		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVE COMPLETED	
			A. BUILDING:	A. BUILDING:		R
		MHL074-158	B. WING			05/2022
AME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S ⁻	TATE, ZIP CODE		
	DON SUPERVISED L	IVING				
			VILLE, NC 278	PROVIDER'S PLAN OF	CORRECTION	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMEN	rs	V 000			
		An annual and follow up survey was completed on January 5, 2022. Deficiencies were cited.				
	category: 10A NCA	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.				
	The survey sample clients.	consisted of 2 of 2 current				
V 118	27G .0209 (C) Med	lication Requirements	V 118			
	 only be administered order of a person a drugs. (2) Medications shat clients only when a client's physician. (3) Medications, include administered only b unlicensed persons pharmacist or other privileged to prepart (4) A Medication Act all drugs administered current. Medication recorded immediated and the second seco	inistration: non-prescription drugs shall ed 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 a trained by a registered nurse r legally qualified person and re and administer medications dministration Record (MAR) o red to each client must be ke s administered shall be ely after administration. The	5. f			
	(C) instructions for(D) date and time the(E) name or initialsdrug.	he following: , and quantity of the drug; administering the drug; he drug is administered; and of person administering the for medication changes or				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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		MHL074-158	B. WING			05/2022
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V 118	Continued From pa	ige 1	V 118			
		orded and kept with the MAR appointment or consultation				
	facility failed to adm	et as evidenced by: eviews and interviews the ninister medications as cian affecting 2 of 2 clients.				
	 46 year old female Diagnoses include Disability, profound disorder; encephale deaf/mute; legally b and asthma. Physician's orders 	of client #1's record revealed: e admitted 6/24/05. ed Intellectual/Developmental ; Anxiety Disorder; seizure opathy; spastic diplegia; blind; alopecia; constipation; s signed 5/05/21 for ures) 32.4 milligrams (mg) 2				
	October 2021 - Jar - Transcriptions for administered at 7:0	s not administered at 7:00 am				
		lient #1 was conducted due to nd inability to communicate.				
	- 65 year old female	of client #2's record revealed: e admitted 6/24/05. ed Intellectual/Developmental				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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				01/	05/2022	
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(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
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V 118	Continued From pa	ge 2	V 118			
	scoliosis; constipati hypertension; gastr ear wax build up; at - Physician's orders (severe osteoporos subcutaneously eve bisacodyl (laxative) hold for loose stool (anti-convulsant) 75 Review on 1/04/22 October 2021 - Jan - Transcriptions for levetiracetam as or - Documentation th administered as fol - Forteo: 10/22/ 11/30/21; 12/01/21 1/01/22 - 1/04/22; Unavailable" - Bisacodyl: 11/ Medication Unavail - Levetiracetam "Exceptions: Medic During interview on took her medicatior During interview on - The pharmacy do for client #2. - She calls the phar the medication.	porosis; dysmenorrhea; on; allergic rhinitis; oesophageal reflux disease; nd hypothyroidism s signed 10/20/21 for Forteo is) inject 20 micrograms (mcg ery evening; signed 5/05/21 for 5 mg 2 tablets at bedtime, s, and levetiracetam 50 mg 1 tablet twice daily. of client #2's MARs for uary 2022 revealed: Forteo, bisacodyl, and dered. e medications were not lows: (21 - 10/31/21; 11/01/21 - and 12/30/21 - 12/31/21; 'Exceptions: Medications 27/21; "Exceptions: able." o 11/13/21 8:00 pm;	n 1:			
	alternative medicat on Forteo. - Client #1's phenol	on but the Physician insisted parbital was available and administered on 11/25/21; the				

STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
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MHL074-158		B. WING			05/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
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(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
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V 118	Continued From pa	ge 3	V 118			
	staff person could r - Staff were re-train clients' medications	ed about the locations of the				
	Group Home Mana stated:					
	Physician to resolve Forteo.	orking with the pharmacy and e issues with client #2's				
		remain on the MAR unless an order to discontinue it.				
	This deficiency con and must be correc	stitutes a re-cited deficiency ted within 30 days.				
