| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ′ | E CONSTRUCTION | (X3) DATE : | | | | |
|---|--|---|---------------------|---|------|--------------------------|--|--|
| | | | | | R-C | | | |
| | MHL034-224 | | B. WING | | 01/0 | 9/2023 | | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | | | |
| INDEPEN | INDEPENDENT LIVING GROUP HOME 924 CLOISTER DRIVE | | | | | | | |
| | TO ENTIRE CROO | WINSTON | N SALEM, NO | 27127 | | | | |
| (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 SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5) COMPLETE DATE | | |
| V 000 | INITIAL COMMENT | -s | V 000 | | | | | |
| | on 1/9/23. The com (intake #NC001958 Deficiencies were c | | | | | | | |
| | category: 10A NCA | sed for the following service C 27G .5600C Supervised ith Developmental Disabilities. | | | | | | |
| | | sed for 3 and has a census of ple consisted of audits of 3 | | | | | | |
| V 118 | 27G .0209 (C) Med | ication Requirements | V 118 | | | | | |
| | only be administere order of a person a | | | | | | | |
| | clients only when au client's physician. | all be self-administered by uthorized in writing by the | | | | | | |
| | administered only b unlicensed persons pharmacist or other | luding injections, shall be y licensed persons, or by trained by a registered nurse, legally qualified person and e and administer medications. | | | | | | |
| | (4) A Medication Ad all drugs administer current. Medication | ministration Record (MAR) of red to each client must be kept administered shall be alter administration. The | | | | | | |
| 1 | MAR is to include the (A) client's name; | ne following: | | | | | | |
| | (C) instructions for | and quantity of the drug; 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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | l ` ′ | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|--|---------------------------|--|-------------------------------|--------------------------|
| | | | | | R | R-C | |
| | | MHL03 | 4-224 | B. WING | | 01/0 | 09/2023 |
| NAME OF | PROVIDER OR SUPPLIER | | | | STATE, ZIP CODE | | |
| INDEPE | NDENT LIVING GROU | P HOME | | STER DRIVE I SALEM, NO | | | |
| (X4) ID PREFIX TAG | SUMMARY STA (EACH DEFICIENC) REGULATORY OR L | | EDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | ON SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE |
| V 118 | Continued From pa (E) name or initials drug. (5) Client requests checks shall be recipile followed up by a with a physician. | of person add for medication corded and ke | n changes or pt with the MAR | V 118 | | | |
| | This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a Medication Administration Record (MAR) was present and included the following: the client's name; name, strength, and quantity of the drug; instructions for administering the date and time the drug was administered; and the name or initials of person administering the drug affecting 1 of 3 current clients (client #1). The findings are: | | | | | | |
| | Review on 1/4/23 of an admission of a Diagnoses of Statellectual Development Hypertension Review on 1/4/23 of 11/18/22 to 1/4/23 of 11/18/22 to 1/4/23 of 11/18/20 of 11/18/2 | date of 9/6/17 Schizoaffective benental Disab of client #1's M revealed: being adminis ns: (a) Buprop (Sustained R t PO (by mou e Solution 1% tongue twice | e Disorder; Mild bility; Tachycardia MARs from tered the pion HCL Release) 150 mg th) twice daily; 5 ML (Milliliter) daily; (c) the morning and | | | | |

Division of Health Service Regulation

| DIVISION | Division of Health Service Regulation | | | | | | | | |
|---|---|-----------------------------|---|--|-----------------|--------------------------|----|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) | | (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPL | LE CONSTRUCTION | (X3) DATE SURVEY | | | |
| | | IDENTIFIC | CATION NUMBER: | A. BUILDING: | : | COMPLETED | | | |
| | | | | | | R- | -C | | |
| MHL034-224 | | B. WING | | 01/09/2023 | | | | | |
| NAME OF PROVIDER OR SUPPLIER STREET ADD | | | | DDESS CITY (| STATE, ZIP CODE | | | | |
| INAIVIE OF F | TROVIDER OR SUPPLIER | | | | • | | | | |
| INDEPEN | NDENT LIVING GROU | IP HOME | | STER DRIVE I SALEM, NO | | | | | |
| (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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE | | | |
| V 118 | Continued From pa | age 2 | | V 118 | · | | | | |
| | • | • | ~ · · · · · · · · · · · · · · · · · · · | | | | | | |
| | tab PO in the morni | | | | | | | | |
| | tablet PO at 4 pm (datablet PO in the morning | | | | | | | | |
| | tab PO in the morni | | | | | | | | |
| | (Sodium) ER (Exter | | | | | | | | |
| | PO in the evening; | | | | | | | | |
| | Squirt 1-2 sprays u | | | | | | | | |
| | 3 days. May increas | | | | | | | | |
| | thereafter; (i) Lithiu | | | | | | | | |
| | in the evening and | | | | | | | | |
| | PO in the evening | 0 , | - | | | | | | |
| | | | 12/1/22-12/31/22) | | | | | | |
| | was available for re | | | | | | | | |
| | medications: Parox | | | | | | | | |
| | the morning; (f) Ato | | | | | | | | |
| | the evening; (g) Div | | | | | | | | |
| | tab PO in the eveni | | | | | | | | |
| | Spray Squirt 1-2 sp bedtime for 3 days. | | | | | | | | |
| | per day thereafter; | | | | | | | | |
| | 2 tab PO in the eve | | | | | | | | |
| | mg 2 tab PO in the | | Hazouone 100 | | | | | | |
| | | Cvoning | | | | | | | |
| | Interview on 1/4/23 | with client # | :1 revealed: | | | | | | |
| | - Staff administe | red his medi | ications to him on | | | | | | |
| | a daily basis | | | | | | | | |
| | Interview on 1/4/23 | and on 1/0/ | 22 with the | | | | | | |
| | Director revealed: | and on 1/8/2 | 23 WIUT UIE | | | | | | |
| | - Client #1 was administered his medications as prescribed; however, one of the pages of the his MAR with the medications in question had been lost and unable to be located This deficiency constitutes a re-cite and must be | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | corrected within 30 | | cite and must be | | | | | | |
| | | days. | | | | | | | |
| V 736 | 27G .0303(c) Facility and Grounds Maintenance | | | V 736 | | | | | |

