Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU	
ANDILAN	or doring of the second of the	IDENTIFICATION NOMBER.	A. BUILDING: _		J COWII EL	.125
		MHL049-145	B. WING		11/17	7/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
THE GRO	VE		TNUT GROVE			
			LLE, NC 28625			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS	;	V 000			
	on 11/17/2021. The cunsubstantiated (intal NC183039). Deficien This facility is license category: 10A NCAC	ke #NC182432 &				
V 118	27G .0209 (C) Medica	ation Requirements	V 118			
	10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR					

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	, ,	SURVEY PLETED	
		MHL049-145	B. WING		11	/17/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE	-	
THE ODO		247 CHE	STNUT GROVE R	OAD		
THE GRO	VE	STATESV	ILLE, NC 28625			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	. 1	V 118			
V 1.10		pointment or consultation	VIII			
	facility failed to ensure medications was docu	ews and interviews, the eadministration of umented immediately on affecting 3 of 3 clients				
	#1's record revealed: - Admission date: 8/13 - Diagnoses: Moderat Autism Spectrum Disc Type I (condition that the brain, nerves and (eating non-food items Insomnia - Age: 18 years, 4 mo - Physician's orders for - Clonidine 0.1 mg (revery morning), date - Clonidine 0.1 mg, 2 bedtime), dated 6/4/2 - Melatonin 3mg, 1 to dated 6/4/2021; - PEG powder (polye grams in 8 oz. (ounce day), dated 6/4/2021; - Risperidone 1mg, 2 (twice daily), dated 6/4	e Intellectual Disabilities; order; Neurofibromatosis, causes tumors to form on spinal column); PICA s); Constipation; and on the following medications: milligrams), 1 tablet QAM d 6/4/2021; 2 tablets QHS (every night at 1021 ablet QPM (every evening), ethylene glycol), dissolve 17 s) liquid and give QD (every 1-1/2 tablets (=1.5mg) BID				

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DIVISION	or riealth Service Negu	ilation				
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLET	TED
		MHL049-145	B. WING		44/47	/2024
		WITIL049-145			11/17	/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		247 CHES	STNUT GROVE	ROAD		
THE GROVE			ILLE, NC 2862	5		
(VA) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	v	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
V 118	Continued From page	2	V 118			
	Continued From page		•			
		21 ad 11/15/2021 of Client				
	#1's MARs for Septer	mber, October and				
	November of 2021 re	vealed:				
	- Each medication ha	d at least one date with a				
	blank on the space us	sed for facility staff to				
	document medication	administration.				
	- There were a total o	of 30 blanks on the				
	September MAR.					
	- There were a total o	of 32 blanks on the October				
	MAR.					
	Reviews on 11/12/202	21 and 11/15/2021 of Client				
	#2's record revealed:					
	- Admission date: 3/1	8/2021				
	- Diagnoses: Autistic	Disorder; Intermittent				
	Explosive Disorder; M	/lild Intellectual Disabilities;				
	Spastic diplegic cereb	oral palsy; Developmental				
	disorder of speech ar	nd language, Dermatitis; and				
	allergy to other foods					
	- Age: 12 years, 9 mo	onths.				
	- Physician's orders for	or the following medications:				
	Aripiprazole 5mg,	1 tablet BID, dated				
	8/24/2021;					
		1 tablet QHS with 20mg				
	dose to equal 30mg,					
	Citalopram 20mg,	1 tablet QHS with 10mg				
	dose to equal 30mg,	dated 7/13/2021;				
	Guanfacine 2mg, 1	1 tablet TID (three times				
	daily), dated 7/13/202					
	Loratadine 10mg,	1 tablet QAM, dated				
	7/13/2021;					
	Methylphenidate 2	7mg, 1 tablet after				
	breakfast, dated 7/13					
		21 ad 11/15/2021 of Client				
	#2's MARs for Septer	mber, October and				
	November of 2021 re	vealed:				
	- Each medication ha	d at least one date with a				
	blank on the space us	sed for facility staff to				

