| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ' | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---------------|--|--|----------------|--|-------------------------------|--|
| | | | A. BUILDING: | | | |
| | | MHL054-180 | B. WING | | R-C 18/2022 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| | ~~. | 3101 HEN | IRY BOULEV | ARD | | |
| HAMILTON | | | I, NC 28504 | | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRE | (X5) | |
| PRÉFIX TAG | | ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) | COMPLETE DATE | |
| V 000 | INITIAL COMMENT | TS . | V 000 | | | |
| | | low up survey was completed . Deficiencies were cited. | | | | |
| | category: 10A NCA | sed for the following service C 27G .5600C Supervised h Developmental Disabilities. | | | | |
| | | sed for 3 and currently has a urvey sample consisted of clients. | | | | |
| V 117 | 27G .0209 (B) Med | ication Requirements | V 117 | | | |
| | (1) Non-prescription dispensed by a phat manufacturer's labely visible; (2) Prescription meteor obtained as samt tamper-resistant parisk of accidental in packaging includes with tamper-resistal unit-of-use package may be adequate; (3) The packaging drug dispensed mutof, the client's name (B) the prescriber's (C) the current dispersed of the cur | kaging and labeling: In drug containers not Irmacist shall retain the Isle with expiration dates clearly edications, whether purchased ples, shall be dispensed in lickaging that will minimize the gestion by children. Such plastic or glass bottles/vials nt caps, or in the case of ed drugs, a zip-lock plastic bag label of each prescription st include the following: lee; lee name; leensing date; for self-administration; ligth, quantity, and expiration | | | | |
| | pharmacy or disper | ess, and phone number of the nsing location (e.g., mh/dd/sa me of the dispensing | | | | |

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

(X6) DATE TITLE

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
|--------------------------|--|--|---------------------|--|-------------------|--------------------------|
| | - 1. m | | R- 08/1 | C 8/2022 | | |
| NAME OF I | PROVIDER OR SUPPLIER | | DRESS, CITY, S | STATE, ZIP CODE | 1 00/1 | 0.2022 |
| HAMILTO | ON | | RY BOULEV | /ARD | | |
| | OLIMANA DV. OTA | | , NC 28504 | PROVIDERIO PLANTOS COPRECTIO | | 4.5 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| V 117 | Continued From pa | ge 1 | V 117 | | | |
| | practitioner. | | | | | |
| İ | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | TI: D | | | | | |
| | This Rule is not me Based on record re | et as evidenced by: view and interview the facility | | | | |
| | failed to ensure that | t medications for | | | | |
| | | e labeled as required for 1 of 2 nt #2). The findings are: | | | | |
| | Daview on 9/17/22 | of alight #21g record revealed | | | | |
| | -37 year old male a | of client #2's record revealed: dmitted 10/2/15. | | | | |
| | -Diagnoses include | d Paranoid Schizophrenic, | | | | |
| | | omental Disability- Moderate, Hyperactive Disorder, Seizure | | | | |
| | Disorder and Mild C | Cognitive Impairment. | | | | |
| | -Physician's order of a packet in the nost | lated 5/12/22 for Sinus Rinse, | | | | |
| | · | • | | | | |
| | | 7/22 at approximately nt #2's medications on hand | | | | |
| | revealed: | m #2 5 medications on hand | | | | |
| | | with 24 unopened packets out | | | | |
| | of a quantity of 30. -No pharmacy label | I with the prescriber's name, | | | | |
| | pharmacy dispense | date, directions for | | | | |
| | administration, or p | harmacy information. | | | | |
| | | 8/17/22 the Director of | | | | |
| | Operations stated h | ne did not know why there was | | | | |
| | | for client #2's Sinus rinse. He uirement to maintain the | | | | |
| | pharmacy label for | client medications and would | | | | |
| | discuss it with the n | nedication coordinator. | | | | |
| | | | | | | |

