Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		COMPLETED
		MHL097-071	B. WING		01/28/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
SPARTA F	ROAD HOME	77 SPARTA			
		NORTH W	ILKESBORO, N	C 28659	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 000	An annual and complaint survey was completed on 1/28/22. The complaint was unsubstantiated (intake #NC 00182801). Deficiencies were cited.		V 000		
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.				
The survey sample consisted of audits of 3 current clients.					
V 118	27G .0209 (C) Medic	ation Requirements	V 118		
	V 118  27G .0209 (C) Medication Requirements  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				

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

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) I			
		MHL097-071	B. WING	B. WING		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	•	/28/2022
SPARTA F	ROAD HOME		TA ROAD			
			WILKESBORO, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	<del>2</del> 1	V 118			
	checks shall be recor	r medication changes or ded and kept with the MAR pointment or consultation				
	This Rule is not met as evidenced by: Based on record reviews, interviews and observations, the facility failed to ensure that medications were administered to a client only on the written order of a physician and that medications were recorded immediately after administration affecting 3 of 3 current clients (#1, #2, and #3). The findings are:					
	record revealed: -admitted on 2/13/17 -diagnoses of Intelled	erate; Bipolar Disorder (d/o),				
	orders for Client #1 re -the following medicaChlorpromazine (an (mg) one tablet threeDivalproex (anticon) bedtime (qhs)Fluvoxamine (antide twice a day (BID)Linzess (gastrointes (mcg) one capsule da	tions were ordered 1/10/21: tipsychotic) 100 milligrams times per day (TID) vulsant) 500mg 3 tablets at epressant) 25mg one tablet stinal) 290 micrograms				

Division of Health Service Regulation

STATE FORM 6899 NIR511 If continuation sheet 2 of 14

Division of	<u>of Health Service Regu</u>	lation				
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVE	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	)
		MHL097-071	B. WING		01/28/2022	
NAME OF D	ROVIDER OR SUPPLIER	QTDEET /	ADDRESS, CITY, STAT	TE ZIR CODE	•	
NAME OF FI	TOVIDER OR SUFFLIER		, ,	E, ZIF GODE		
SPARTA F	ROAD HOME		RTA ROAD	0.0000		
			WILKESBORO, NO			
(X4) ID		TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) OMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
V 118	Continued From page	<u> </u>	V 118			
, ,,,			• • • •			
	to affected area daily					
		ticonvulsant) 300mg one				
	tablet BID	1 A illi-mana talalat				
	BID ordered 1/20/21	arkinson) 1 milligram tablet				
		ctrolyte) one tablet BID				
		mia) 325mg one tablet qd				
	ordered 10/28/21					
		amine) 10mg one tablet qd				
	ordered 5/5/20					
	_	les (laxative), mix 1 capsule				
	in 240 milliliters of wa 10/5/20	ater and give BID ordered				
		otection factor (spf) 15, apply				
		ed area of face daily after				
	bath ordered 11/4/19	•				
		chotic) 2.5mg one tablet BID				
	ordered 4/29/21	, 3				
	-Olanzapine (antipsyd	chotic) 5 mg one tablet qhs				
	4/29/21					
	-Vitamin B-12 2500m 9/3/19	ncg one tablet qd ordered				
		kiety) 0.5mg one tablet BID				
	for 7 days ordered 11					
		/62.5mg take 2 tablets BID				
	for 10 days ordered 1	0/21/21.				
	Review on 1/24/22 at	nd 1/25/22 of Client #1's				
		and December 2021 and				
	January 2022 reveale					
	-Vitamin D-3 2000 un					
		- 1/24/22 without a written				
	physician's order					
	-Amoxicillin 875/125m	ng one tablet BID				
	administered 11/29/2	11 to 1/9/22 without a written				
	physician's order					
	-there was a handwri	tten note that the Thermo				