Division of Health Service Regulation STATE FORM

6899 If continuation sheet 3 of 6 2HK311

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|----------------------------|---|-------------------------------|---------|--|
| | | | | | R | R-C | |
| | | MHL034-224 | B. WING | | 01/ | 09/2023 | |
| NAME OF | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | | |
| INDEPE | NDENT LIVING GROU | PHOME | ISTER DRIVE N SALEM, NO | | | | |
| (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 C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY | (X5) COMPLETE DATE | | |
| V 736 | Continued From page 3 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 odor. | | V 736 | | | | |
| | This Rule is not met as evidenced by: Based on observations and interview, the facility was not maintained in a safe, clean, attractive and orderly manner. The findings are: Observation of the facility's interior on 1/4/23 between 3:44 pm and 3:55 pm revealed: (a) Kitchen: - A heavily scratched dining room table - The space where a dishwasher had been installed held an overflowing trash can (b) Client #1's bedroom: - Piles of clothing and baseball caps sitting on top of a desk - A four drawer dresser with two of the four drawers sitting on top of the dresser with clothing piled on top of the drawers and clothing spilling out of the spaces where the drawers would normally be inserted - A pile of clothing sitting next to the dresser - No curtains or window blinds present - Patched but unpainted areas on the closet door (c) Client #2's bedroom: - Items of clothing hanging from the one of the drawers of the dresser with additional items piled on top of the dresser - No curtains or window blinds present | | | | | | |

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | , , | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|---------------------|--|-------|--------------------------|
| | | A. BUILDING: | | | | |
| | | MHL034-224 | B. WING | | | -C)9/2023 |
| NAME OF | PROVIDER OR SUPPLIER | STREET ADD | ORESS, CITY, S | STATE, ZIP CODE | | |
| INDEDE | NDENT LIVING GROU | P HOME 924 CLOIS | STER DRIVE | : | | |
| INDEFE | ADENT EIVING GROO | WINSTON | SALEM, NO | 27127 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETE DATE |
| V 736 | • | | V 736 | | | |
| | A five drawer dimissing No curtains or view (e) The doorknob of (f) Splintered area | o door g lying on the floor of the closet resser with one drawer window blinds present on the back door was loose on the door to the closet nedications were stored | | | | |
| | 3:55 pm and 4 pm (a) - A covered (minivan) parked be - The license sticker dated "2-21" plate had expired ir - The van wa of dust that had cat and hood along with side windows and t (b) - The cemer entrance pad had be (c) - The alumin dents and dust on i (d) - The carpor covering the entiret (e) - An overflow having fallen from a the carport (f) - A mop and scratched and fadir (g) - Storage but facility that had dan approximately 16/15 the shingles | carport had a white vehicle eneath it e plate on the vehicle had a white vehicle had a white which indicated the license a February of 2021 as covered with a heavy layer paw prints on the windshield a writing in the dust on the he back window of the vehicle at floor on the carport and black stains um-type siding had multiple the surface to ceiling had black stains | | | | |
| | corner (i) - The door le | en hanging loose at one eading to the beneath the ed with peeling white paint | | | | |

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|--|---------------------------|--|-----------------------------------|--------------------------|
| | | MHL0 | 34-224 | B. WING | | | -C 09/2023 |
| NAME OF | PROVIDER OR SUPPLIER | | | | STATE, ZIP CODE | | |
| INDEPE | NDENT LIVING GROU | P HOME | | STER DRIVE I SALEM, NO | | | |
| (X4) ID PREFIX TAG | SUMMARY STA (EACH DEFICIENCY REGULATORY OR L | | CEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE |
| V 736 | Interview on 1/9/23 - Client #1 had a property destruction some of the damage times outside of the - She was in the repairs completed; property and items the backyard did not The deficiency consand must be correct | with Directo history of er and was re les inside the facility process of h however, it was such as the of belong to h | ngaging in esponsible for e facility and at naving some was a rental storage building in ner | V 736 | | | |

Division of Health Service Regulation STATE FORM