Division of Health Service Regulation

STATE FORM 6899 MFWB11 If continuation sheet 2 of 8

| | IT OF DEFICIENCIES | | (V2) MULTIPL | E CONSTRUCTION | (V2) DATE | SLIDVEV |
|-------------------|--|--|----------------|--|-------------------|----------|
| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | (X3) DATE COMP | LETED |
| | - | | A. BUILDING: | | | |
| | | | D WING | | R- | |
| | | MHL054-180 | B. WING | | 08/1 | 8/2022 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| | | 3101 HEN | RY BOULEV | ARD | | |
| HAMILTO | ON | KINSTON | NC 28504 | | | |
| (V4) ID | SLIMMARV STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| (X4) ID PREFIX | | MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOUL | | COMPLETE |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION) | | TAG | CROSS-REFERENCED TO THE APPRO DEFICIENCY) | PRIATE | DATE |
| | | | | DEI IOIEIGET) | | |
| V 118 | Continued From pa | ge 2 | V 118 | | | |
| V 118 | 27G .0209 (C) Med | ication Requirements | V 118 | | | |
| | 10A NCAC 27G .02 REQUIREMENTS | 09 MEDICATION | | | | |
| | (c) Medication adm | inistration: | | | | |
| | | non-prescription drugs shall | | | | |
| | | ed to a client on the written | | | | |
| | | uthorized by law to prescribe | | | | |
| | drugs. | , , | | | | |
| | | all be self-administered by | | | | |
| | | uthorized in writing by the | | | | |
| | client's physician. | | | | | |
| | | cluding injections, shall be | | | | |
| | | y licensed persons, or by | | | | |
| | | trained by a registered nurse, | | | | |
| | | legally qualified person and e and administer medications. | | | | |
| | | ministration Record (MAR) of | | | | |
| | | red to each client must be kept | | | | |
| | | s administered shall be | | | | |
| | | ely after administration. The | | | | |
| | MAR is to include the | | | | | |
| | (A) client's name; | | | | | |
| | | and quantity of the drug; | | | | |
| | \ / | administering the drug; | | | | |
| | | ne drug is administered; and | | | | |
| | ` ' | of person administering the | | | | |
| | drug. | | | | | |
| | | for medication changes or | | | | |
| | checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. | | | | | |
| | | | | | | |
| | a priyotolari. | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | This Rule is not me | et as evidenced by: | | | | |

Division of Health Service Regulation

STATE FORM 6899 MFWB11 If continuation sheet 3 of 8

| ווטופועום | of Health Service Re | eguiation | 1 | | , | |
|-------------------|--|--|--------------|--|-------------------------------|------------------|
| | IT OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPL | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMP | LETED |
| | | | | | R- | .c |
| | | MHL054-180 | B. WING | | | 8/2022 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AF | DRESS CITY S | STATE, ZIP CODE | | |
| 10 101 | TO VIDER OR GOLF EIER | | NRY BOULEV | , | | |
| HAMILTON KINSTON | | | AILD | | | |
| (V4) ID | SI IMMADV STA | TEMENT OF DEFICIENCIES | - | PROVIDER'S PLAN OF CORRECTION | N. | (VE) |
| (X4) ID PREFIX | | / MUST BE PRECEDED BY FULL | ID PREFIX | (EACH CORRECTIVE ACTION SHOUL | .D BE | (X5) COMPLETE |
| TAG | REGULATORY OR L | SC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPRO DEFICIENCY) | PRIATE | DATE |
| | | | | BEITGIENOTY | | |
| V 118 | Continued From pa | ge 3 | V 118 | | | |
| | | views and interviews, the | | | | |
| | | ninister medications on the | | | | |
| | | hysician affecting two of two | | | | |
| | clients (#1 and #2). | The illidings are: | | | | |
| | Review on 8/17/22 | of client #1's record revealed: | | | | |
| | -31 year old male. | | | | | |
| | -Admission date of | 10/2/15. | | | | |
| | | lar Disorder, Intermittent | | | | |
| | • | , Autism, Attention Deficient | | | | |
| | | er, Anxiety, Allergic Rhinitis, | | | | |
| | Periodontal Diseas | e and Constipation. | | | | |
| | Review on 8/17/22 | of client #1's signed | | | | |
| | | dated 12/4/21 and 8/8/22 | | | | |
| | revealed: | | | | | |
| | | ar) 2 milligrams (mg) take 1 | | | | |
| | twice daily. | 00/ D: / : : ::: \ 40 | | | | |
| | milliliter (ml) swish | 2% Rinse (gingivitis) 10 | | | | |
| | | g (anxiety) 1 at bedtime. | | | | |
| | | id) 40mg 1 twice daily. | | | | |
| | | ar) 4mg 1 twice daily. | | | | |
| | | y) 100mg 1 at bedtime. | | | | |
| | . | | | | | |
| | | of client #1's August 2022 | | | | |
| | MARs revealed the -Benztropine 2 mg | | | | | |
| | | o/ 13/22 at 6.00pm. nl 8/13/22 at 8:00pm. | | | | |
| | | g 8/8/22 and 8/13/22 at | | | | |
| | 8:00pm. | <u> </u> | | | | |
| | -Famotidine 40mg | | | | | |
| | -Risperidone 4mg 8 | | | | | |
| | -Trazodone 100mg | 8/13/22 at 8:00pm. | | | | |
| | Intonvious on 9/17/0 | 2 client #1 stated he received | | | | |
| | his medications as | 2 client #1 stated he received | | | | |
| | mo modications as | 0.40.04. | | | | |
| | Review on 8/17/22 | of client #2's record revealed: | | | | |

