	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED		
		MHL031-078	B. WING		07/	27/2022		
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	CITY, STATE, ZIP CODE				
	EALTHCARE INC	321 ROE	ERT F HARGF	ROVE ROAD				
		MOUNT	OLIVE, NC 28	365				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / 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) COMPLET DATE		
V 000	INITIAL COMMEN	rs	V 000					
	An annual survey w 2022. Deficiencies	/as completed on July 27, were cited.						
	This facility is licensed for the following service category: 10A NCAC 27G .5600C, Supervised Living for Adults with Developmental Disabilities.							
		sed for 6 and and currently has survey sample consisted of	3					
V 113	27G .0206 Client Records		V 113					
	 (a) A client record sindividual admitted contain, but need n (1) an identification (A) name (last, first (B) client record nu (C) date of birth; (D) race, gender an (E) admission date (F) discharge date; (2) documentation of developmental disa diagnosis coded ac (3) documentation of assessment; (4) treatment/habiliti (5) emergency information of the persist sudden illness or an and telephone numphysician; 	face sheet which includes: , middle, maiden); mber; nd marital status; , of mental illness, ubilities or substance abuse cording to DSM IV; of the screening and tation or service plan; rmation for each client which me, address and telephone on to be contacted in case of ccident and the name, address ber of the client's preferred	5					
	responsible person	ent from the client or legally granting permission to seek om a hospital or physician;						

STATEMEN	of Health Service Re T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COM	
		MHL031-078	B. WING		07/	27/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PEACE H	HEALTHCARE INC		ERT F HARGF DLIVE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 113	Continued From pa	ige 1	V 113	BEHOLINO	')	
V 113	Continued From page 1 (7) documentation of services provided; (8) documentation of progress toward outcomes; (9) if applicable: (A) documentation of physical disorders diagnosis according to International Classification of Diseases (ICD-9-CM); (B) medication orders; (C) orders and copies of lab tests; and (D) documentation of medication and administration errors and adverse drug reactions. (b) Each facility shall ensure that information relative to AIDS or related conditions is disclosed only in accordance with the communicable disease laws as specified in G.S. 130A-143.					
	failed to maintain a clients audited (#1. Finding #1: Review on 7/27/22 -42 year-old male a -Diagnoses include developmental disa pulmonary disease disorder, and overa -No consent to see treatment under cu	view and interview the facility complete record for 3 of 3 #2, #3). The findings are: of client #1's record revealed: admitted 1/22/20 id intellectual and ability- mild, chronic obstructive , seizure disorder, psychotic active bladder k emergency care and				
vision of H	Finding #2: Review on 7/27/22 -55 year-old male a -Diagnoses include ealth Service Regulation					

Division of Health Service Regulation STATE FORM

6899

THD811

If continuation sheet 2 of 9

STATEMEN	of Health Service Re NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. DUILDING.			
		MHL031-078	B. WING		07/:	27/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
PEACE I	HEALTHCARE INC		ERT F HARGE LIVE, NC 283			
(X4) ID			ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	HE APPROPRIATE	COMPLET DATE
V 113	Continued From pa	ge 2	V 113			
	schizoaffective disc	k emergency care and				
	-50 year-old male a -Diagnoses include developmental disa schizophrenia, seiz and anemia	d intellectual and				
	stated:	2 the qualified professional the forms were completed.				
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	only be administered order of a person a drugs. (2) Medications sha clients only when a client's physician. (3) Medications, ind administered only b unlicensed persons pharmacist or other privileged to prepar (4) A Medication Ad all drugs administered					

STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		MHL031-078	B. WING		07/	27/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
PEACE	IEALTHCARE INC		ERT F HARGF OLIVE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
	recorded immediate MAR is to include the	ely after administration. The	V 118			
	 (C) instructions for (D) date and time the field of the field of	, and quantity of the drug; administering the drug; he drug is administered; and of person administering the for medication changes or corded and kept with the MAR appointment or consultation				
		view and interview the facility urrent MAR's for 3 of 3 clients				
	-42 year-old male a -Diagnoses include developmental disa	d intellectual and bility- mild, chronic obstructive , seizure disorder, psychotic	•			
	dated 1/31/22 revea -Risperidone - 1 mi (antipsychotic) -Vitamin D3 - 125 m daily (vitamin-d def	lligram (mg): 1 tablet daily nicrograms (mcg)- 1 tablet				

STATE FORM

	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHJ 024 078				(X3) DATE SU COMPLE	
		MHL031-078	B. WING		07/	27/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
PEACE	IEALTHCARE INC		ERT F HARGF OLIVE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pa	ge 4	V 118			
	(nerve pain) -Risperidone 2mg - (antipsychotic) -Atorvastatin 40mg cholesterol) -Oxybutynin 5mg - bladder) -Fluvoxamine 100m (obsessive compuls -Gabapentin 300mg (nerve pain) Review of May, 202 -No MARs for May Finding #2: Review on 7/27/22 -55 year-old male a -Diagnoses include developmental disa schizoaffective disco Review on 7/27/22 dated 1/31/22 revea -Pantoprazole Sodi (gastroesophageal -Atorvastatin 40mg -Clozapine 200mg - (antipsychotic) -Divalproex Sodium -Benztropine 2mg -	 1 capsule in the evening 1 tablet in the evening 1 tablet in the evening (high 1 tablet twice daily (overactive ng - 1 capsule twice daily sive disorder) g - 1 capsule three times daily 22 - July, 2022 MARs revealed of 2022. of client #2's record revealed: dmitted 1/22/20 d intellectual and bility- mild, hypertension, and order-bipolar type of client #2's signed FL2 form aled: um 40mg - 1 tablet daily 	:			
	blood pressure)	- 1 tablet twice daily (high 22 - July, 2022 MARs revealed	:			