V 290	27G .5602 Supervis	sed Living - Staff	V 290			
	numbers specified of this Rule shall be enable staff to resp needs.	os above the minimum in Paragraphs (b), (c) and (d) e determined by the facility to ond to individualized client				
	present at all times premises, except w	one staff member shall be when any adult client is on the hen the client's treatment or cuments that the client is	9			
	capable of remainir without supervision as needed but not l	ing in the home or community The plan shall be reviewed ess than annually to ensure to be capable of remaining in				
	the home or commu- specified periods of (c) Staff shall be p	unity without supervision for time. resent in a facility in the				
	child or adolescent (1) children o	f ratios when more than one client is present: r adolescents with substance all be served with a minimum				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL074-158				CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S ⁻ MBLEDON DR I			
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V 290	Continued From pa	ige 4	V 290			
	clients present. He present during slee emergency back-up the governing body (2) children of developmental disa one staff present for present and two sta more clients present need be present du specified by the em determined by the em determined by the em diagnosis is substa (1) at least of duty shall be trained withdrawal symptor secondary complicat drug addiction; and (2) the service	or adolescents with abilities shall be served with or every one to three clients aff present for every four or nt. However, only one staff uring sleeping hours if bergency back-up procedures governing body. The serve clients whose primary nce abuse dependency: ne staff member who is on d in alcohol and other drug ms and symptoms of ations to alcohol and other d bes of a certified substance hall be available on an				
	facility failed to mai the minimum numb to individualized clie	et as evidenced by: views and interviews the ntain staff-client ratios above pers to enable staff to respond ent needs in the event of an g 2 of 2 clients (#1 and #2).				
	by the Division of H expiration date 12/3 - "Ambulatory: A pe	of the facility's license issued lealth Service Regulation, 31/22, revealed: rson who can evacuate the ysical or verbal assistance				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION		E SURVEY PLETED
	OF CONNECTION	IDENTIFICATION NOWBER.	A. BUILDING:			
		MHL074-158	B. WING			R 05/2022
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V 290	Continued From pa	ge 5	V 290			
	 during a fire or other emergency." - " Number of Ambulatory Beds Approved 2" Review on 1/04/22 of client #1's record revealed: - 46 year old female admitted 6/24/05. - Diagnoses included Intellectual/Developmental Disability, profound; Anxiety Disorder; seizure disorder; encephalopathy; spastic diplegia; deaf/mute; legally blind; alopecia; constipation; and asthma. - "Risk/Support Needs Assessment" dated 7/15/21 included documentation of client #1's use of a wheelchair for mobility, and need for staff assistance to evacuate in the event of an emergency. 					
		ient #1 was conducted due to d inability to communicate.				
	 65 year old femal Diagnoses include Disability, mild; Cer quadriplegia; osteo scoliosis; constipati hypertension; gastr ear wax build up; at "Individual Support documentation of c 	oesophageal reflux disease; nd hypothyroidism 't Plan" dated 8/01/21 included lient #2's use of an electric ility, a hospital bed with rails,				
	liked living at the fa	1/04/22 client #2 stated she cility and she felt safe there.				
	- She had conducte	1/05/22 staff #2 stated: ed fire drills in the past. e drills when she was the only	,			

Division	of Health Service Re	egulation				IAPPROVEI
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL074-158	B. WING			R 05/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	DON SUPERVISED L	IVING 1650 WI	MBLEDON DR	IVE #101		
		GREENV	ILLE, NC 278	58		1
(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 ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 290	Continued From pa	ige 6	V 290			
	wheelchair and rolle during drills. - Client #2 had a ho were up when she - Client #2 could no independently. - Client #2 required her bed to her whee her electric wheelch	t lower her bedrails assistance to transfer from elchair; she could maneuver				
	 Clients #1 and #2 assistance to evacu- Client #2 could dristaff had to transfer wheelchair. Client #1 required Staff had been insisted a been window at necessary to keep emergency that required During interview on stated a Hoyer lift window but staff did not alw 	ive her electric wheelchair, but ther from her bed to her assistance to evacuate. structed to open the clients' nd put them outside if them safe during an juired evacuation of the facility 1/05/22 the Regional Director vas available for use if needed vays use it.				
	She understood the and to have minimu	e need to keep the clients safe um staffing to meet client consider additional staff.				
