STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-157	A. BUILDING: _____ B. WING _____	R 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE 2	510 CRISSY DRIVE JACKSONVILLE, NC 28541

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and follow up survey was completed on January 19, 2023. 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 3. The survey sample consisted of audits of 3 current clients.	V 000		
V 112	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.	V 112		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-157	A. BUILDING: _____ B. WING _____	R 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE 2	510 CRISSY DRIVE JACKSONVILLE, NC 28541

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 1	V 112		

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to obtain written consent for treatment/habilitation or service plans annually for 3 of 3 (#1, #2, and #3) current clients. The findings are:

Review on 1/18/23 of client #1's record revealed:
- 62 year old female admitted 6/15/07.
- Diagnoses included Intellectual/Developmental Disability, mild; Unspecified Anxiety Disorder; Unspecified Neurocognitive Disorder; Schizoaffective Disorder, depressive Type; Diabetes.
- Guardian of the Person was a corporate advocacy agency.
- Person Centered Plan with short range goals and strategies dated 8/27/22; no guardian signature/consent.

Review on 1/18/23 of client #2's record revealed:
- 46 year old male admitted 9/20/21.
- Diagnoses included Intellectual/Developmental Disability, severe; Unspecified Depressive Disorder; Attention Deficit Hyperactivity Disorder, combined presentation; and Obesity.
- Guardian of the Person was a family member.
- Person Centered Plan with short range goals and strategies implemented 3/01/22; no guardian signature/consent.

Review on 1/18/23 of client #3's record revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-157	A. BUILDING: _____ B. WING _____	R 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE 2	510 CRISSY DRIVE JACKSONVILLE, NC 28541

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 112	Continued From page 2 - 19 year old male admitted 1/18/22. - Diagnoses included Intellectual/Developmental Disability, moderate; Disruptive Mood Dysregulation Disorder; Attention Deficit Hyperactivity Disorder; perpetrator of non-parental child sexual abuse. - Person Centered Plan with short range goals and strategies implemented 2/01/22; no guardian signature/consent. During interviews on 1/18/23 and 1/19/23 the House Manager/Staff #1 stated: - Thought all of the plans had been signed by the guardians; - Would ensure guardian signatures were obtained on the plans. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 112		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use.	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-157	A. BUILDING: _____ B. WING _____	R 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE 2	510 CRISSY DRIVE JACKSONVILLE, NC 28541

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	Continued From page 3 This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure fire and disaster drills were held quarterly and repeated on each shift. The findings are: During interview on 1/18/23 the House Manager/Staff #1 stated the facility operated with 3 shifts, 7 days per week; 7:00 am - 3:00 pm; 3:00 pm - 11:00 pm, and 11:00 pm - 7:00 am. Review on 1/18/23 at 4:30 pm of the facility's fire and disaster drill documentation revealed: - No third shift fire or disaster drill documented for the first and second quarters (January - June) 2022. - No third shift disaster drill documented for the third quarter (July - September) 2022. - "Fire Drill Report" included "Date: Jan (January) 18, 23 (2023) Time: 8pm . . . Number of Participants: Clients: 3 Staff: 2 . . . Type of Drill: Fire . . . Total Time to Evacuate Building: 3 min (minutes) . . . Comments: All clients exited safely. Explained importance of moving as fast as can to exit . . . Staff Member in Charge: [House Manager/Staff #1]." During interview on 1/18/23 client #1 stated she participated in drills, but was not sure how often they were held. She stated she went outside for fire drills. During interview on 1/18/23 client #3 stated he went outside for fire drills; he wasn't sure how often drills were held. During interview on 1/18/23 staff #2 stated: - Fire drills were held weekly.	V 114		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-157	A. BUILDING: _____ B. WING _____	R 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE 2	510 CRISSY DRIVE JACKSONVILLE, NC 28541