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Division o	of Health Service Regu	liation	_			
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
			P WING			
		MHL049-145	B. WING		11/1	7/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE		
	10115211 011 001 1 21211		, ,	,		
THE GROVE		TNUT GROVE				
		STATESV	ILLE, NC 28625	5		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	MAIE	DAIL
V 118	Continued From page	e 3	V 118			
	document medication	n administration.				
	- There were a total of	of 30 blanks on the				
	September MAR.					
	- There were a total of	of 51 blanks on the October				
	MAR.					
	Reviews on 11/12/202	21 and 11/15/2021 of Client				
	#3's record revealed:					
	- Admission date: 4/1					
		Spectrum Disorder; Mild				
	_	Cerebral Palsy; Strabismus				
		abismus in which one or				
	both eyes turn inward	•				
		y tube; History of stroke; and				
	Extreme immaturity.	a.				
	- Age: 18 years, 10 m					
		or the following medications:				
	•	tablet TID, dated 6/4/2021;				
		tablet QD,dated 6/4/2021;				
		oray 0.65%, use 5 sprays in				
	each nostril prior to a	dministration of fluticasone,				
	dated 6/4/2021;					
	Divalproex 125mg	, 3 capsules (=375mg) QAM,				
	dated 6/4/2021;					
	Divalproex 125mg	, 4 capsules (=500mg) QHS,				
	dated 6/4/2021;					
	Fish oil softgel 500	mg, 1 tablet QD, dated				
	6/4/2021;					
		g (micrograms), 1 spray in				
	each nostril QD, date					
		ng, 1 tablet BID with 50mg to				
	equal 150mg, dated 6	•				
		g, 1 tablet BID with 100mg to				
	equal 150mg, dated 6	-				
	Propranolol 20mg,					
		i tablet TID, dated				
	6/4/2021;	oito 1 toblot OD datad				
		nits, 1 tablet QD, dated				
	6/4/2021.					

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Reviews on 11/12/2021 ad 11/15/2021 of Client

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		MHL049-145	B. WING		11/17/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
THE GRO	VE		NUT GROVE		
STATESVI			LE, NC 28625	<u> </u>	
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
V 118	Continued From page	e 4	V 118		
	blank on the space us document medication - There were a total of September MAR.	vealed: d at least one date with a sed for facility staff to administration.			
	Interview on 11/16/2021 with the Residential Team Leader (RTL) revealed: - Nursing staff reviewed MARs for completeness and accuracy. - There was a possibility that some of the blanks on the MARs were due to clients being on home visits. - She believed that Clients' #1, #2 and #3 had been administered all of their medications correctly.				
	Interviews on 11/16/2021 and 11/17/2021 with the Qualified Professional (QP) revealed: - She did not typically oversee MARs the Registered Nurse (RN) showed her the MARs with missing documentation The RN was already addressing the documentation issues with the MARs.				
	- She had reviewed the begun investigating was some of the blanks been on home visits Facility staff had been home visits on the Market She compared the Market beautiful the medications were				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S COMPLI	
		MHL049-145	B. WING		11/1	7/2021
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
THE ODO	.r	247 CHES	TNUT GROVE I	ROAD		
THE GRO	VE	STATESV	ILLE, NC 28625	3		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From page	5	V 118			
V 289	27G .5601 Supervise	d Living - Scope	V 289			
	10A NCAC 27G .5601 SCOPE (a) Supervised living is a 24-hour facility which provides residential services to individuals in a home environment where the primary purpose of these services is the care, habilitation or rehabilitation of individuals who have a mental illness, a developmental disability or disabilities, or a substance abuse disorder, and who require supervision when in the residence. (b) A supervised living facility shall be licensed if the facility serves either: (1) one or more minor clients; or (2) two or more adult clients. Minor and adult clients shall not reside in the same facility. (c) Each supervised living facility shall be licensed to serve a specific population as designated below: (1) "A" designation means a facility which serves adults whose primary diagnosis is mental illness but may also have other diagnoses; (2) "B" designation means a facility which serves minors whose primary diagnosis is a developmental disability but may also have other diagnoses; (3) "C" designation means a facility which serves adults whose primary diagnosis is a					