V 736	10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a saf	ty and Grounds Maintenance 303 LOCATION AND IREMENTS 1 its grounds shall be e, clean, attractive and orderly e kept free from offensive	V 736			

Division of Health Service Regulation STATE FORM

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If continuation sheet 7 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERSUPPLIENCIEN IDENTIFICATION NUMBER (X2) MULTUPIC CONSTRUCTION A BUILDING. (X2) MULTUPIC PROVIDER OR SUPPLIENCIES IN MULTUPIC TO BUILTUPIC INSTRUCT ADDRESS OT V: STATE ZIP CODE INSTRUCT ADDRESS OT V: STATE ZIP CODE INTE VIEW ADDRESS OT V: STATE ZIP COD	Division	of Health Service Re	gulation				
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Interview Interview Interview PROVIDER SPLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECIDED BY FULL PRECIME OF CORRECTION BIGUES BENTY INGNETION AND INFORMATION) Interview PROVIDERS PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECIDED BY FULL CROSS-REFERENCE OF THE APPROVINGATE DEPICIENCY) COMPLET (EACH DEPICIENCY) V 736 Continued From page 7 odor. V 736 V 736 Interview Interview <t< td=""><td></td><td></td><td>MHL074-158</td><td>B. WING</td><td></td><td></td><td></td></t<>			MHL074-158	B. WING			
WINDLEDON SUPERVISED LIVING CREENVILE, NC 27858 Image: Constraint of the prediction of the predict	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
Prigrix TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PREINT TAG (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) Continued From page 7 V 736 V736 Continued From page 7 V 736 V V Precision File DEFICIENCY) DEFICIENCY) Based on observations and interviews the facility was not maintained in a safe, clean, altractive manner. The findings are: V V Precision <	WIMBLE	DON SUPERVISED LI	VING				
odor. This Rule is not met as evidenced by: Based on observations and interviews the facility was not maintained in a safe, clean, attractive manner. The findings are: Observations on 1/04/22 between 10:30 am and 3:00 pm revealed: The vinyl upholstery on a brown sofa in the living room was torn and peeling, with one arm of the sofa covered with vinyl tape. A live roach inside the upper cabinet next to the microwave. Matter inside the kitchen light fixture. The veneor on the edge of the kitchen counter near the chest freezer was broken and peeled away from the counter surface. A golf ball sized hole in the wall by client #2's bedroom closet. The windy win client #2's bedroom uses blocked by a large television and was not easily accessible. The wall beside client #1's bedroom closet door was scuffed. A large hole in the bathroom wall at the floor by the door; a covered drin pipe was exposed; The vaneur on the edge of the bathroom counter was broken bald bathroom sink was broken and heavily rusted. The vaneur on the all bathroom was damaged.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	COMPLETE
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 The vinyl upholstery on a brown sofa in the living room was torn and peeling, with one arm of the sofa covered with vinyl tape. A live roach inside the upper cabinet next to the microwave. Matter inside the kitchen light fixture. The veneer on the edge of the kitchen counter near the chest freezer was broken and peeled away from the counter surface. A golf ball sized hole in the wall by client #2's bedroom closet. The window in client #2's bedroom was blocked by a large television and was not easily accessible. The wall beside client #1's bedroom closet door was scuffed. A large hole in the hall bath was very loud. The veneer on the edge of the bathroom closet. The veneer on the edge of the bathroom sink was broken and heavily rusted. The bathroom drain stopper was broken and in the middle of the tub floor. The bathroom the bathroom was damaged. 			04/22 between 10:30 am and				
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER					(X3) DATE SURVEY COMPLETED		
	OF CONNECTION	BENTI ICATON NOMBER.	A. BUILDING:				
MHL07		MHL074-158	B. WING			R 01/05/2022	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
VIMBI F	DON SUPERVISED L		MBLEDON DRI				
		GREEN	/ILLE, NC 278				
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE	
V 736	Continued From pa	age 8	V 736				
	bathroom sink was - The vinyl floor cov hallway near client - Walls throughout During interview or - She reported the would spray the fac - The damage to the from the clients' wh During interview or stated she was away	vering was peeling up in the #2's bedroom door. the facility were scuffed. n 1/04/22 the Shift Lead stated: roach and maintenance staff cility. ne walls and door frames was					