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 114	Continued From page 4 - Tornado drills were held, but he didn't like for the clients to have to get on the floor because "they are older and have trouble getting down and getting back up." - Other drills were done, such as intruders and medical emergencies. During interview on 1/19/23 the House Manager/Staff #1 stated she understood the requirement for drills to be held on each shift.	V 114		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-157	A. BUILDING: _____ B. WING _____	R 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE 2	510 CRISSY DRIVE JACKSONVILLE, NC 28541

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 5 (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews the facility failed to keep MARs current for 2 of 3 current clients (#1 & #2) and to ensure medications administered were recorded on each client's MAR immediately after administration affecting 2 of 3 current clients (#1 and #2). The findings are: Refer to tag V119 for information regarding medication disposal. - Staff removed meloxicam from client #1's bubble card and disposed of it. - The House Manager/Staff #1 discussed medication issues with the Pharmacist monthly. Review on 1/18/23 of client #1's record revealed: - 62 year old female admitted 6/15/07. - Diagnoses included Intellectual/Developmental Disability, mild; Unspecified Anxiety Disorder; Unspecified Neurocognitive Disorder; Schizoaffective Disorder, depressive Type; Diabetes. - "Physician"s Orders" signed by client #1's Medical Provider 8/02/22 included ". . . meloxicam (anti-inflammatory) 15mg (milligrams) Take 1 tablet by mouth at bedtime . . . stop hydroxyzine pamoate 25 mg - start hydroxyzine pamoate 50 mg tid (three times daily)."	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-157	A. BUILDING: _____ B. WING _____	R 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE 2	510 CRISSY DRIVE JACKSONVILLE, NC 28541

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 6 - "Physician"s Orders" signed by client #1's Medical Provider 10/17/22 included: trazodone (anti-depressant) 150 mg (milligrams) 1 tablet at bedtime fluoxetine (anti-depressant) 20 mg 3 capsules (60 mg) every morning rosuvastain (high cholesterol) 20 mg 1 tablet at bedtime cetirizine (antihistamine) 10 mg 1 tablet every day fluticasone (allergy symptoms) 50 mcg (micrograms) inhale 1 spray in each nostril twice daily Januvia (anti-diabetic) 50 mg 1 tablet every day Vitamin D2 (vitamin D deficiency) 50000 units 1 gel capsule once weekly Ventolin Inhaler (bronchodilator) 90 mcg 2 puffs four times a day as PRN (as needed) meloxicam (anti-inflammatory) 15mg 1 tablet at bedtime polyethylene 3350 powder (laxative) mix 1 capful in 8 ounces of juice or milk and drink daily Advair (asthma) 250-50 mg 2 puffs twice daily montelukast (asthma) 10 mg 1 tablet at bedtime hydroxyzine pamoate (agitation) 50 mg 1 capsule by mouth every 8 hours as needed. Ketoconazole Shampoo 2% (anti-fungal) use 5 mls (milliliters) topically to scalp twice weekly Celebrex (anti-inflammatory) 100 mg twice daily with food omeprazole (heartburn and indigestion) 20 mg 1 capsule every morning clozapine (anti-psychotic) 100 mg 4 tablets at bedtime "Discontinue Meloxicam." Reviews on 1/18/23 and 1/19/23 of client #1's MARs for October 2022 - January 2023 revealed: - Transcription for hydroxyzine 50 mg 1 capsule	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-157	A. BUILDING: _____ B. WING _____	R 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE 2	510 CRISSY DRIVE JACKSONVILLE, NC 28541

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 7	V 118		

every 8 hours prn.
- October 2022 transcription for meloxicam with documentation of administration 10/01/22 - 10/16/22.
- No documentation of administration of Celebrex 8:00 pm 1/17/23; 1/18/23; and 8:00 am 1/19/23, with no documented explanation for the blanks.
- Ketoconazole Shampoo 2% was documented one time for the week of 1/08/23 - 1/14/23; and once in October; no documentation of the use of Ketoconazole Shampoo 2% in November 2022; no documental explanation for the blanks.