Division of Health Service Regulation

-37 year old male.

STATE FORM 6899 MFWB11 If continuation sheet 4 of 8

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|-------------------|---|---|-------------------------|--|-------------------------------|--------------------------|
| | | | | | R-C | |
| | | MHL054-180 | B. WING | | 08/1 | 8/2022 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| HAMILTO | ON | | RY BOULEV , NC 28504 | ARD | | |
| (X4) ID PREFIX | 4) ID SUMMARY STATEMENT OF DEFICIENCIES EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO | D BE | (X5) COMPLETE DATE |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION) | | TAG | DEFICIENCY) | MAIL | 5/112 |
| V 118 | -Admission date of 10/2/15Diagnoses of Paranoid Schizophrenic, Moderate Intellectual Disabilities, Attention Deficient Hyperactive Disorder, Seizure Disorder, Mild | | V 118 | | | |
| | Review on 8/17/22 medication orders of Clonazepam (anxionate) -Clonazepam (anxionate) -Clonazepam (anxionate) -Artificial Tears Droeach eye dailyMelatonin (insomnate) -Melatonin (insomnate) -Melatonin (anxionate) -Melatonin (a | of client #2's signed dated 03/3/22 revealed: ety) 0.5mg 1 three times daily. e rinse) Packet 1 in nostril ps (dry eyes) 1.4% 1 drop ia) 5mg 1 at bedtime. of client #2's July 2022 and revealed the following blanks: g 7/29/22 at 2:00pm. | | | | |
| | 8:00am: August 2022: -Artificial Tears Dro 8:00pm. -Clonazepam .5mg -Melatonin 5mg 8/ | ket 7/28/22 -7/30/22 at ps 1 drop each eye 8/13/22 at 8/13/22 at 8:00pm. 13/22 at 8:00pm. 2 client #2 stated he received | | | | |
| | (QP) stated: -She had assisted a medication data system -The client's medicathem. | 2 the Qualified Professional with training staff on the stem. ations were always available to | | | | |
| | Interview on 8/18/22 the Medication Coordinator stated: -The QP had not documented the medications as | | | | | |

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STATE FORM 6899 MFWB11 If continuation sheet 5 of 8