tablets had been discontinued but there was no

discontinuation order in the chart

STATE FORM 6899 NIR511 If continuation sheet 3 of 14

	or riealth Service Regu		<del></del>		<del></del>		
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	EIED	
		MHL097-071	B. WING		01/3	28/2022	
		11112007-071			1 01/2	.0/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE, ZIP CODE			
SPARTA F	ROAD HOME		TA ROAD				
OI AITIA I	COAD HOME	NORTH V	VILKESBORO, N	NC 28659			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE	
				52.16.2.16.1			
V 118	Continued From page	e 3	V 118				
	there were no initial	on 12/20/21 indicating that					
		s on 12/30/21 indicating that					
	the 8:00pm dose was						
	Benztropine 1 mg, Di						
	_	Metamucil single, Olanzapine					
		omg, Oxcarbazepine 300mg,					
	and Amoxicillin 875/1						
		on 12/30/21 indicating that					
		om doses were administered					
	for Chlorpromazine 100 mg.  Interview on 1/24/22 with Client #1 revealed:						
	-	o questions regarding his					
	medications; ne want	ed to talk about his music.					
	Boylow on 1/24/22 o	nd 1/25/22 of Client #2's					
		ind 1/25/22 of Gliefit #2 \$					
	record revealed:	2					
	-admitted on 12/21/13						
	_	affective d/o, Eating d/o,					
	Depression, Obsession	•					
		y of Pulmonary Embolism,					
		esophageal Reflux Disease					
	(GERD), Constipation	n, and Appendectomy.					
	D - : i - : : - : 4/05/00 - f	:					
		physician orders for Client					
	#2 revealed:	and 40/5/04 for the following					
		ed 10/5/21 for the following					
	medications:						
		crine)70mg one tablet once					
	per week on Mondays						
		g chew one tablet daily					
	Atorvastatin 10mg	•					
	• `	Parkinson) 0.5mg one tablet					
	BID Coloium/Vitamin D	12 600mg/400u ann tablet					
		3 600mg/400u one tablet					
	BID	0.11.4					
	Divalproex 500mg						
		o) 2mg one tablet qhs					
		) 60mg one tablet BID					
		nosis)20mg 2 tablets qhs					
	Rexulti (schizoaffec	tive) 3mg one tablet daily					

Division of Health Service Regulation

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DIVISION	of Health Service Regu	liation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
			7 50.25			
		MHL097-071	B. WING	<del></del>	01/2	28/2022
NAME OF D	DOVIDED OD CLIDDLIED	CTDEET A	DDRESS, CITY, STA	TE 710 CODE		
NAIVIE OF P	ROVIDER OR SUPPLIER		, ,	KIE, ZIP CODE		
SPARTA F	ROAD HOME	77 SPAR	TA ROAD			
		NORTH '	WILKESBORO, I	NC 28659		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	DATE
				DEI IOIENOT)		
V 118	Continued From page	e 4	V 118			
		ake 2 capsules qhs order				
	dated 8/25/20.					
	Review on 1/24/22 ar	nd 1/25/22 of Client's #2's				
	MARs for November	and December 2021 and				
	January 2022 revealed	ed:				
	-there were no initials	s on 12/30/21 indicating that				
	the 8:00pm doses we	ere administered for				
	Atorvastatin 10mg, Bo	enztropine 0.5mg,				
	Calcium/Vitamin D3 600mg/400u, Divalproex					
	500mg, Eszopiclone	2mg, Latuda 60mg, and				
	Olanzapine 20mg					
	-there were no initials	on 12/30/21 and 12/31/21				
	indicating the daily do	ose of Hydroxyzine 25mg				
	was administered					
	-there were no initials	on 11/30/21 indicating the				
	daily dose of Aspirin 8	81mg was administered				
	-there were no initials	on 11/15/21 and 1/17/22				
	indicating that the we	ekly dose of Alendronate				
	70mg was administer	red				
	-there was no explana	ation on the MAR for the				
	missed medications.					
	Review on 1/27/22 of	medication error reports for				
	Client #2 revealed:	·				
	-an error report was o	completed for the 1/17/22				
	missed dose for Alene					
		ot completed for any other				
	missed medications.	,				
	Interview on 1/24/22	with Client #2 revealed:				
	-she took medication					
	medication "when I ar					
		1-1				
	Review on 1/24/22 ar	nd 1/25/22 of Client #3's				
	record revealed:					
	-admitted on 12/21/13	3				
	-diagnoses of Intermi					
	Schizophrenia- disorg					
		ic d/o, Oppositional Defiant				
	Depression, Psycholi	ic a/o, Oppositional Deliant				

