Division of Health Service Regulation

T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			(X3) DATE SURVEY COMPLETED	
				F		
	MHL098-165	B. WING		11/3	0/2022	
ROVIDER OR SUPPLIER						
SY'S 1309						
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE	
INITIAL COMMENT	-S	V 000				
on November 30, 20 This facility is licens category: 10A NCAO Living for Adults with This facility is licens census of 4. The su	one of the following service of the following service of 27G .5600C Supervised of the Developmental Disabilities. Seed for 4 and currently has a survey sample consisted of					
Assessment/Treatm 10A NCAC 27G .02 TREATMENT/HABI PLAN (c) The plan shall be assessment, and in legally responsible pof admission for clie receive services be (d) The plan shall in (1) client outcome (achieved by provision projected date of ac (2) strategies; (3) staff responsible (4) a schedule for rannually in consultar responsible person (5) basis for evaluation outcome achieveme (6) written consent responsible party, o	O5 ASSESSMENT AND LITATION OR SERVICE De developed based on the partnership with the client or person or both, within 30 days ents who are expected to yond 30 days. Include: S) that are anticipated to be on of the service and a chievement; Developed of the plan at least atton with the client or legally or both; atton or assessment of ent; and or agreement by the client or a written statement by the	V 112				
	ROVIDER OR SUPPLIER SY'S 1309 SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS INITIAL COMMENT An annual and follor on November 30, 20 This facility is licens category: 10A NCAC Living for Adults with This facility is licens census of 4. The surplication of 3 current of the surplication of the surplication of the surplication of the plan shall be assessment, and in legally responsible por admission for client cereive services be (d) The plan shall in (1) client outcome (achieved by provision projected date of acceptable of the plan shall in (1) client outcome (2) strategies; (3) staff responsible projected date of acceptable of the plan shall in (1) client outcome (2) strategies; (3) staff responsible projected date of acceptable of the plan shall in (1) client outcome (2) strategies; (3) staff responsible projected date of acceptable of the plan shall in (2) strategies; (3) staff responsible provider stating why provider stating why	MHL098-165 ROVIDER OR SUPPLIER SY'S 1309 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An annual and follow up survey was completed on November 30, 2022. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 3 current clients. 27G .0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement; (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be obtained.	ROVIDER OR SUPPLIER STREET ADDRESS, CITY, S SY'S 1309 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An annual and follow up survey was completed on November 30, 2022. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. 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WING STREET ADDRESS, CITY, STATE, ZIP CODE 1309 GROVE STREET SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE) WAST OF PROPINGEN (EACH CORRECTION (MISSON IN 27893) SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE WAST OF PROPINGE INFORMATION) INITIAL COMMENTS An annual and follow up survey was completed on November 30, 2022. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 4 and currently has a census of 4. The survey sample consisted of audits of 3 current clients. 27G. 0205 (C-D) Assessment/Treatment/Habilitation Plan 10A NCAC 27G. 0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN (C) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. 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Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

DIVISION	Division of Health Service Regulation						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
						,	
		MHL098-165	B. WING		F 44/2	0/2022	
		WITE090-105			11/3	0/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
14100 D 4	10)///0 4000	1309 GRC	VE STREET	•			
MISS DA	ISY'S 1309	WILSON,	NC 27893				
(X4) ID	SHMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)	
PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE	
				DEFICIENCY)			
V 112	Continued From pa	age 1	V 112				
V	Continued i Tom pa		V				
	This Rule is not me						
		views and interviews, the					
		elop and implement goals and					
	•	ss client needs for one of three					
	audited clients (#1)	. The findings are:					
	D : :	2 1 44/00/00 - f -1' 1 //41-					
		2 and 11/30/22 of client #1's					
	record revealed:						
	- 70 year old male.	5.00/44/00					
	- Admission date of						
		izophrenia, Mood Disorder Not					
		d by history, Profound					
		omental Disability (IDD), Major					
		order, Obesity, Hypertension					
	and Diabetes.	1. 1.00/04/00					
	- Treatment Plan da						
		gies to address client #1's					
		plint and Continuous Positive					
	Airway pressure (C	FAF) use.					
	Peview on 11/20/22	2 and 11/30/22 of a signed					
		client #1 dated 11/23/21					
	revealed Pureed Di]	
	TOVERIEU FUICEU DI	ot.]	
	Review on 11/29/22	2 of an order for client #1 dated]	
		ne needed to wear a hand]	
	splint daily.	to hooded to wear a flama]	
	opinit dany.						
	Client #1 is nonvert	oal due to Profound IDD.					
		ca. add to i foldulid IDD.					
	Interview on 11/29/2	22 staff #1 stated:]	
	- Staff have to pure						

