ATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		A. BOILDING:	A. BUILDING:		R
	MHL036-329	B. WING		02/03/202	
ME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
ATRIOTS		EAST HUDSON BO	ULEVARD		
	GASTO	NIA, NC 28054			
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 000 INITIAL COMMENTS	3	V 000			
	An annual and follow up survey was completed on February 3, 2022. Deficiencies were cited. The facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.				
category: 10A NCA					
The survey sample of current clients.	consisted of audits of 3				
V 118 27G .0209 (C) Medic	cation Requirements	V 118			
 only be administered order of a person auditive drugs. (2) Medications shall clients only when audiclient's physician. (3) Medications, incluadministered only by unlicensed persons to pharmacist or other I privileged to prepare (4) A Medication Admall drugs administered current. Medications recorded immediatel MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for a (D) date and time the 	histration: on-prescription drugs shall I to a client on the written thorized by law to prescribe I be self-administered by thorized in writing by the uding injections, shall be licensed persons, or by trained by a registered nurse, egally qualified person and and administer medications. ninistration Record (MAR) of ed to each client must be kept administered shall be y after administration. The				
drug. (5) Client requests fo	or medication changes or				

PRINTED: 02/03/2022 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL036-329	B. WING		02	R 2/03/2022
AME OF PF	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
ATRIOTS		1208-L E	AST HUDSON BOL	ILEVARD		
		GASTO	NIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From page	e 1	V 118			
		ded and kept with the MAR pointment or consultation				
	failed to ensure all me administered on the v authorized by law to p that all MARs were ke	nd record review, the facility				
	-Admitted 12/15/17; -Diagnosed with Mild Disability; -No physician's order (fiber), Omega Fish C Spray (allergies); -Physician's order dat DR (heartburn) 20mg daily and Oxybutynin (bladder control) 15m -Physician's order dat (seizures) 300mg one Hydroxyzine (antihista daily, Lithium Carbon two caps twice daily; -Physician's order dat	Client #1's record revealed: Intellectual Developmental s for Polyethylene Glycol Dil (supplement), Nasal ted 3/15/21 for Omeprazole (milligram) one cap (caplet) ER (Extended Release) og one tab (tablet) daily; ted 5/27/21 for Gabapentin e cap three times per day, amine) 25mg two caps twice ate (mood stabilizer) 300mg ted 5/4/21 for Vitamin B12 cg (micrograms) one tab				

STATE FORM

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL036-329	B. WING		a	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
PATRIOTS		1208-L E	AST HUDSON BOU	JLEVARD		
AIRIOIS	5	GASTO	NIA, NC 28054			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From page	2	V 118			
	 B12, and nasal spray -no administratio Lithium Carbonate, an -incorrect dosage on the January, 2022 MARs. Observation on 2/3/22 of Client #1's medicat Bottle of Polyethylen 12/9/21 with label instr cap (17grams) in eigf Blister pack of Omep 1/3/22 with label instr cap daily; Blister pack of Gaba 1/24/22 with label instr cap three times daily; Blister pack of Oxybu 12/13/21 with label instr cap three times daily; Blister pack of Omep 1/1/22 with label instr cap three times daily; Blister pack of Omep 12/13/21 with label instr cap three times daily; Blister pack of Omep 12/13/21 with label instr caps twice daily; Blister pack of Hydrod 1/11/22 with label instr caps twice daily; Blister pack of Lithiun dispensed 1/11/22 with label instr caps twice daily; Blister pack of Vitam 12/28/21 with label in tab daily; Slister pack of Vitam 12/28/21 with label in tab daily; Triamcinolone 55mep 	entin, Hydroxyzine, Vitamin ; n directions for Hydroxyzine, nd nasal spray; e directions for Oxybutynin and December, 2021 2 at approximately 11:15am tions revealed: e Glycol 3350 dispensed tructions to administer one nt ounces of water daily; orazole DR 20mg dispensed uctions to administer one pentin 300mg dispensed tructions to administer one utynin ER 15mg dispensed structions to administer one ga Fish Oil 1,000mg with label instructions to aily; oxyzine 25mg dispensed tructions to administer 2 m Carbonate 300mg th label instructions to ce daily; in B12 2500mcg dispensed structions to administer one				
		prays per nasal route.				
	Finding #2 Review on 2/3/22 of 0					

