Division of Health Service Regulation

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|---------------------------|---|------|-------------------------------|--|
| , | | 152.1111.107.11101.11101.1152.11 | A. BUILDING: _ | A. BUILDING: | | | |
| | | MHL080-169 | B. WING | B. WING 05/16/2022 | | 6/2022 | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | | |
| CABARRI | JS COUNTY GROUP HO | ME 10 | ELOT ROAD RY, NC 28147 | | | | |
| (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 | (X5) COMPLETE DATE | |
| V 000 | INITIAL COMMENTS | | V 000 | | | | |
| | An annual survey was completed on May 16, 2022. Deficiencies were cited. The facility is licensed for the following service | | | | | | |
| | | 27G .5600C Supervised Developmental Disability. | | | | | |
| The facility is licensed for 6 and currently has a census of 5. The survey sample consisted of audits of 3 current clients. | | | | | | | |
| V 114 | 27G .0207 Emergence | y Plans and Supplies | V 114 | | | | |
| | 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. | | | | | | |
| | failed to ensure fire a | nd record review, the facility nd disaster drills were arterly and repeated for gs are: | | | | | |

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

TITLE (X6) DATE Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
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| MHL080-169 | | B. WING | | 05/16/2022 | | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | |
| CABARRI | JS COUNTY GROUP HOM | ΛΕ 10 | LOT ROAD Y, NC 28147 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | / MUST BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COM | (5) PLETE ATE |
| V 114 | (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 114 Continued From page 1 Disaster Drill Log revealed: -No A shift disaster drills for 2nd Quarter (April-June), 2021; -No B shift fire drills and no A or B shift disaster drills for 3rd Quarter (July-September), 2021; -No A or B shift disaster drills for 4th Quarter (October - December), 2021; -No B shift disaster drills for 1st Quarter (January - March), 2022; -No A or B shift disaster drills for 2nd Quarter (April - June), 2022. Interview on 5/13/22 with House Manager (HM) #1 revealed: -Completed fire and disaster drills monthly; -Completed both drills on one wee of her shift - completing the fire drill one day and the disaster drill the next day. Interview on 5/13/22 with HM #2 revealed: -Completed fire and disaster drills weekly; -Completed on drill on each of his two weeks which he worked; -Documentation of the emergency drills are kept in the log at the facility. Interview on 5/12/22 and 5/16/22 with the Administrator/Licensee revealed: -HM #1 and HM #2 are responsible for completing fire and disaster drills at the facility; -HM#1 and HM#2 work 7 days on and 7 days off | | V 114 | | | |
| | completing fire and di -HM#1 and HM#2 wor with HM#1 working SI Shift B; -HM#1 and HM#2 will disaster drill training of -Fire and disaster drill | saster drills at the facility; | | | | |

Division of Health Service Regulation

STATE FORM 5899 ZVCH11 If continuation sheet 2 of 5

PRINTED: 05/16/2022 FORM APPROVED

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | , , | (X2) MULTIPLE CONSTRUCTION (A. BUILDING: | | | |
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| | | MHL080-169 | B. WING 05/1 | | /16/2022 | |
| NAME OF P | ROVIDER OR SUPPLIER | | DDRESS, CITY, STATE | E. ZIP CODE | 1 00 | 710/2022 |
| | | 160 CAM | ELOT ROAD | ., 0001 | | |
| CABARRI | JS COUNTY GROUP HO | ME 10 SALISBU | JRY, NC 28147 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETE DATE |
| V 118 | Continued From page | 2 | V 118 | | | |
| V 118 | 27G .0209 (C) Medica | ation Requirements | V 118 | | | |
| | | | | | | |

Division of Health Service Regulation

STATE FORM 5899 ZVCH11 If continuation sheet 3 of 5

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | , , | (X3) DATE SURVEY COMPLETED | | |
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| NAME OF D | | | | 7/0.0005 | 1 00 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | |
| NAME OF P | ROVIDER OR SUPPLIER | | DDRESS, CITY, STATE | , ZIP CODE | | | |
| CABARRI | US COUNTY GROUP HO | ME 10 | ELOT ROAD IRY, NC 28147 | | | | |
| | CUMMADVCT | ATEMENT OF DEFICIENCIES | | DDOVIDEDIC DI ANI OF CO | NODECTION. | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | ED TO THE APPROPRIATE DATE | | |
| V 118 | Continued From page | e 3 | V 118 | | | | |
| | failed to ensure MAR | nd record review, the facility s were kept current affecting (Client #1). The findings | | | | | |
| | revealed: -Admitted 2/26/18; -Diagnosed with Opp Depressive Disorder, Disorder, Asthma, Es Glaucoma; -Medication order dat (antibiotic) 100mg 1 t days; -April, 2022 MAR reve | and 5/13/22 with the | | | | | |
| | -Received an order d health provider for Cli 100mg too be admini (10 pills); -Order was processed 4/6/22 at approximated -Medication was delive | ated 4/6/22 from a local ient #1 for Nitrofurantoin stered twice daily for 5 days d and sent for delivery on | | | | | |
| | #1 revealed: -Client #1's Nitrofurar -Administered the las on 4/12/22; -When asked about the April, 2022 MAR in Nitrofurantoin to Clier | with House Manager (HM) Intoin was started on 4/6/22; It dose of the Nitrofurantoin The presence of her initials on indicating administration of int #1 after 4/12/22, HM#1 Ity signed on the other days, | | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | | |
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| MHL080-169 | | | B. WING 05/ | | | /16/2022 | | |
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| CABARRI | JS COUNTY GROUP HO | ME 10 | ELOT ROAD RY, NC 28147 | | | | | |
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| V 118 | honestly it was just an Interview on 5/13/22 v-Received Client #1's transcribed it on the N-10 pills were delivered. The medication was days; -It was an oversight the signed as administered of the month. Interview on 5/12/22 and Administrator/Licensed-HM#1 and HM#2 will medication administrative week of 5/16/22; | with HM #2 revealed: Nitrofurantoin and MAR; ed; to be administered for 5 hat the medication was ed on the MAR until the end and 5/16/22 with the ee revealed: | V 118 | | | | | |

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