STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			B. WING			
		MHL0411234			03	8/13/2023
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	ZIP CODE		
DARTFOR	D DRIVE		SBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENTS	3	V 000			
	on 3/13/23. The com	laint survey was completed plaint was substantiated 1). Deficiencies were cited.				
	category: 10A NCAC	ed for the following service 27G .5600B Supervised Developmental Disability.				
		ed for 3 and currently has a vey sample consisted of ents.				
V 118	27G .0209 (C) Medic	ation Requirements	V 118			
	 only be administered order of a person aut drugs. (2) Medications shall clients only when aut client's physician. (3) Medications, incluading administered only by unlicensed persons to pharmacist or other la privileged to prepare (4) A Medication Administered current. Medications recorded immediately MAR is to include the (A) client's name; (B) name, strength, automatications (C) instructions for automatications 	histration: on-prescription drugs shall to a client on the written thorized by law to prescribe be self-administered by thorized in writing by the uding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. hinistration Record (MAR) of d to each client must be kept administered shall be y after administration. The				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL0411234	B. WING		03	8/13/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
DARTFOR	D DRIVE		ARTFORD DRIVE SBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
	Continued From page 1 drug. (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.		V 118			
	order of a physician	iews, interviews and ity failed to ensure Iministered on the written and that the MAR for each ent affecting 2 of 3 current				
	-Admission date of 7 -Age of 16; -Diagnoses included Generalized Anxiety Hyperactivity Disord Obsessive-Compuls -Orders dated 3/1/23 Acid (HCL) .1 milligra mouth (po) every mo 2 tablets po before b HCL 50mg, take 1 tab	Autism Spectrum Disorder, Disorder, Attention-Deficit er (ADHD) and				
	-Admission date of 1 -Age of 17;	Autism Spectrum Disorder,				

STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
	MHL0411234		B. WING		03	8/13/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
DARTFOR	RD DRIVE		RTFORD DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From page 2		V 118			
	and Sensory Process -Orders dated 1/11/2 50 micrograms, 2 spr for Eucerin Lotion, ap	regulation Disorder, ADHD sing Disorder; 3 for Fluticasone Propionate rays in each nostril daily and oply to feet with socks QHS.				
	Finding #1: Review on 3/13/23 of client #1's MAR for the month of March 2023 revealed no documentation regarding the dosage amount (.1 mg) of Clonidine HCL to be administered.					
	-Aware that MAR's w dosage amount of ea	ility of the Manager to ensure				
	he didn't realize that	with the Manager revealed he had not documented the HCL to be administered to				
	Finding #2:					
	month of March 2023	f client #1's MAR for the revealed documentation of te 1 tablet po QHS for mood.				
	pack of Risperidone 2 -Filled date 3/8/23;	ictions of take 1/2 tablet in				
	the pharmacy used to revealed the order fo	with a representative from o fill client #1's medications r Risperidone 2mg was om take 1 tablet QHS to take				

STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL0411234	B. WING		03	8/13/2023
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
DARTFOR	RD DRIVE		RTFORD DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From page 3		V 118			
	1/2 tablet in the morr	ing and 1 tablet QHS.				
	Further interview on 3/13/23 with the Owner revealed he wasn't aware that client #1's order for Risperidone 2 mg. had been changed.					
	Finding #3:					
	Review on 3/13/23 of client #1's MAR for the month of March 2023 revealed Trazodone HCL 50mg had not been administered for the month of March 2023.					
	-He thought the orde administer as needed	trouble sleeping so the				
	Finding #4:					
	month of March 2023	f client #2's MAR for the 3 revealed Fluticasone rin Lotion had not been				
	-Fluticasone Propion not administered to h -He and his family did medications daily, so requested by his fam	dn't think he needed the facility staff had been ily to administer the				
	medications prn inste -Not aware if the cha administration had be physician.					
	revealed:	3/13/23 with the Manager one Propionate and Eucerin				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	ROVIDER OR SUPPLIER	MHL0411234	ADDRESS, CITY, STATE		03	/13/2023
			ADDRESS, CHT, STATE	, ZIF CODE		
DARTFOR			SBORO, NC 27407			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pag	e 4	V 118			
	Lotion had not been -Client #2 and his far medications were ne them to be administe	administered to client #2; mily didn't feel that the reded daily and asked for ered prn; ications were required to be				