Review on 1/19/23 of client #1's prescriptions provided by the Pharmacist revealed:
- Prescriptions electronically signed by client #1's Mental Health Provider 11/23/22 and 10/26/22 for Vistaril 50 mg 1 capsule twice a day.
- Prescription electronically signed 10/17/22 by client #1's Medical Provider for hydroxyzine 50 mg 1 tablet 3 times per day as needed.

Observation on 1/18/23 at approximately 12:50 pm of client #1's medications on hand revealed:
- Pharmacy dispensed bubble cards contained each of client #1's prescribed pills and capsules in one bubble for each administration time; for example all of her night time pill/capsules were contained in one bubble; pharmacy labels for each medication contained in the bubble were affixed on the opposing flap of the bubble card; the large bubble card was dispensed 12/22/22.
- The bubble for client #1's night time medications contained 8 tablets of varying sizes, shapes and colors.
- Pharmacy labels affixed to the bubble card included:
trazodone (anti-depressant) 150 mg (milligrams) 1 tablet at bedtime
fluoxetine (anti-depressant) 20 mg 3 capsules

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-157	A. BUILDING: _____ B. WING _____	R 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE 2	510 CRISSY DRIVE JACKSONVILLE, NC 28541

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 8	V 118		

(60 mg) every morning
rosuvastain (high cholesterol) 20 mg 1 tablet at bedtime
cetirizine (antihistamine) 10 mg 1 tablet every day
fluticasone (allergy symptoms) 50 mcg (micrograms) inhale 1 spray in each nostril twice daily
Januvia (anti-diabetic) 50 mg 1 tablet every day
Vitamin D2 (vitamin D deficiency) 50000 units 1 gel capsule once weekly
meloxicam (anti-inflammatory) 15mg 1 tablet at bedtime
montelukast (asthma) 10 mg 1 tablet at bedtime
hydroxyzine pamoate (agitation) 50 mg 1 capsule by mouth every 8 hours as needed.
omeprazole (heartburn and indigestion) 20 mg 1 capsule every morning
clozapine (anti-psychotic) 100 mg 4 tablets at bedtime
- A label for meloxicam 15 mg 1 tablet every day at bedtime was included on the bubble card,
- A separate bubble card for Celebrex 100 mg take 1 capsule twice daily with food, dispensed 12/07/22.
- Advair 250-30 1 puff twice daily dispensed 10/11/22.
- Polyethylene glycol mix 1 capful with juice or milk and drink daily dispensed 10/17/22
- Ventolin 90 mcg 2 puffs four times daily as needed dispensed 11/28/22.
- Ketoconazole shampoo 2% use 5 mls topically to scalp twice weekly, dispensed 10/17/22.

During interview on 1/18/23 client #1 stated she took her medications daily with staff assistance and she had never missed any doses.

Review on 1/18/23 of client #2's record revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-157	A. BUILDING: _____ B. WING _____	R 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE 2	510 CRISSY DRIVE JACKSONVILLE, NC 28541

