| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING |  | (X3) DATE SURVEY<br>COMPLETED   |                         |
|---|---|---|---|--|---------------------------------|-------------------------|
|   |   | MHL092-573  |   |  |                                 | R<br>09/20/2022         |
| NAME OF   | PROVIDER OR SUPPLIER  |   | DDRESS, CITY, ST                                |  |                                 |                         |
| MEEKS   | #2  |   | GEMONT ROA<br>_L, NC 27591                      | D  |                                 |                         |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                             | PROVIDER'S PLAN OF (<br>(EACH CORRECTIVE ACT)<br>CROSS-REFERENCED TO T<br>DEFICIENC' | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| ∨ 000   | INITIAL COMMENTS  |   | V 000   |  |                                 |                         |
|   | An annual and follow up survey was completed on 9/20/22. Deficiencies were cited.   |   |   |  |                                 |                         |
|   | This facility is licensed for the following service category:10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.  |   |   |  |                                 |                         |
|   | currently has a cent  | sed for five clients and<br>sus of five. The survey<br>f audits of three current  |   |  |                                 |                         |
| V 112   | 27G .0205 (C-D)<br>Assessment/Treatn  | nent/Habilitation Plan  | V 112   |  |                                 |                         |
|   | PLAN<br>(c) The plan shall be<br>assessment, and in<br>legally responsible<br>of admission for clie<br>receive services be<br>(d) The plan shall i<br>(1) client outcome(<br>achieved by provisi<br>projected date of ac<br>(2) strategies;<br>(3) staff responsibl<br>(4) a schedule for the<br>annually in consultar<br>responsible person<br>(5) basis for evaluar<br>outcome achievement<br>(6) written consent<br>responsible party, consultar | ILITATION OR SERVICE<br>be developed based on the<br>a partnership with the client or<br>person or both, within 30 days<br>ents who are expected to<br>yond 30 days.<br>nclude:<br>(s) that are anticipated to be<br>on of the service and a<br>chievement;<br>(e;<br>review of the plan at least<br>ation with the client or legally<br>or both;<br>ation or assessment of |   |  |                                 |                         |

02JN11

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br>MHL092-573 |   | . ,   | CONSTRUCTION        |  |                |                                     |  |
|---|---|---|---------------------|--|----------------|-------------------------------------|--|
|   |   | IDENTIFICATION NUMBER:  | A. BUILDING:        |  | COM            | COMPLETED                           |  |
|   |   | MHL092-573  | B. WING             | R<br><b>09/20/2022</b>   |                |                                     |  |
| NAME OF F   | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, ST    | TATE, ZIP CODE   |                |                                     |  |
| MEEKS   | <b>#2</b>   |   | GEMONT ROA          | D  |                |                                     |  |
|   |   |   | L, NC 27591         |  |                |                                     |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)                                     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | TION SHOULD BE | (X5)<br>COMPLE <sup>-</sup><br>DATE |  |
| V 112   | Continued From pa   | ge 1  | V 112               |  |                |                                     |  |
|   | failed to ensure one<br>treatment plan was<br>findings are:<br>Review on 9/14/22<br>-Admission date of<br>-Diagnoses of Schi<br>Retardation, Nutritio | view and interview the facility<br>of three (#1) client's<br>completed annually. The<br>of client #1's record revealed: |                     |  |                |                                     |  |
|   | -Not sure where the<br>she had the new or<br>-The Qualified Prof<br>and was sure she p  | 2 The Licensee stated:<br>e treatment plan would be as  |                     |  |                |                                     |  |
| V 118   | 10A NCAC 27G .02<br>REQUIREMENTS<br>(c) Medication adm<br>(1) Prescription or r<br>only be administered   |   | V 118               |  |                |                                     |  |

STATE FORM

02JN11

If continuation sheet 2 of 4

| Division  | of Health Service Re  | equiation   |                     |  | FORM                          | APPROVED                 |
|---|---|---|---------------------|--|-------------------------------|--------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  |                     |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|   |   | IDENTIFICATION NUMBER.  | A. BUILDING:        |  |                               |                          |
|   |   | MHL092-573  | B. WING             |  |                               | R<br><b>20/2022</b>      |
| NAME OF I   | PROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY,       | STATE, ZIP CODE  |                               |                          |
| MEEKS #   | ¥2  |   | GEMONT RO           |  |                               |                          |
| MILLING 7   | TZ  | WENDEL  | L, NC 2759          |  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENC | TION SHOULD BE                | (X5)<br>COMPLETE<br>DATE |
| V 118   | Continued From page 2   |   | V 118               |  |                               |                          |
|   | clients only when a<br>client's physician.<br>(3) Medications, ind<br>administered only b<br>unlicensed persons<br>pharmacist or other<br>privileged to prepar<br>(4) A Medication Ad<br>all drugs administe<br>current. Medication<br>recorded immediate<br>MAR is to include ti<br>(A) client's name;<br>(B) name, strength<br>(C) instructions for<br>(D) date and time ti<br>(E) name or initials<br>drug.<br>(5) Client requests<br>checks shall be reco<br>file followed up by a<br>with a physician. | , and quantity of the drug;<br>administering the drug;<br>he drug is administered; and<br>of person administering the<br>for medication changes or<br>corded and kept with the MAR<br>appointment or consultation |                     |  |                               |                          |
|   | medication was ad<br>of a physician. The  | e of three (#1) client's<br>ministered on the written order<br>e findings are:<br>of client #1's record revealed:   |                     |  |                               |                          |
|   | -Admission date of<br>-Diagnoses of Schi  | 5/18/08<br>zophrenia, Mild Mental   |                     |  |                               |                          |
| ivision of H<br>TATE FORI   | ealth Service Regulation  |   | 6899                |  | If continu                    | ation sheet 3 o          |

02JN11

| Division of Health Service Regulation         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         MHL092-573 |   |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED     |                         |
|--|---|--|---|--|-----------------------------------|-------------------------|
|  |   | B. WING  |   |  | R<br>09/20/2022                   |                         |
| NAME OF F  | PROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY, ST                        | TATE, ZIP CODE   |                                   |                         |
| MEEKS #  | <b>#2</b>   |  | GEMONT ROA<br>LL, NC 27591              | D  |                                   |                         |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO<br>DEFICIENC | FION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLET<br>DATE |
| V 118  | Continued From page 3   |  | V 118                                   |  |                                   |                         |
|  | Retardation, Nutritional Anemia, Chronic Reflux,<br>Hyperlipidemia, Hypertensive Heart Disease and<br>risk of fall. |  |   |  |                                   |                         |
|  | Review on 9/14/22 of client #'s physician order dated 3/7/22 revealed "Polyethylene Glycol, once a day."            |  |   |  |                                   |                         |
|  | Review on 9/14/22 of client #1's medications revealed the Polyethylene Glycol was not present in the facility.      |  |   |  |                                   |                         |
|  | Polyethylene Glyco  | of the MAR revealed the<br>I had been administered daily<br>Igust and September 2022.  |   |  |                                   |                         |
|  | -She had thrown th<br>because she was of<br>-The new bottle sho<br>-Always burned a b<br>and papers weekly          | 2 the Licensee stated:<br>nat bottle out yesterday<br>but.<br>ould be coming any day.<br>bag of old medication bottles<br>to protect the client's identity.<br>es from now on, until the new |   |  |                                   |                         |
|  |   |  |   |  |                                   |                         |
|  |   |  |   |  |                                   |                         |
|  |   |  |   |  |                                   |                         |

02JN11