STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
,	o. oo.u.20o		A. BUILDING:			
		MHL019-021	B. WING		08/3	1/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PERKINS	S PLACE		DLINA AVEN			
	0.10.40.40.70.70.40.70.70.70.70.70.70.70.70.70.70.70.70.70		ΓY, NC 2734 Τ			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	rs	V 000			
	An annual and complaint survey was completed on August 31, 2022. The complaint was substantiated (intake #NC00191260). Deficiencies were cited.					
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.					
		sed for 6 and currently has a urvey sample consisted of clients.				
V 118	27G .0209 (C) Med	lication Requirements	V 118			
	only be administered order of a person a drugs.  (2) Medications shat clients only when a client's physician.  (3) Medications, included administered only builties only builties only builties only builties on their privileged to prepare (4) A Medication Act all drugs administer current. Medication recorded immediate MAR is to include the (A) client's name;  (B) name, strength,	inistration: non-prescription drugs shall ed to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by a trained by a registered nurse, r legally qualified person and re and administer medications. Iministration Record (MAR) of red to each client must be kept administered shall be ely after administration. The the following:				
	(C) instructions for	administering the drug; ne drug is administered; and				

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		MHL019-021	B. WING		08/3	31/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PERKIN	S PLACE		DLINA AVENI TY, NC 2734			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 118	(E) name or initials drug. (5) Client requests checks shall be rec	ge 1 of person administering the for medication changes or orded and kept with the MAR appointment or consultation	V 118			
	facility failed to kee two of three current The findings are:  a. Review on 8/30/2 revealed: -Admission date of -Diagnoses of Mod Developmental Dist Diabetes, Gastroes Allergic Rhinitis, To Hypertension, Hypertension, Hypertension and H Review on 8/30/22 -Order dated 6/1/22 Review on 8/31/22 client #1 revealed: -No staff initials as 7/28 and 7/29 for bloomer the finding are sufficient.	views and interviews, the p the MARs current affecting audited clients (#1 and #2).  22 of client #1's record  8/26/15.  erate Intellectual or ability, Psychotic Disorder, ophageal Reflux Disease, bacco Dependence, Essential erlipidemia, Leukoplakia, earing Loss.  of physician's orders revealed: 2 for Blood Pressure Checks.  of the July 2022 MAR for checked on 7/19 thru 7/22, lood pressure.				

Division of Health Service Regulation
STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MIII 040 004			00/0	4/0000
		MHL019-021			08/3	1/2022
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S D <b>LINA AVEN</b> I	STATE, ZIP CODE		
PERKINS	SPLACE		Y, NC 2734			
(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 APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 2	V 118			
		Intellectual or Developmental Attention Deficit Disorder and It Disorder.				
	-Order dated 9/8/21 (mg) (Anemia), one 50 mg (Depression	of physician's orders revealed: for Folic Acid 1 milligrams tablet twice daily; Sertraline , Anxiety Disorder), one tablet -35-28 (Birth Control), one				
	Review on 8/31/22 of the July 2022 MAR for client #2 revealed: -No staff initials as administered on 7/29 for Folic Acid 1 mg and Sertraline 100 mgNo staff initials as administered on 7/23 for Alyacen 1-35-28.					
	-She wasn't sure with blood pressure was 2022She knew client #1 and possibly refuse checked because substituting -She thought staff fully 2022 MAR to it givenShe confirmed state current for clients #1 Interview on 8/31/2.	r medications as prescribed. orgot to sign off on client #2's ndicate the medication was  ff failed to keep the MARs				
	#1 and #2.  Due to the failure to medication adminis	the MARs current for clients  accurately document tration it could not be received their medications				