Division of Health Service Regulation

STATE FORM 6899 NIR511 If continuation sheet 5 of 14

DIVISION	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (	OF CORRECTION	DENTIFICATION NUMBER:	' '		COMPL	ETED
			A. BOILBING.	<del></del>		
		MHL097-071	B. WING		01/2	8/2022
					•	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
SDVDTV E	OAD HOME	77 SPAR	TA ROAD			
SFARIA	TOAD HOME	NORTH '	WILKESBORO, 1	NC 28659		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ı	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE	DATE
				DEFICIENCY)		
V 118	Continued From page		V 118			
V 110	Continued From page	; 5	V 110			
	disorder, Mild IDD, Er	nuresis, Hemorrhoids,				
	Hypertension.	·				
	71					
	Review on 1/25/22 ar	nd 1/27/22 of physician's				
		for Client #3 revealed:				
		on) 300mg XL one tablet in				
	the morning	on, doding AL one tablet in				
	•	atological) 0.77% apply to				
	face BID	atological) 0.77 % apply to				
		atamina) Francisco tab daile				
		stamine) 5mg one tab daily				
		ion) 10mg one tablet daily				
		n 0.75% apply to face BID				
	. , .	sion) 30mg one tablet at				
	bedtime					
	-Polyeth glycol (const	ipation) mix 17grams in 4 to				
	8 ounces of liquid and	d drink three times per week				
	-Quetiapine (psychos	is) 100mg one tablet in the				
	morning	,				
		is) 400mg one tablet every				
	evening	, 3				
	•	1% apply to scalp and leave				
	on for 3 minutes then					
		ake 2 tablets by mouth daily				
	- Vitallilli Do oolllog te	and 2 tablets by mount daily				
	Review on 1/24/22 ar	nd 1/25/22 of Client #3's				
		mber 2021 and January				
	2022 MARs revealed					
		on 11/30/21 indicating that				
	the 8:00pm doses we					
		Metronidazole cream				
		ampoo 1% and Mirtazapine				
	30mg					
		on 12/30/21 indicating that				
	the evening dose of C	. •				
	Metronidazole cream	0.75%, Ciclopirox Shampoo				
		g, and Quetiapine 400mg				
	were administered	, ,				
		on 12/15/21 indicating the				
		il 10mg was administered				
		yrup, 5 mls by mouth daily				
	-i iyuromet ə/ i.əmg s	yrup, o mis by mount daily				

Division of Health Service Regulation

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	PLETED
			B. WING			
		MHL097-071	B. WING		01	/28/2022
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
SPARTA F	ROAD HOME		TA ROAD	10.00050		
			WILKESBORO, N			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	e 6	V 118			
	as needed for up to 1 11/24/21 to 11/7/21 w order -there was no explanate the missed medication. Interview on 1/24/22 the takes medications names of the medications names of the medicationsstaff give him his medidn't know if he missed. Interview with the Rest 1/24/22 revealed: -she has overseen the hif there were missing were to complete a minif there was a blank of previous shift, staff kn receive their medication.	0 days was administered vithout a written physician's ation on the MAR explaining ins.  with Client #3 revealed: so but could not recall the tions dication when it's time; he sed any doses.  sident Team Lead (RTL) on its facility for 18 years initials on the MAR, staff nedication error report on the MAR from the mew if the client didn't ion because the pill would				
	revealed: -she has worked at the three years -if she noticed a blank the RTL or the staff we she would know if the because the pill would for that dose -if the staff person did that was considered a was a form to comple  Interviews on 1/25/22 the Qualified Professionshe spoke with the First staff person did that was considered a was a form to comple	and 1/26/22 with Staff #1  the facility for approximately  ix on the MAR, she notified who missed initialing the medication wasn't given the still be in the bubble pack that give the medication then the medication error and there the.  2, 1/26/22 and 1/27/22 with the ional (QP) revealed:  IXTL and the staff who 2/30/21 stated she gave the				

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL097-071	B. WING		01/28/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
SPARTA R	OAD HOME	77 SPART	A ROAD ILKESBORO, N	IC 29650		
(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	client didn't receive the would see the pill from bubble pack -it is agency policy to report if that were to conursing staff -it is agency policy that the bubble packs at the returned to nursing -she verified with nursing -she verified with nursing -she completed an in-reviewing company periodications immediate completing the medication administrated to the failure to a medication administrated termined if clients in ordered by the physical 27G .0209 (H) Medical 10A NCAC 27G .0208 REQUIREMENTS (h) Medication errors.	next shift would know if a neir medication because they in the previous dose in the complete a medication error occur which is given to at any extra medications in the end of the cycle are sing staff that the turned to the pharmacy for eservice training on 1/26/22 tolicy on initialing for tely after administration and ation error report form.  Inccurately document ation it could not be eceived their medication as tian.  Ation Requirements  In MEDICATION  Drug administration errors are drug reactions shall be	V 118	DEFICIENCY)		
	pharmacist. An entry and the drug reaction	of the drug administered shall be properly recorded client's refusal of a drug				