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 9 - 46 year old male admitted 9/20/21. - Diagnoses included Intellectual/Developmental Disability, severe; Unspecified Depressive Disorder; Attention Deficit Hyperactivity Disorder, combined presentation; and Obesity. - Physician's orders signed 10/21/22 for: gabapentin (seizures and neuropathic pain) 300 mg 1 tablet 3 times daily and bedtime hydroxyzine 50 mg 4 tablets at bedtime losartan (high blood pressure) 50 mg 1 tablet daily fluticasone 50 mcg 1 spray each nostril daily Fish Oil (dietary supplement) 1200 mg 1 gel tab daily atorvastatin (high cholesterol) 20 mg 1 tablet daily. Observation on 1/18/23 at approximately 1:15 pm of client #2's medications on hand revealed: - Pharmacy dispensed bubble cards contained each of client #2's prescribed pills/capsules in one bubble for each administration time; for example night time pills and capsules were contained in one bubble; pharmacy labels for each medication contained in the bubble card were affixed on the opposing flap of the bubble card; the large bubble card was dispensed 12/22/22. - Pharmacy labels affixed to the bubble card included: gabapentin 300 mg 1 capsule three times daily. hydroxyzine 50 mg 4 tablets every night at bedtime as needed losartan 50 mg 1 tablet daily atorvastatin 20 mg 1 tablet daily. - Fluticasone 50 mcg 1 spray each nostril daily dispensed 9/09/22.. - Fish Oil 1200 mg; over the counter with expiration date of 03/2025.	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-157	A. BUILDING: _____ B. WING _____	R 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE 2	510 CRISSY DRIVE JACKSONVILLE, NC 28541

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 10 Review on 1/18/23 of client #2's MARs for October 2022 - January 2023 revealed:\ - Transcriptions for medications as ordered. - The following blanks: gabapentin 4:00 pm and 8:00 pm 1/07/23, 1/14/23, and 12:00 pm, 4:00 pm, and 8:00 pm 1/17/23 hydroxyzine 1/17/23 atorvastatin 1/08/23 and 1/15/23. - No documented explanation for the blanks. During interview on 1/18/23 client #2 did not respond to questions about his medications. Reviews on 1/18/23 and 1/19/23 of staff #2's personnel record revealed: - Hired 5/22/19, title Direct Care Provider. - Medication Administration training by a Registered Nurse 3/22/22. During interview on 1/18/23 staff #2 stated: - Administered evening and night time medications; medications were always available; - Clients saw the Physician monthly. - Medication changes were communicated verbally and in writing. - If he saw a supply of a medication was running low, he would notify the House Manager/Staff #1 or the pharmacy. Reviews on 1/18/23 and 1/19/23 of the House Manager/Staff #1's personnel record revealed: - Hired 9/06/14. - Medication Administration training by a Registered Nurse 3/22/22. During interviews on 1/18/23 and 1/19/23 the House Manager/staff #1 stated: - Was responsible for picking up medications from the pharmacy and reconciling the	V 118		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-157	A. BUILDING: _____ B. WING _____	R 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE 2	510 CRISSY DRIVE JACKSONVILLE, NC 28541

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	Continued From page 11 medications with the Physician's orders and Medication Administration Records (MARs); - Was responsible for printing the MARs for each client; - If the Physician made changes to a client's medications she would ensure the changes were documented on the MARs. - Was present for every medication administration at the facility; - Was not sure why there were blanks on the MARs, but she knew the clients received their medications as ordered; - The Pharmacist was scheduled to go to the facility to review the medications and orders within the next week. Due to the failure to accurately document medication administration it could not be determined if clients received their medications as ordered by the Physician. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		
V 119	27G .0209 (D) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal	V 119		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-157	A. BUILDING: _____ B. WING _____	R 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE 2	510 CRISSY DRIVE JACKSONVILLE, NC 28541

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 119	Continued From page 12 date and method, the signature of the person disposing of medication, and the person witnessing destruction. (3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments. (4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge. This Rule is not met as evidenced by: Based on observation, record reviews and interviews the facility staff failed to dispose of prescription medications in a manner that guards against diversion for 1 of 3 current clients (#1). The findings are: Review on 1/18/23 of client #1's record revealed: - 62 year old female admitted 6/15/07. - Diagnoses included Intellectual/Developmental Disability, mild; Unspecified Anxiety Disorder; Unspecified Neurocognitive Disorder; Schizoaffective Disorder, depressive Type; Diabetes. -"Physicians' Orders" signed by client #1's Mental Health Provider 8/02/22 to "stop hydroxyzine pamoate (antihistamine - generic for Vistaril) 25 mg (milligrams) - start hydroxyzine pamoate 50 mg twice daily;" prescribed for agitation. - "Physician"s Orders" signed by client #1's	V 119		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-157	A. BUILDING: _____ B. WING _____	R 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE 2	510 CRISSY DRIVE JACKSONVILLE, NC 28541