Division of Health Service Regulation

STATE FORM B70I11 If continuation sheet 3 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	LTIPLE CONSTRUCTION (X3) DATE COMPI		
		MHL019-021	B. WING		08/3	1/2022
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/0	172022
PERKINS	S PLACE		LINA AVEN			
			Y, NC 2734			
(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 118	Continued From pa	ge 3	V 118			
	as ordered by the p	hysician				
V 738	27G .0303(d) Pest	Control	V 738			
	EXTERIOR REQUI	03 LOCATION AND REMENTS be kept free from insects and				
	This Rule is not me Based on observati staff failed to mainta environment. The f	ons and interviews the facility ain an insect free				
	of client #2 revealed	eddish bite marks on both				
	of client #5 revealed	ately eight pinkish colored				
	of client #1's bedroo -The box spring cov	1/22 at approximately 8:55 am om revealed: ver had approximately eight and brownish bug shells.				
	Attempted interview unsuccessful becau	on 8/31/22 with client #1 was use she was deaf.				
	-She was tired of se	2 with client #2 revealed: eeing bed bugs in the facility. in the facility were small and				

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL019-021	B. WING		08/31/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		-
PERKINS	S PLACE		LINA AVEN			
	-		Y, NC 2734			
(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 APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 738	Continued From pa	ge 4	V 738			
	2022. She saw a be bedroomShe last saw bed be she had a bed bug Interview on 8/31/2: -She heard the faci she never saw any	2 with client #3 revealed: lity had bed bugs, however in the facility. es on her arms. She wasn't				
	-She was itching and staff told her she was probably being bitten by bed bugs.					
	Interview on 8/31/22 with client #4 revealed: -She knew the facility had bed bugsShe thought she saw a bed bug last night on her bedShe was never bitten by any bed bugs. She heard some of the other clients were being bitten by bed bugsShe thought client #2 was being bitten by bed bugs a lot because she saw bites on her arms and legs.					
	-She heard the other bed bugs in the factory and the saw and s	y bed bugs in the facility. eing bitten by something, never see anything biting her. omething wrong in the facility, what it was at the time.  2 with staff #1 revealed: #3 brought it to her attention				

Division of Health Service Regulation

STATE FORM B70I11 If continuation sheet 5 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL019-021	B. WING		08/3	1/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PERKIN	S PLACE		LINA AVENI			
	I		Y, NC 2734	4		
(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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 738	Continued From pa	ge 5	V 738			
	bug issueShe did put powder powder was supposed interview on 8/31/2: -The facility had an -She started seeing June 2022She saw bed bugs comforterClient #1 also told -Client #1 had bug -The majority of the bugsShe reported the is #1 in June 2022She thought staff # and a powder to try -Staff #1 started sp the powder in June -She felt like the sp bugs did not workShe continued to sclients were still bei	r around client #1's bed. The sed to help with the bed bugs.  2 with staff #2 revealed: issue with bed bugs. bed bugs in the facility in in client #1's bedroom on her that she was itching. bites on her arms. It clients were bitten by the bed issue with the bed bugs to staff and get rid of the bed bugs. It is also the facility and using 2022. It is also the facility and using 2022. It is also the facility and ing bitten.				
	-She thought the ist attention at beginning. -She was visiting of streaks on her bedone- -She kept looking a bug on the bed shirt- -She called the Execute the bed bug that sature. -She stripped the bedoling.	ient #1 and saw some dark ding. round the bed and saw a bed t. ecutive Director about seeing				

Division of Health Service Regulation

STATE FORM B70I11 If continuation sheet 6 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. BOILDING.			
		MHL019-021	B. WING		08/3	1/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
PERKIN	S PLACE		LINA AVEN			
	OLIMA AA DV OTA		Y, NC 2734		211	0.5
(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 APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 738	Continued From pa	ge 6	V 738			
	Executive Director -The facility had an -She thought the ist their attention towa -Staff #3 noticed mclient #1Staff #2 also notice armsShe contacted pesof August 2022The pest control costaffed and could n 6, 2022When the bed bug #3 she sprayed clie Alcohol was suppos -They also purchas brought 15 of them while the clients we -About 3 or 4 days facilityThey were trying to bed bugs at firstThey wanted to us because bed bug tr -A heat treatment fo \$7000.00. The age	issue with bed bugs. Sue with the bed bugs came to ords end of July 2022. The property of the control company the middle of the company said they were short of come out until September of the swere first discovered by staff on the staff of the company said they were short of the come out until September of the swere first discovered by staff on the staff of the swere short of the search of the staff of th				

Division of Health Service Regulation STATE FORM