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		MHL097-071	B. WING		01	/28/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
SPARTA I	ROAD HOME		RTA ROAD WILKESBORO, N	C 28659		
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 123	Continued From page	e 8	V 123			
	facility failed to report immediately to a phys affecting 3 of 3 currer The findings are:  Review on 1/24/22 ar record revealed: -admitted on 2/13/17 -diagnoses of Intelled Disability (IDD), model History of Constipation Childhood Seizures.  Review on 1/25/22 ar orders for Client #1 re-Benztropine (anti-Parante one tablet twice a day-Chlorpromazine (anti-Parante three times per-Divalproex (seizures bedtime (qhs) ordered 1/10/21 -Metamucil fiber singlin 240 milliliters (ml) ordered 10/5/20 -Olanzapine (antipsydordered 4/29/21 -Olanzapine (antipsydordered 4/29/21 -Oxcarbazepine (seizured 1/1/21)	ews and interviews, the a medication errors sician or pharmacist and clients (#1, #2, and #3).  Ind 1/25/22 of Client #1's equal Developmental erate, Bipolar Disorder (d/o), on, Acid Reflux, and evealed: erkinson) 1 milligram (mg) of (BID) ordered 1/20/21 eipsychotic) 100 mg one enday (TID) ordered 1/10/21 elesion) 25mg one tablet BID eles (laxative), mix 1 capsule of water and give BID echotic) 2.5mg one tablet BID echotic) 5 mg one tablet qhs eures/bipolar) 300mg one				

Division of Health Service Regulation

MARs for November and December 2021 and

STATE FORM 6899 NIR511 If continuation sheet 9 of 14

Division	of Health Service Regu	ialion i	1		1
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		MHL097-071	B. WING		01/28/2022
		MHC097-071			01/20/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
004074	2045 110145	77 SPAR	A ROAD		
SPARIA	ROAD HOME	NORTH V	/ILKESBORO, N	IC 28659	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(* /
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
V 123	Continued From page 9		V 123		
	Continued From page				
	January 2022 reveale	ed:			
	-there were no initials	on 12/30/21 indicating that			
	the 8:00pm dose was	administered for			
	Benztropine 1 mg, Di	valproex 500mg,			
	Fluvoxamine 25mg, N	/letamucil single, Olanzapine			
	2.5 mg, Olanzapine 5	mg, Oxcarbazepine 300mg,			
	and Amoxicillin 875/125 -there were no initials on 12/30/21 indicating that the 3:00pm and 8:00pm doses were administered for Chlorpromazine 100 mg				
	-no evidence that the				
	pharmacy or the phys				
	. , ,				
	Review on 1/24/22 ar	nd 1/25/22 of Client #2's			
	record revealed:				
	-admitted on 12/21/13	3			
	-diagnoses of Schizoa	affective d/o, Eating d/o,			
	Depression, Obsessiv				
		y of Pulmonary Embolism,			
		esophageal Reflux Disease			
	(GERD), Constipation	· ·			
	,, ,				
	Review on 1/25/22 of	physician orders for Client			
	#2 revealed:				
	-physician orders date	ed 10/5/21 for the following			
	medications:	_			
	-Alendronate (endoc	crine) 70mg one tablet once			
	per week on Mondays	S			
	-Aspirin chew 81mg	one tablet daily			
	-Atorvastatin 10mg o				
		arkinson) 0.5mg one tablet			
	BID	· -			
	-Calcium/Vitamin D3	3 600mg/400u one tablet			
	BID	-			
	-Divalproex 500mg	2 tablets qhs			
		2mg one tablet qhs			
		60mg one tablet BID			
		osis) 20mg 2 tablets qhs			

Division of Health Service Regulation

dated 8/25/20.

-Hydroxyzine 25mg take 2 capsules qhs order

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Division of Health Service Regulation