Division of Health Service Regulation STATE FORM

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Division of Health Service Regulation

	of Health Service Re	ľ	r		T.	
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		SURVEY PLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	- LC I CD
						R
		MHL098-165	B. WING		11/3	30/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
			OVE STREET	,		
MISS DA	ISY'S 1309		NC 27893			
(V4) ID	SHMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
(X4) ID PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO	ULD BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	ROPRIATE	DATE
V 112	Continued From pa	ge 2	V 112			
	- 2nd shift staff put	on client #1's hand splint for				
	one hour per day.					
		CPAP machine overnight.				
	Interview 11/30/22 t					
	Professional/Owner	r stated: lient #1's treatment plan				
		•				
	needed to contain strategies to address his needs.					
	- She would create a plan of correction to address					
	identified issues.	•				
V 114	27G .0207 Emerge	ncy Plans and Supplies	V 114			
		207 EMERGENCY PLANS				
	AND SUPPLIES					
		n for each facility and plan shall be developed and				
		by the appropriate local				
	authority.	y the appropriate local				
		e made available to all staff				
		cedures and routes shall be				
	posted in the facility	/.				
		r drills in a 24-hour facility				
		st quarterly and shall be				
		shift. Drills shall be conducted				
		at simulate fire emergencies. All have basic first aid supplies				
	accessible for use.	ill flave basic first ald supplies				
	accessible for use.					
	This Rule is not me					
		view and interviews the facility				
		and disaster drills were held nd repeated on each shift				
		at simulate fire emergencies.				
	The findings are:	at annuate in a cinergenoles.				

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XZJ711 If continuation sheet 3 of 8

Division of Health Service Regulation

OTATEMENT OF DEFICIENCIES (VA) PROVIDER/OURRI LER/OUR		(VO) MUUTIDI	E CONCERNICATION	(V2) DATE	CLIDVEV	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND LEAN	O. SOMEOTION	IDENTIFICATION NOMBER.	A. BUILDING:			
					F	≀
		MHL098-165	B. WING		1	0/2022
NAME OF F	PROVIDER OR SUPPLIER	CTDEFT ADI	DESS CITY O	STATE, ZIP CODE		
INAIVIE OF F	NO VIDER OR SUFFLIER		VE STREET			
MISS DA	ISY'S 1309	WILSON,	_			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
V 114	Continued From pa	de 3	V 114			
V 11-7	Continued i Tom pa	ge 5	V 114			
		of facility records for 2022				
	revealed:					
		drills for 2nd shift in the 3rd				
	quarter of 2022.					
		conditions that simulate fire				
		d shift for the 2nd and 3rd				
	quarters of 2022.					
	Interview on 11/29/22 staff #1 stated: - 1st shift was 7am to 3pm.					
	 - 2nd shift was 3pm to 11pm. - 3rd shift was 11pm to 7am. Interview on 11/30/22 the Assistant Director					
	stated:					
	- Staff should have	all residents leave the facility				
	during fire drills.					
	- He spoke with the	House Manager about the fire				
	drill procedures.	_				
V 117	27G .0209 (B) Med	ication Requirements	V 117			
	()	•				
	10A NCAC 27G .02	09 MEDICATION				
	REQUIREMENTS					
		kaging and labeling:				
		n drug containers not				
		rmacist shall retain the				
		el with expiration dates clearly				
	visible;					
		edications, whether purchased				
		ples, shall be dispensed in				
		ckaging 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				
	may be adequate;					
	(3) The packaging	label of each prescription				

