
		person(s) to be responsible				
		of the corrections and				
	preventive measure					
		to confidentiality requirements				
		Article 2A, 10A NCAC 26B,				
	42 CFR Parts 2 and 164; and	d 3 and 45 CFR Parts 160 and				
		ng documentation regarding				
		(1) through (a)(6) of this Rule.				
		e requirements set forth in				
	Paragraph (a) of thi	s Rule, ICF/MR providers				
		ents as required by the federal				
	regulations in 42 CF	FR Part 483 Subpart I.				
	(c) In addition to th	e requirements set forth in				
		is Rule, Category A and B				
	providers, excluding	g ICF/MR providers, shall				
		nent written policies governing				
		level III incident that occurs				
		s delivering a billable service				
		on the provider's premises.				
	The policies shall re	equire the provider to respond				
	by:					
	(1) immediate by:	ely securing the client record				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BOILDING.		R	
	MHL040-009	B. WING			2/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADI	STATE, ZIP CODE			
FAIR FAX 2535 HIGHWAY 903 SOUTH					
		L, NC 2858			
PREFIX (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 366 Continued From pa	ge 12	V 366			
(A) obtaining to (B) making a (C) certifying (D) transferring review team; (2) convening review team within 2 internal review team who were not involved were not responsible with direct professions services at the time review team shall confollows: (A) review the determine the facts and make recommon occurrence of future (B) gather off (C) issue writh within five working of preliminary findings LME in whose catch located and to the Lift different; and (D) issue a find owner within three refinal report shall be catchment area the LME where the client final written report sidentified by the interior include all public do incident, and shall reminimizing the occural documents need available within three LME may give the present the context of the profession of	the client record; photocopy; the copy's completeness; and g the copy to an internal a meeting of an internal a meeting of an internal a hours of the incident. The a shall consist of individuals and in the incident and who e for the client's direct care or anal oversight of the client's of the incident. The internal amplete all of the activities as copy of the client record to and causes of the incident endations for minimizing the	V 366			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
7.1.12 . 2.1.1	o. oo20.10.1		A. BUILDING:				
		MHL040-009	B. WING			R 12/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
FAIR FAX			HWAY 903 SC LL, NC 2858				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
V 366	(3) immediate (A) the LME rearea where the service Rule .0604; (B) the LME redifferent; (C) the provide for maintaining and treatment plan, if disprovider; (D) the Depart (E) the client applicable; and	ely notifying the following: esponsible for the catchment vices are provided pursuant to where the client resides, if der agency with responsibility updating the client's fferent from the reporting	V 366				
	failed to implement reporting/response medications not ad Reviews between 1 incident reports bet revealed no level 1 medications documbecause they had because they had because they had because on 11/9/21 record revealed: -21 year-old male -Admission date of -Diagnoses include	view and interview, the facility written policies for to level I incidents of ministered. The findings are: 1/9/21 and 11/12/21 of facility ween 8/1/21 - 11/9/21 incident reports for lented as not administered been unavailable. and 11/12/21 of client #1's					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 t. BOILBII 10.		F	2
		MHL040-009	B. WING			2/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE,				STATE, ZIP CODE		
FAIR FA	x	2535 HIGI				
.,			LL, NC 2858			
(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 366	Continued From pa	ge 14	V 366			
V 366	(ODD), intellectual moderate (I/DD), exhearing impairment -8/10/21 noon dose (milligrams) was not been delivered on the administered daily and -11/8/21 dose of Cowas not administered daily.) Finding #2: Review on 11/9/21 record revealed: -23 year-old male -Admission date of -Diagnoses included disorder (PTSD), hyschizoaffective disording disorder (PTSD), hyschizoaffective (PTSD), hyschizoaffective (PTSD), hyschizoaffective (PTSD), hyschizoaffecti	and developmental disability - kpressive language disorder, and cerebral palsy. of Clonidine 0.1 mg of given because it had not ime. (Ordered 8/1/21 to be eat noon.) oncerta ER (extended release) od 11/8/21 because it was not on 8/1/21 and 9/30/21 to be and 11/12/21 of client 2's 6/14/21 d posttraumatic stress ypothyroidism, hyperlipidemia, order - bipolar type, and IDD - 21-8am dose of Vitamin D3 od because it was not 7/21/21 to be given 1x otine 21 mg/24 hr patch was because it was not available. To be given daily.) 10/22/21, and 10/25/21-8am extended release (ER) was because it was not available. To be given daily for mood	V 366			
	was not administerd available. (Ordered bedtime.) -10/20/21 - 8am do	/31/21 - 8pm dose of Prazosin ed because it was not 7/21/21 to be given daily at se of Quetiapine was not use it was not available.				
	(Ordered 3/16/21 to					

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	Of Fleatin Service IN				0.00 - 1	0.15.45.4
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		(X3) DATE SURVEY COMPLETED		
741012741	or contraction	BERTH 10, THEIR HOMBER.	A. BUILDING:		O O IVIII	
					F	₹
		MHL040-009	B. WING		11/1	2/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
			HWAY 903 S			
FAIR FA	X		LL, NC 2858			
	OUR MAA EN COTA		1			
(X4) ID PREFIX	-	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
V 366	Continued From pa	ge 15	V 366			
V 000	Continued i Tom pa	ge 13	V 000			
	Finding #3:					
		and 11/12/21 of client 3's				
	record revealed:					
	-59 year-old male.					
	-Admission date of					
	-Diagnoses include					
		bility - moderate (IDD), major r - unspecified, type II				
		pphageal reflux disease				
		ostate hypertrophy with				
		and partial leg amputation.				
		e of Tylenol 650 mg was not				
	given because it was not available. (Ordered 6/1/21 to be given 3 times daily for pain.) -8/1/21 - 8/11/21 Temazepam 15 mg at bedtime					
		ause it was not available.				
	(Ordered 6/21/21 fc					
		Polyethylene Glycol 3350				
		ministered, a total of 9				
	consecutively sched	duled doses, because the				
	medication was not available. (Ordered 8/18/21 to					
	be given Monday, Wednesday, and Friday for					
	constipation.)					
	Interview on 11/09/2					
		oyed with the agency for				
	approximately 6-7 r					
		a medication on hand that was				
		ered he would make a				
		the Medical Coordinator				
	would notify the pha	olete an incident report if a				
	medication was mis					
	medication was fills	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	Interview on 11/9/2	1 the Medical Coordinator				
	stated:	modical cool dillator				
		perienced problems with				
		after pharmacy had changed				
		situation had improved.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		F	,	
		MHL040-009	B. WING			2/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
FAIR FA	FAIR FAX 2535 HIGHWAY 903 SOUTH SNOW HILL, NC 28580						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 366	-If a medication wa notified the Medica the pharmacy to ha -If she, the Medical pharmacy she did r report. -If staff contacted the medications were r complete a level 1 if	s not available and staff Coordinator, she contacted ve it delivered. Coordinator, contacted the not complete a level 1 incident ne pharmacy because not available, they would incident report. el 1 incident reports for or medications not available	V 366				

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