STATE FORM

	of Health Service Regu					E SURVEY PLETED
		MHL036-329	B. WING	B. WING		R 2/ 03/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
		1208-L E	AST HUDSON BOL	JLEVARD		
PATRIOTS	5	GASTO	NIA, NC 28054			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C	F CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN) THE APPROPRIATE	COMPLETE DATE
V 118	Continued From page	e 3	V 118			
	-Admitted 8/15/19;					
	-	lar Disorder, Pervasive				
	Developmental Disab	pility, Moderate Intellectual				
	Developmental Disab	pility;				
	-Physician's order dat	ted 1/19/21 for Emergen-C				
		nt) 250mg (milligrams) two				
	gummies three times					
		ted 3/1/21 for Polyethylene				
		ke one cap (17grams) in				
	eight ounces of water					
		ted 6/8/21 for Levothyroxine				
		rograms) 1 tab (tablet) daily				
	each morning;	tod C/1C/21 for Donation in a				
	(anti-tremors) 1mg 1	ted 6/16/21 for Benztropine				
	, .	for Omeprazole (heartburn)				
	200mg;					
		ber, 2021 and January and				
	February, 2022 revea					
		f Emergen-C Gummies				
	500mg 1 tab three tin	-				
	-no dose for Poly					
	-	f Levothyroxine 50mg 1 tab				
	daily instead of Levot					
	(microgram) 1 tab dai	ily;				
	-no dose for Ben	ztropine on the January and				
	February, 2022 MAR					
		f Omeprazole 200mg 1 tab				
	daily.					
	Observation on 2/2/2	2 at approximately 11:30am				
	of Client #2's medicat					
		Gummies 250mg gummies				
		ith label instructions to				
	administer two gumm					
	_	ne Glycol 3350 dispensed				
		tructions to administer one				
	cap (17gm) in eight o					
		hyroxine 50mcg dispensed				
	1/12/22 with label ins	tructions to administer one				

Division of Health Service Regulation STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL036-329	B. WING			R 02/03/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE			
		1208-L E	AST HUDSON BOU	JLEVARD			
PATRIOTS		GASTO	NIA, NC 28054				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
V 118	Continued From page	e 4	V 118				
	1/11/22 with label inst tab daily; -Blister pack of Omep	ropine 1mg dispensed tructions to administer one orazole 200mg dispensed tructions to administer one					
	-Admitted 12/15/17; -Diagnosed with Inter Severe Intellectual De Autism, Schizophreni -Physician's order dat (anxiety) 1mg (milligra daily as needed; -Physician's order dat (pseudobulbar affect) daily; -No physician's order body lotion, or Vitami -MARs dated Deceml February, 2022 revea -Lorazepam 1mg standing order as opp -no dose for Neu MAR;	ted 3/2/21 for Lorazepam am) one tab (tablet) twice ted 4/1/21 for Neudexta 10mg 1 cap (caplet) twice for WalMucil Powder (fiber), n D (supplement); ber, 2021 and January and led: g one tab twice daily as a posed to as needed; dexta on the January, 2022 Mucil Powder or Vitamin D;					
	Observation on 2/3/2 of Client #3's medicat -Blister pack of Loraz 1/18/22 with label insi tab twice daily as nee -Blister pack of Neudo	2 at approximately 11:05am tions revealed: epam 1mg dispensed tructions to administer one eded; exta 10mg dispensed tructions to administer one					

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
			A. BUILDING:			
		MHL036-329	B. WING		02	R 2/03/2022
AME OF PF	ROVIDER OR SUPPLIER	STREETA	ADDRESS, CITY, STATE	, ZIP CODE		
ATRIOTS	1	1208-L E	EAST HUDSON BOU	JLEVARD		
		GASTO	NIA, NC 28054			
(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	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From page	e 5	V 118			
	label instructions to a -Blister pack of Vitam (caplets) dispensed 1 to administer one cap Interview on 2/3/22 w Officer revealed: -Will ensure all medic and kept on file at the -Will ensure all medic are corrected immedia	dispensed 12/14/21 with pply to body twice daily; in D 1,000 unit caps /24/22 with label instructions o daily. with the Chief Operating cation orders are obtained e facility; cation administration records fately.				
V 752	27G .0304(b)(4) Hot	Water Temperatures	V 752			
	EQUIPMENT (b) Safety: Each faci constructed and equi ensures the physical visitors. (4) In areas of exposed to hot water	4 FACILITY DESIGN AND lity shall be designed, pped in a manner that safety of clients, staff and the facility where clients are , the temperature of the ined between 100-116				
	failed to ensure hot w	as evidenced by: nd observation, the facility vater temperatures were 100-116 degrees Fahrenheit.				
	Observation on 2/2/2 2:15pm of the facility	2 at approximately 2L05pm - revealed:				

	of Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
			A. BUILDING:			R	
		MHL036-329	B. WING		02	2/03/2022	
IAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
ATRIOTS	;		EAST HUDSON BOU NIA, NC 28054	JLEVARD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TH DEFICIE	CTION SHOULD BE	(X5) COMPLET DATE	
V 752	Continued From page	e 6	V 752				
		in the kitchen and both ility registered 118 degrees					
	revealed:	with Clients #1, #2, and #3 om the hot water at the					
	Interviews on 2/2/22 and 2/3/22 with Staff #1, House Manager, and Qualified Professional revealed: -Denied any clients sustained burns from the hot water at the facility.						
	Officer revealed: -Contact was made to	vith the Chief Executive o the maintenance ater temperature to be					
	alth Service Regulation						