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|---|---|---|---------------------|---|--------------------------------------|--|
| | | | 7. Bolebino. | | R-C | |
| | | MHL054-180 | B. WING | | 08/18/2022 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADD | DRESS, CITY, S | STATE, ZIP CODE | | |
| HAMILTON | | RY BOULEV NC 28504 | ARD | | | |
| (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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | TION SHOULD BE CO THE APPROPRIATE | |
| V 118 | Continued From pa | ge 5 | V 118 | | | |
| | given on those days | s when she worked the shift. | | | | |
| V 736 | Interview on 8/17/2 stated: -He understood me administered as ord the Medication Cool This deficiency con and must be correct 27G .0303(c) Facili 10A NCAC 27G .03 EXTERIOR REQUITED (c) Each facility and maintained in a safe | 2 the Director of Operations edications were to be dered and would discuss it with ordinator. stitutes a re-cited deficiency eted within 30 days. ty and Grounds Maintenance | V 736 | | | |
| | was not maintained and orderly manner Observation on 8/1 11:20am revealed: -The kitchen windor fridge was dirty and Dark spills on the fland the refrigerator -2 doors on the bac ripped away from the A discarded refriger | on and interview, the facility in a safe, clean, attractive T. The findings are: 7/22 at approximately w and window sill beside the interview in between the cabinet in the blind had a broken slat; oor in between the cabinet in the porch had screens that were | | | | |

Division of Health Service Regulation STATE FORM

6899 MFWB11 If continuation sheet 6 of 8

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | ` / | X3) DATE SURVEY COMPLETED | |
|---|---|---------------------------|---|------------------------|------------------------------|--|
| AND FLAN OF CONNECTION | IDENTIFICATION NOMBER. | A. BUILDING: | A. BUILDING: | | | |
| | MHL054-180 | B. WING | | R-C —— 08/18 | | |
| NAME OF PROVIDER OR SUPPLIE | R STREET AL | DRESS, CITY, S | STATE, ZIP CODE | | | |
| HAMILTON | | IRY BOULEV I, NC 28504 | ARD | | | |
| PREFIX (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T | .D BE | (X5) COMPLETE DATE | |
| had rust spots ar -The hall bath ha away at the corn approximately 3 wood on the floo -Client #2's bedre the double windo and the other blir vent cover was re heavy dust and h missing 3 knobsClient #1's bedre and paint chipper stained areas in heavy dust and to the blades; The coverClient #1's bath required emptyin with brown/dark se between the tiles shower faucet; tr -The hallway retu -There were 2 loo the back door en Interview on 8/18 stated she had n items discussed Interview on 8/17 Operations state -The landlord was refrigerator away -There had been landlord was in the This deficiency h | g vent above the carport door and was hanging from the ceiling. It was pulled ar of the shower and an foot (ft) long by 2 ft piece of the shower and toilet. From window sill had heavy dust, whad a blind with 1 broken slated had 2 broken slate; the ceiling usty, table lamp shade had is 3 drawer night stand was from door had a surface crack draway on the front; 3 large the carpet; the ceiling vent had he ceiling fan had heavy dust on closet light fixture did not have a from had a trashcan that g; the shower had several areas stains; 4 tiles were missing under the he window sill had heavy dust. For every dust, went had heavy dust. For every dust on the ceiling inside the facility at trance. 1/22 the Qualified Professional of questions regarding facility at exit of the survey. 1/22 and 8/18/22 the Director of dictics supposed to take the | V 736 | | | | |

Division of Health Service Regulation

STATE FORM 6899 MFWB11 If continuation sheet 7 of 8

| | MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR COMPLETE (X3) DATE SUR COMPLETE | | SURVEY PLETED | | | | |
|--------------------------|---|--|----------------------------|--|--------------------------|--------------------------|--|
| | | MHL054-180 | B. WING | | R-C 08/18/2022 | | |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | | |
| HAMILT | ON | | ENRY BOULEV N, NC 28504 | /ARD | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETE DATE | |
| V 736 | Continued From parwithin 30 days. | ge 7 | V 736 | | | | |

Division of Health Service Regulation

STATE FORM 6899 MFWB11 If continuation sheet 8 of 8