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Division of Health Service Regulation						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	,
		MHL098-165	B. WING			0/2022
		WITE030-103			11/3	0/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1309 GRO	VE STREET	•		
MISS DA	ISY'S 1309	WILSON.	NC 27893			
(VA) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX		/ MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
				DEFICIENCY)		
V 117	Continued From pa	na 1	V 117			
V 117	Continued i Torri pa	196 -	V 117			
	drug dispensed mu	st include the following:				
	(A) the client's nam	ne;				
	(B) the prescriber's	s name;				
	(C) the current disp	pensing date;				
		for self-administration;				
	(E) the name, strer	ngth, quantity, and expiration				
	date of the prescrib					
		ess, and phone number of the				
		nsing location (e.g., mh/dd/sa				
	center), and the na	me of the dispensing				
	practitioner.					
	This Rule is not me					
		views, observation and				
		ity failed to maintain pharmacy				
	packaging labels as					
		spensed for one of three				
	audited clients (#2)	. The findings are:				
		2 of client #2's record revealed:				
	- 35 year old female					
	 Admission date of 					
		plar Disorder Unspecified,				
		Disorder Unspecified,				
		al Developmental Disability,				
		ve Disorder, Affective Mood				
		deficiency, Fetal Alcohol				
	Syndrome and Seiz	zures Disorder.				
		2 of client #2's signed				
		ated 09/20/22 revealed APRI				
	(birth control) take	one tablet daily.				
	Observation on 11/2	29/22 at approximately				

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If continuation sheet 5 of 8 XZJ711

Division of Health Service Regulation

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED	
			A. BOLDING.		 	,	
		MHL098-165	B. WING		1	0/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
MISS DA	ISY'S 1309		VE STREET NC 27893				
(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 APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 117	Continued From pa	ge 5	V 117				
		2's medications revealed: ills in a blue dust cover. the medication.					
	Interview on 11/29/22 staff #1 stated: - The blister pack of pills in the blue dust cover were birth control pills for client #2. - She was not able to locate the pharmacy label for client #2's birth control pills. Interview on 11/30/22 the Qualified Professional/Owner stated she understood all prescription medications should be properly labeled. [This deficiency constitutes a re-cite deficiency and must be corrected within 30 days.]						
V 120	27G .0209 (E) Med	ication Requirements	V 120				
	well-lighted, ventilat and 86 degrees Fal (B) in a refrigerator, degrees and 46 degrefrigerator is used shall be kept in a se or container; (C) separately for e (D) separately for e (E) in a secure mar for a client to self-m (2) Each facility that controlled substance	age: hall be stored: cked cabinet in a clean, led room between 59 degrees harenheit; if required, between 36 grees Fahrenheit. If the for food items, medications eparate, locked compartment ach client; xternal and internal use; harer if approved by a physician					

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Division of Health Service Regulation

Division of Health Service Regulation						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
						₹
		MHL098-165	B. WING			0/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
IVAIVIL OF I	NOVIDEN ON GOLL FIELD		OVE STREET			
MISS DA	ISY'S 1309		NC 27893			
	OLIMAN DV OTA	<u> </u>		DDOV/DEDIO DI ANI OF CODDECTIO		0.4=0
(X4) ID PREFIX		TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
V 120	Continued From pa	ge 6	V 120			
	·					
	subsequent amend	S. 90, Article 5, including any				
	subsequent amenu	ments.				
	This Rule is not me					
		views, observation and				
		ity failed to ensure a				
		ition was kept in a locked				
	compartment or container for one of three audited clients (#1).					
	Cilerits (#1).					
	Review on 11/29/22	2 and 11/30/22 of client #1's				
	record revealed:					
	- 70 year old male.					
	- Admission date of					
		izophrenia, Mood Disorder Not				
		d by history, Profound				
		omental Disability (IDD), Major				
	and Diabetes.	order, Obesity, Hypertension				
	and Diabetes.					
	Review on 11/29/22	of a signed FL-2 for client #1				
	dated 03/26/22 reve	•				
	- Xalatan (Latanopr	ost-treats high eye pressure)				
	0.005% (fridge) - 1	drop in each eye at bedtime.				
	Obs m 4 - 4	20/00 -4				
		29/22 at approximately				
	- Client food items.	lity client refrigerator revealed:				
	-	n eye drops was stored in a				
	plastic bag in the cl					
	Financia sag in the or					
	Interview on 11/29/2	22 staff #1 stated:				
	- There was not a lo	ock box for client #1's eye				
	drops.					
		Il medications in the facility				
	refrigerator should I	be kept in a locked box.				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		MUU 000 405	B. WING		F	
		MHL098-165	·		11/3	0/2022
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1309 GROVE STREET						
MISS DA	ISY'S 1309		NC 27893			
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 120	Continued From pa	ge 7	V 120			
V 120	Interview on 11/30/2 Professional/Owne	22 the Qualified r stated she understood all in the client refrigerator	V 120			

Division of Health Service Regulation STATE FORM