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serves minors whose primary diagnosis is

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AND DLAN OF CORRECTION INDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S			
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
		MHL049-145	B. WING		11/1	7/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STAT	TE, ZIP CODE		
THE CRO	\/E	247 CHES	TNUT GROVE F	ROAD		
THE GRO	VE	STATESVI	LLE, NC 28625	;		
(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 289	Continued From page	e 6	V 289			
V 289	substance abuse depother diagnoses; (5) "E" designal serves adults whose substance abuse depother diagnoses; or (6) "F" designal private residence, who three adult clients who mental illness but madisabilities, or three actions whose primary developmental disabilities who family provides the seexempt from the follo .0201 (a)(1),(2),(3),(4) (A),(B),(E),(F),(G),(H),(18) and (b); 10A NCAC 27G .0208 (b),(e); 10 non-prescription med (1)(A),(D),(E);(f);(g); a (b)(2),(d)(4). This factories	tion means a facility which primary diagnosis is sendency but may also have tion means a facility in a ich serves no more than ose primary diagnoses is y also have other dult clients or three minor y diagnoses is lities but may also have live with a family and the ervice. This facility shall be wing rules: 10A NCAC 27G	V 289			
	facility failed to ensur	ews and interviews, the e that services were only fecting 2 of 3 clients (#1 &				
		1 of the facility's Division of ation licensure documents				

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AND DIAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE (A. BUILDING:			E SURVEY PLETED
	MHL049-145	B. WING		11	/17/2021
NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, STATI	E, ZIP CODE		
THE GROVE	247 CHE	STNUT GROVE R	OAD		
THE OROVE	STATES'	VILLE, NC 28625			
PREFIX (EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
order to provide time older than 18. - There were no curr #3 to receive service reached the age of 1 Reviews on 11/12/20 #1's record revealed - Admission date: 8/ Diagnoses: Modera Autism Spectrum Dis Type I (condition that the brain, nerves and (eating non-food item Insomnia. - Age: 18 years, 4 m Reviews on 11/12/20 #3's record revealed - Admission date: 4/ Diagnoses: Autism intellectual disability with right estopia (stroth eyes turn inwar Atrophy; Gastrostom Extreme immaturity Age: 18 years, 10 r Interview on 11/17/2 revealed: - When Client #3 wa facility, she was told that he could remain if he continued to att - Client #3 was attereach week.	ained waivers in the past in e-limited services to clients ent waivers for Client #1 or is at the facility after they 8. 221 and 11/15/2021 of Client : 13/2021 ate Intellectual Disabilities; sorder; Neurofibromatosis, to causes tumors to form on dispinal column); PICA ins); Constipation; and conths. 221 and 11/15/2021 of Client : 1/2020. Spectrum Disorder; Mild in it is in the control of stroke; and in it is in the control of stroke; and in it is initially admitted to the by the former Administrator at the facility until he was 21	V 289			

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
		MHL049-145	B. WING		11/17	7/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
THE GROVE		TNUT GROVE I LLE, NC 28625				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT 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 APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 289	Continued From page facility beyond his 18th Interviews on 11/16/2 Qualified Professiona - Client #1 had been shis mother's home be placement did not occided to leave him - Referrals to other resent out for Client #1, contacted had express Client #1 She had started wor Client #3 had already - There were not curres #1 and #3 that she was - She had never request to continue providing minors for clients who - She thought that the responsible for requesclients who could not placements before the Interview on 11/17/20 revealed: - She had started in the within the past year She had not seen an	h birthday. 221 and 11/17/2021 with the I (QP) revealed: scheduled for discharge to fore he turned 18, but that cur because his mother at the facility. sidential providers had been but none of the facilities sed interest in admitting king at the facility after turned 18. ently any waivers for Clients as aware of. ested a waiver from DHSR services at a facility for were turning 18. QP would be the staff sting waivers from DHSR for be transferred to adult	V 289		KATE	DATE
	- She had any conver	sations about Client #3 he facility until he was 21.				

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