STATE FORM

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		MHL031-078	B. WING		07/	27/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PEACE	HEALTHCARE INC		ERT F HARGF DLIVE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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	(X5) COMPLET DATE
V 118	Continued From pa	ge 5	V 118			
	-50 year-old male a -Diagnoses include developmental disa schizophrenia, seiz and anemia Review on 7/27/22 dated 1/31/22 revea -Certavite - 1 tablet -Ferrous Sulfate 32 -Atorvastatin 10mg -Paroxetine 20mg - (antidepressant) -Divalproex Sodium morning -Lisinopril 20mg - 1 pressure) -Pantoprazole Sodi (gastroesophageal -Divalproex Sodium evening -Carbamazepine 20 (seizures) -Sodium Chloride 1 (hydration) -Metformin 1000mg (diabetes) -Risperidone 3mg - Review of May, 202 -No MARs for May Interview on 7/27/2 -Clients received m -He had been out o	d intellectual and bility- moderate, ure disorder, hypertension, of client #3's signed FL2 form aled: daily (vitamin deficiency) 5mg - 1 tablet daily (anemia) - 1 tablet daily 1 tablet in the morning 250mg - 2 tablets in the tablet daily (high blood um 40mg - 1 tablet daily reflux disease) 500mg - 1 tablet twice daily gm - 1 tablet twice daily gm - 1 tablet twice daily 1 tablet twice daily 2 - 1 tablet twice daily 2 - 1 tablet twice daily 2 - 1 tablet twice daily				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		MHL031-078	B. WING		07/	27/2022
AME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST	TATE, ZIP CODE		
PEACE H	IEALTHCARE INC	321 ROB	ERT F HARGE DLIVE, NC 28	ROVE ROAD		
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736			
	EXTERIOR REQUI (c) Each facility and maintained in a safe	10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive				
		on and interview the facility in a safe, clean, attractive				
	revealed: -A fly strip was iden of the dining room v insects stuck to it. -Unidentified brown stains, were noted of	7/22 at approximately 9:30am tified in the upper left corner with more than 25 dead stains, resembling liquid on the dining room walls. s food and beverage stains on o the kitchen.				
	-A kitchen cabinet of stovetop was missin protruding from the once was. -Grease stains were the stovetop. -The microwave ha	loor to the left under the ng. There were 3 nails open area where the door e observed on the wall behind d peeling paint and rust spots				
	corners of the living insects attached to	rips located in the upper room with over 25 dead them. roximately 6-8"was observed				

STATE FORM

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		MHL031-078	B. WING		07/	27/2022			
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE					
PEACE HEALTHCARE INC 321 ROBERT F HARGROVE ROAD MOUNT OLIVE, NC 28365									
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE			
V 736	from client #5's bed -The closet doors in the hinges and prop drawer underneath Knobs from client # there were broken s the far left next to th -Client #4's bedroon and mildew forming in the middle of the was mildew forming shower/tub and a lig fixture over the van -The showerhead a shower wall and the touch in bathroom # from the back corne on the vanity in bath During interview on Professional reveal	was emitting a chirping sound lroom. In client #4's bedroom were off oped against the wall. A client #4s bed was broken. 4's dresser were missing and slats in the bedroom blinds on the bathroom. In bathroom had paint peeling on the window frame located shower/tub. In addition, there g in the left corner of the ghtbulb missing in the light ity. Ind faucet were loose from the e handle was loose to the #1. Caulking was separating er of the wall around the fauce hroom #1.							
V 752	10A NCAC 27G .03 EQUIPMENT (b) Safety: Each fa constructed and eq ensures the physica visitors. (4) In areas c exposed to hot wate	ot Water Temperatures 604 FACILITY DESIGN AND cility shall be designed, uipped in a manner that al safety of clients, staff and of the facility where clients are er, the temperature of the tained between 100-116 t.	V 752						

STATEMEN	of Health Service Re T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		MHL031-078	B. WING		07/27/202	
NAME OF F	ROVIDER OR SUPPLIER		DRESS, CITY, ST	TATE, ZIP CODE		
PEACE H	IEALTHCARE INC		ERT F HARGE LIVE, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
V 752	water temperatures 100-116 degrees Fa clients were expose are: Observation on 7/2 revealed: -The hot water tem bathroom was 81 d -The hot water tem was 80 degrees Fa Interview on 7/27/2 stated:	et as evidenced by: ion and interview, the facility is were not maintained between ahrenheit in areas where ed to hot water. The findings 7/22 at approximately 9:30am perature in client #4's egrees Fahrenheit at the sink. perature at the kitchen sink hrenheit. 2 the Qualified Professional up to ensure the proper range	V 752			
vision of He	ealth Service Regulation		6899 T L	HD811		ation sheet 9