DIVISION	of Health Service Regu	liation				
STATEMENT	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		MHL097-071	B. WING	<del></del>	01/2	28/2022
NAME OF D	DOVIDED OD CUDDUED	CTDEET A	DDDECC CITY CTA	TE 710 CODE		
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	II E, ZIP CODE		
SPARTA F	ROAD HOME	77 SPAR	TA ROAD			
017111711	(0)(5)(10)(12	NORTH V	WILKESBORO, N	NC 28659		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
V 123	Continued From page	- 10	V 123			
V 120	20 Continued From page 10		V 125			
	Review on 1/24/22 ar	nd 1/25/22 of Client's #2's				
	MARs for November	and December 2021 and				
	January 2022 reveale					
		s on 12/30/21 indicating that				
	the 8:00pm doses we					
	Atorvastatin 10mg, B					
	_	600mg/400u, Divalproex				
	500mg, Eszopiclone 2mg, Latuda 60mg, and Olanzapine 20mg -there were no initials on 12/30/21 and 12/31/21					
		ose of Hydroxyzine 25mg				
	was administered					
		on 11/30/21 indicating the				
		81mg was administered				
	-there were no initials	s on 11/15/21 and 1/17/22				
	indicating that the we	ekly doses of Alendronate				
	70mg had been admi	nistered				
	-a medication error re	eport was completed for the				
	1/17/22 missed dose	of Alendronate; it was				
	signed by the facility's	s Licensed Practical Nurse				
	(LPN) but the physicia					
	, , ,	ff contacted a pharmacy or				
	the physician.	,				
	   Review on 1/24/22 ar	nd 1/25/22 of Client #3's				
	record revealed:	14 1/20/22 01 0110111 //00				
	-admitted on 12/21/13	3				
	-diagnoses of Intermi					
	Schizophrenia- disorg					
		-				
		c d/o, Oppositional Defiant nuresis, Hemorrhoids,				
		nuresis, nemormolas,				
	Hypertension.					
	D : 4/05/05	14/07/00 6 1				
		nd 1/27/22 of physician's				
		for Client #3 revealed:				
		atological) 0.77% apply to				
	face BID					
		ion) 10mg one tablet daily				
	-Metronidazole cream	n 0.75% apply to face BID				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE SI	
			A. BUILDING:			
		MHL097-071	B. WING		01/2	8/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SPARTA R	ROAD HOME	77 SPARTA				
		NORTH WI	LKESBORO, N	IC 28659	Г	
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 123	Continued From page	<del>:</del> 11	V 123			
V 120	-Mirtazapine (depress-Quetiapine (psychosevening) -Ciclopirox shampoo on for 3 minutes then Review on 1/24/22 ar November and Decer 2022 MARs revealed -there were no initials the 8:00pm doses we Ciclopirox gel 0.77%, 0.75%, Ciclopirox Sha 30mg -there were no initials the evening dose of CMetronidazole cream 1% Mirtazapine 30mg were administered -there were no initials daily dose of Lisinopr-no evidence that the pharmacist or the phy Interview on 1/25/22 arevealed: -staff were expected the error report and forwarshe sent an in-service 1/26/22 regarding the	sion) 30mg one tablet qhs is) 400mg one tablet every  1% apply to scalp and leave rinse off at bedtime  and 1/25/211 of Client #3's anber 2021 and January  and 1/30/21 indicating that are administered for ampoo 1% and Mirtazapine  and 1/30/21 indicating that ciclopirox gel 0.77%,  0.75%, Ciclopirox Shampoo generate and Quetiapine 400mg  and Quetiapine 400mg  and 1/26/22 with the QP  and 1/26/22 with the QP  and complete a medication and it to nursing for review the training form to staff on a medication policy, ion error report before the	V 120			
V 736	•	and Grounds Maintenance	V 736			
	10A NCAC 27G .0303 EXTERIOR REQUIRI (c) Each facility and it	EMENTS				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY					
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED					
		MHL097-071	B. WING		01/28/2022						
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE							
SPARTA ROAD HOME 77 SPARTA ROAD											
SPARTA ROAD HOME NORTH WILKESBORO, NC 28659											
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE					
V 736	Continued From page 12		V 736								
. 100	maintained in a safe,	clean, attractive and orderly kept free from offensive	,,,,,								
	This Rule is not met as evidenced by: Based on observations and interviews, the facility was not maintained in a safe, clean and attractive manner. The findings are:										
	Observations at 5:09pm and 5:35pm on 1/24/22										
	vents throughout the -a vent measuring apinches on the wall ne -a vent measuring apthe wall under a close -a vent on the wall in measuring approxima -a ceiling vent in the I approximately 3 feet to be dust covering the around dinner plate in the living room was and appeared to cover -there was an approximate the base of the cliving room and kitched -the bathroom on the cracked toilet seat -the bathroom in Clief the toilet tank lid	Client #1's bathroom ately 12 inches by 6 inches iving room measuring x 3 feet had what appeared be majority of the vent size metal piece on the wall be separated from the wall er a vent pipe imately 2 inch round hole door located between the									
	the front of the facility	measuring approximately 4 ing paint around the entire									

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL097-071	B. WING		01	1/28/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
SPARTA R	OAD HOME		RTA ROAD WILKESBORO, NC	29650		
0/0.15	SUMMARY STA	PROVIDER'S PLAN OF	CORRECTION	0/5)		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 736	Continued From page 13		V 736			
	and not owned -the Direct Support M order approximately 3 toilet tank lid and app weeks to replace the -she will follow up with vents	ad (RTL) revealed:  Illity that the agency leased  entor (DSM) put in the work  to 4 weeks ago for the  roximately in the last 2				

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