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 119	Continued From page 13 Medical Provider 10/17/22 to discontinue meloxicam (anti-inflammatory) 15 mg and start Celebrex (anti-inflammatory) 100 mg twice daily. Observation on 1/18/23 at approximately 12:50 pm of client #1's medications on hand revealed: - Pharmacy dispensed bubble cards contained each of client #1's prescribed pills and capsules in one bubble for each administration time; for example all of her night time pill/capsules were contained in one bubble; pharmacy labels for each medication contained in the bubble were affixed on the opposing flap of the bubble card; the large bubble card was dispensed 12/22/22. - The bubble for client #1's night time medications contained 8 tablets of varying sizes, shapes and colors. - A label for meloxicam 15 mg 1 tablet every day at bedtime was included on the bubble card. Observation on 1/19/23 at approximately 2:00 pm of the contents of a filing cabinet inside the locked medication closet revealed: - 29 bubble cards of hydroxyzine pamoate 25 mg with dispensed dates from 1/27/21 - 4/27/22 and discard dates from 1/22/22 to 4/07/23. - Each bubble card contained 24 - 30 tablets for a total of 826 unused tablets of 25 mg hydroxyzine pamoate. - 5 bubble cards of hydroxyzine pamoate 50 mg with dispense dates from 6/04/22 - 11/23/22 and discard dates from 6/24/23 - 11/23/23. - Each bubble card contained 28 - 29 tablets for a total of 142 unused tablets of 50 mg hydroxyzine pamoate. - In total there were 968 unused hydroxyzine tablets. During interview on 1/18/23 client #1 stated she took her medications daily with staff assistance	V 119		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-157	A. BUILDING: _____ B. WING _____	R 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE 2	510 CRISSY DRIVE JACKSONVILLE, NC 28541

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 119	Continued From page 14 and had never missed any doses. During interview on 1/19/23 the Pharmacist stated: - The pharmacy continued to package medications until the order to discontinue the medication was received from the Medical Provider. - Prescriptions and orders were sent directly to the pharmacy from the Medical Provider. - Told the House Manager/staff #1 "it would be okay to dispose of [client #1's] meloxicam because it could not be re-issued or re-used;" - To his knowledge none of client #1's meloxicam had been returned to the pharmacy for disposal. - Two different Medical Providers prescribed hydroxyzine for client #1. - One disadvantage to packaging medications based on administration times was if a medication was discontinued staff would have to remove that medication from the bubble card until the pharmacy was able to issue a new bubble card of medications according the the new order. Review on 1/19/23 of the Licensee's "Safe Disposal of Medications" policy approved 7/09/15 revealed: - ". . . All partially used or unused injectable or controlled substances will be dropped off to the local Police department within the hours of 8am - 12am by two staff (preferably Home Manager and additional staff). The disposal of any medications will be processed once monthly during the drop-off box operating hours. the medication to be disposed of will include used, unused, or expired medications." - " . . . Qualified staff shall account for disposal through documentation on the agencies Medication Disposal Log. This document will be available upon request. All disposal activities	V 119		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-157	A. BUILDING: _____ B. WING _____	R 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE 2	510 CRISSY DRIVE JACKSONVILLE, NC 28541

