STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	A. BUILDING:			
			P WING			
MHL080096		B. WING		02/04/2022		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
BRENTWO	OOD		SOME ROAD IRY, NC 28144			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	An annual and complaint survey was completed on 2/4/22. The complaint was unsubstantiated(Intake #184820). Deficiencies were cited.					
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disabilities.				
	This survey sample c current clients.	onsisted of audits of 3				
V 118	V 118 27G .0209 (C) Medication 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 MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for ac (D) date and time the	after administration. The following: nd quantity of the drug;				

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

TITLE (X6) DATE

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL080096	B. WING		02	02/04/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATI	E, ZIP CODE			
BRENTW	OOD		SOME ROAD				
		SALISBU	IRY, NC 28144				
(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 T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 118	Continued From page	: 1	V 118				
	checks shall be record	medication changes or ded and kept with the MAR pointment or consultation					
	interviews, the facility all drugs administered current and medication recorded immediately	iew, observations and failed to ensure a MAR of d to each client was kept ons administered were					
	record revealed: -admission date of 4/2 -diagnoses of PTSD(I Disorder), ADHD(Atte Disorder), IDD(Intelled Disorder)-Mild, Interm Schizophrenia, Mood Otherwise Specified), Constipation, Dyslipid Ataxia, strabismus an -physician's order 1/1, 20mg(milligram) inject seizures longer that 5 order dated 1/5/22; -physician's order date one spray alternating longer than 5 minutes	Post Traumatic Stress ention Deficit Hyperactivity ctual Developmental nittent Explosive Disorder, D/O(Disorder) NOS(Not Impulse D/O NOS, Iemia, Allergies, Reflux, d History of Seizures; /22 for Diastat t 10mg gel rectally for minutes with a discontinue ed 1/5/22 for Valtoco 10mg prn(as needed) for seizures					

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STATE FORM 6899 VG4S11 If continuation sheet 2 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A.				
		MHL080096	B. WING		02/04/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
BRENTWO	OOD		OME ROAD RY, NC 28144			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETE	
V 118	"hold Valtoco until pricand available from ph-physician's order dat 500mg two tablets da dated 1/24/22 for epil-physician's order dat 1mg one tablet three seizures/spasms.  Observation on 2/1/22 medications revealed -Diastat 20mg inject 1 seizures longer that 5 -Valtoco 10mg one spaceded) for seizures site; -levetiracetam 500mg site; -clonazepam 1mg ond dispensed 1/20/22.  Review on 1/28/22 ar from 11/1/21-1/27/22 -levetiracetam 500mg documented as admin with no signed physician's -legend on MAR designed and make the company of the company	or authorization is completed harmacy;" hed 1/10/22 for levetiracetam hilly with a discontinue order epsy; hed 1/10/22 for clonazepam times daily for  2 at 2:25pm of client #1's higher minutes dispensed 1/3/22; horay alternating prn(as longer than 5 minutes not on a two tablets daily not on the etablet three times daily  and 2/1/22 of client #1's MARs revealed: by two tablets daily was nistered 12/27/21-12/31/21 clian order prior to these  be tablet three times daily mistered 1/1/22-1/6/22 with the order prior to these dates; by the dosing dates from the dications; by the dosing dates from the client #3's record revealed:  client #3's record revealed:  24/88;	V 118	DEFICIENCY		
	-diagnoses of IDD, O	24/88; bstructive Sleep Apnea abetes, Hyperlipidemia,				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL080096	MHL080096 B. WING		02/04/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
BRENTW	OOD		OME ROAD RY, NC 28144			
0/0.15	STIMMADA ST	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTION	ON OVE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
V 118	Continued From page	e 3	V 118			
	Myopia, Ulcers, HTN, Acne, Osteoporosis and Seizures; -client #3 was in rehabilitation for a broken ankle from 10/6/21-12/30/21, returned to the facility on 12/31/21; -physicians' orders dated 1/5/22 for the following medications: Alendronate 70mg one tablet once a week for bone health, cordran 4mcg(microgram) apply every two days for itchy skin, Flonase 50mcg one spray daily for allergies and Petroleum jelly apply daily for dry skin/rashes; -physician order dated 1/5/22 for Ted Hose wear daily put on first thing in the morning and remove at night before bed.  Observations on 2/1/22 at 2:15pm of client #3's medications revealed: -Alendronate 70mg one tablet once a week not on site; -cordran 4mcg(microgram) apply every two days dispensed 1/4/22; -Flonase 50mcg one spray daily for allergies dispensed 1/4/22; -Petroleum jelly apply daily dispensed 3/2/21.					
	12/31/21-1/27/22 revelosing date of 1/7/22 explanation on the Macone tablet once a weel-dosing dates of 1/3/2 explanation on the Macone dates of 1/1/2 explanation on the Macone dates of 1/1/2 1/15/22-1/21/22 and with no explanation of 50mcg one spray dailedosing dates of 1/1/2	2 left blank with no AR for Alendronate 70mg ek; 22-1/27/22 left blank with no AR for cordran bly every two days; 22-1/5/22, 1/7/22-1/13/22, 1/24/22-1/27/22 left blank in the MAR for Flonase				

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_ ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL080096	B. WING		02/0	4/2022
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
BRENTWO	OOD		OME ROAD Y, NC 28144			
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118			V 118			
V 131	Verification  G.S. §131E-256 HEAREGISTRY (d2) Before hiring health care facility or health care facility shall be shall	HCPR - Prior Employment  LTH CARE PERSONNEL  Alth care personnel into a service, every employer at a all access the Health Care and shall note each incident opriate business files.	V 131			

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AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  A. BUILDING:  B. WING  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  609 NEWSOME ROAD	COMPLETED 02/04/2022
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	02/04/2022
ENO NEWSOME DOAD	
BRENTWOOD SALISBURY, NC 28144	
	ER'S PLAN OF CORRECTION (X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CO	RECTIVE ACTION SHOULD BE COMPLETE PRENCED TO THE APPROPRIATE DATE  DEFICIENCY)
V 131 Continued From page 5 V 131	
This Rule is not met as evidenced by: Based on records review and interviews, the facility failed to access the HCPR(Health Care Personnel Registry) for 3 of 3 staff (Staff #1, Qualified Professional/QP and Residential Team Lead/RTL). The findings are:  Review on 1/27/22 of personnel records revealed: -staff #1 was hired on 12/2/21, was a transfer from the parent agency in Tennessee, original hire date in Tennessee was 2/9/21 and the HCPR was accessed on 1/28/22; -the QP was hired on 4/19/21 and the HCPR was accessed on 7/22/21; -the RTL was hired on 12/18/19 and the HCPR was accessed on 2/19/21.  Interview on 2/4/22 with the Director of Operations revealed: -aware some the HCPRs were late; -have corrected the issue.	

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