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 119	Continued From page 15 shall be witnessed by at least one (1) individual in addition to the staff person actually completing the disposal process." Review on 1/19/23 of the facility's "Disposal Log" documents dated 10/17/2 - 1/18/23 revealed the House Manager/Staff #1 documented disposal of meloxicam 15 mg daily. During interview on 1/18/23 staff #2 stated: - Medication changes were communicated verbally and in writing. - Client #1 did not take meloxicam but it was still being dispensed by the pharmacy and was included in the bubble cards. - Removed client #1's meloxicam tablet from the bubble card and disposed of it in the office trashcan. - Client #1 did not require her hydroxyzine very often. During interviews on 1/18/23 and 1/19/23 the House Manager/staff #1 stated: - Was responsible for picking up medications from the pharmacy and reconciling the medications with the Physician's orders and Medication Administration Records (MARs); - Had spoken with the Pharmacist monthly to have the meloxicam removed from the bubble cards. - The pharmacy stopped dispensing meloxicam but then resumed refilling it. - The meloxicam was removed from the bubble card and disposed of daily; she returned the unused meloxicam to the pharmacy. - Knew which pill was the meloxicam because she asked the Pharmacist and she paid close attention to medications contained in the bubble cards; - Staff had removed meloxicam from the bubble	V 119		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-157	A. BUILDING: _____ B. WING _____	R 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE 2	510 CRISSY DRIVE JACKSONVILLE, NC 28541

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 119	Continued From page 16 card and she returned it to the pharmacy since October 2022. - Gave the meloxicam to whomever was working at the pharmacy counter; - Was present for every medication administration at the facility; - Staff #2 did not put the meloxicam tablet into the trashcan. - Client #1 did not require her hydroxyzine very often. - The hydroxyzine had "always been prn (as needed)." - The extra bubble cards of hydroxyzine were "overflow" and were locked in the medication closet. - There was "no reason" for the large quantity of overflow hydroxyzine; she "did not realize there was that much." - Would return the overflow hydroxyzine to the pharmacy; - The Pharmacist was scheduled to go to the facility to review the medications and orders within the next week.	V 119		
V 736	27G .0303(c) Facility and Grounds Maintenance 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. This Rule is not met as evidenced by: Based on observations and interview the facility	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-157	A. BUILDING: _____ B. WING _____	R 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE 2	510 CRISSY DRIVE JACKSONVILLE, NC 28541

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 736	Continued From page 17 was not maintained in a safe, clean, attractive, and orderly manner. The findings are: Observations of the facility on 1/18/23 between 10:30 am and 11:00 am revealed: - The front door opened into an entry hall with the living room straight in front and the staff office immediately to the left; a backdoor from the living room opened onto a patio area and a locked door from the kitchen led into the garage; a hallway from the living room led into the bedroom area; there was no exit door from the bedroom area. - The double window in client #2 and #3's bedroom would not open; the window was blocked by a bed and a heavy wooden dresser; there was no other window in the room. - The double window in client #1's bedroom would not open; the window was blocked by a heavy wooden dresser; there was no other window in the room. - A smoke detector emitted a low chirping sound at regular intervals. - Walls in the kitchen and dining area had multiple small splatter stains that appeared consistent with dried liquid. - The finish on the lower kitchen cabinet doors was faded and worn. - The black vinyl upholstery on the back rest and seat of a recliner in the living room was torn and peeling. - Approximately 6 inch by 6 inch brown stain consistent with water damage on the living room ceiling; a softball sized area of the popcorn finish on the living room ceiling was bubbled at the entrance to the dining room; an unpainted repair to the living room ceiling in front of the fireplace. - Approximately 10 - 12 feet length of unsecured television cable extended from the ceiling beside the entrance to the dining room down the living room wall and back up to the television.	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-157	A. BUILDING: _____ B. WING _____	R 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE 2	510 CRISSY DRIVE JACKSONVILLE, NC 28541

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 736	Continued From page 18 - Client #3's dresser was missing 2 drawer pulls. - Client #2 and #3's bathroom: the exhaust fan was very dusty; 1 of 3 light bulbs in the fixture over the bathroom sink was not working; the bathtub drain lever was loose and hanging with an exposed hole in the bathtub wall; the floor covering at the base of the toilet was dark and discolored; the bathtub had dark stains on the floor and lower walls; white residue on the sink surface and the sink faucet. - A large area of client #1's mattress sagged from the upper right hand corner to the middle of the mattress. - Client #1's mirrored dresser had broken drawer fronts and was missing 2 drawer pulls; the large dresser had one drawer off track and was missing 3 drawer pulls; one folding closet door was off the track and propped against the wall. - The air return grate in the hallway was very dusty. Observation on 1/18/23 at 1:30 pm of client #1 revealed she used a walker for ambulation stability. During interview on 1/18/23 client #1 stated she slept well and felt safe at the facility. During interview on 1/18/23 client #2 did not answer any questions about the facility. During interview on 1/18/23 client #3 stated he felt safe at the facility. During interview on 1/18/23 the House Manager/staff #1 stated she could not get the bedroom windows up because she could not get them unlatched. She understood the windows should open easily in the event of an emergency and would contact maintenance immediately to	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-157	A. BUILDING: _____ B. WING _____	R 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE 2	510 CRISSY DRIVE JACKSONVILLE, NC 28541

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 736	Continued From page 19 have the issue resolved. Interview on 1/19/23 with the Administrator during the survey exit meeting revealed: - She would contact maintenance immediately to have the issue with the bedroom windows resolved. - When asked if there was additional information to present or comments to make, no additional information was provided. Review on 1/19/23 of the Plan of Protection dated 1/19/23 written by the Administrator revealed: - "What immediate action will the facility take to ensure the safety of the consumers in your care? Contact maintenance immediately to come & (and) fix the windows. Continue to monitor all consumers for safety till the window is fixed ASAP (as soon as possible). - Describe your plans to make sure the above happens. I will contact maintenance immediately to get the windows fixed today." Clients #1, #2, and #3 had diagnoses of mild to severe Intellectual/Developmental Disabilities. Client #1 used a walker for ambulation. Clients #2 and #3 shared a bedroom. Both client bedrooms had a large double window, blocked by furniture, that could not be unlatched to be raised. There was no other means of egress from the bedrooms in the event of an emergency that required evacuation; both bedrooms opened into the hallway and there was no exterior door from the bedroom hall. This deficiency constitutes a Type A2 rule violation for substantial risk of serious harm and must be corrected within 23 days. An administrative penalty of $500.00 is imposed. If the violation is not corrected within 23 days, an additional administrative penalty of $500.00 per day will be imposed for each day the	V 736		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-157	A. BUILDING: _____ B. WING _____	R 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE 2	510 CRISSY DRIVE JACKSONVILLE, NC 28541

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 736	Continued From page 20 facility is out of compliance beyond the 23rd day.	V 736		
V 752	27G .0304(b)(4) Hot Water Temperatures 10A NCAC 27G .0304 FACILITY DESIGN AND EQUIPMENT (b) Safety: Each facility shall be designed, constructed and equipped in a manner that ensures the physical safety of clients, staff and visitors. (4) In areas of the facility where clients are exposed to hot water, the temperature of the water shall be maintained between 100-116 degrees Fahrenheit. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to maintain water temperatures between 100 and 116 degrees Fahrenheit in areas where clients are exposed to hot water. The findings are: Observations on 1/18/23 between approximately 10:30 am and 11:00 am revealed: - Hot water temperature in client #2 and client #3's bathtub was 120 degrees. - Hot water temperature in the hall bathroom bathtub was 120 degrees. - Hot water temperature in the kitchen sink was 118 degrees. During interview on 1/18/23 client #1 stated the water was warm enough for bathing. During interview on 1/18/23 client #2 stated the water was warm. During interview on 1/18/23 the House	V 752		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL067-157	A. BUILDING: _____ B. WING _____	R 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE 2	510 CRISSY DRIVE JACKSONVILLE, NC 28541

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 752	Continued From page 21 Manager/staff #1 stated she did not realize the water temperature was too high; she would have it adjusted to 100 - 116 degrees.	V 752		