STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		COWIFLE	160
		MHL011-167	B. WING		R 04/10/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
EADM CC	JOOL BOAD HOME	23 OLD FA	RM SCHOOL F	ROAD		
FARIN SCI	HOOL ROAD HOME	ASHEVILL	E, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	completed on April 10	, and follow up survey was), 2023. The complaint was ‡199822). A deficiency was				
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disabilities.				
	census of 2. The sur	d for 3 and currently has a vey sample consisted of ents and 1 deceased client.				
V 118	27G .0209 (C) Medica	ation Requirements	V 118			
	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 le privileged to prepare (4) A Medication Adm all drugs administered current. Medications a recorded immediately	egally qualified person and and administer medications. inistration Record (MAR) of d to each client must be kept administered shall be after administration. The				
	(C) instructions for ad	nd quantity of the drug;				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		MHL011-167	B. WING		04	R I/10/2023
NAME OF D				7/0.0005		
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
FARM SC	HOOL ROAD HOME		FARM SCHOOL RC LLE, NC 28805	AD		
(V4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	: 1	V 118			
	drug. (5) Client requests for checks shall be record	person administering the medication changes or ded and kept with the MAR pointment or consultation				
	failed to keep the MA	as evidenced by: ew and interview, the facility Rs current affecting 2 of 3 Client #2). The findings				
	Admission date: 7/15 Diagnoses: Autistic E Intellectual and Devel Other Amnesia, Head Hyperlipidemia, Unsp Other Schizophrenia, Unspecified lack of ex development in childh Physician orders date -Divalproex 500 millig (seizures), 1 tab at be -Escitalopram 20mg tab every day; -Olanzapine 20mg tab bedtime;	Disorder (D/O), Moderate copmental Disabilities (IDD), lache, D/O of teeth, ecified urinary incontinency, Schizoaffective D/O, and expected normal physiological mod and Seborrhea. ed 10/30/21 included: ram (mg) tablet (tab), edtime; ab (depression), take 1 tab to (anti-psychotic), 1 tab at				
	affected area, every o	I 4/5/23 of MARs for Client				

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STATE FORM 6899 7RWB11 If continuation sheet 2 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		R	
	MHL011-167 B. WING		04/10/2023			
NAME OF PF	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
FARM SCH	HOOL ROAD HOME		RM SCHOOL I E, NC 28805	ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 118	-2/19/23 to 2/21/23, 2 Divalproex and Olanz -3/23/23, 3/25/23, and Review on 4/4/23 of Oladission Date: 2/18 Diagnoses: Autism Signates Anxiety D/O, and Social Physician orders inclusively at bedtime, written 3/1-Levetiracetam 1000rtab, every 12 hours, websides -Senna Lax tab (considay, written 2/2/21; -CBD Oil 20mg cap (adaily, written 1/23/23. Review on 4/4/23 and #2 from February 1, 2 revealed the following -3/13/23 for CBD oil, illustracetam, and Signates Interview on 4/4/23 websides his shook his head "yedidn't respond to quemedication. Interview on 4/4/23 westher the shook his head "yedidn't respond to quemedication. Interview on 4/4/23 westher the shook his head "yedidn't respond to quemedication. Interview on 4/4/23 westher the shook his head "yedidn't respond to quemedication. Interview on 4/4/23 westher were no medical aware of in the last the Interview on 4/6/23 westher were no medical aware of in the last the Interview on 4/6/23 westher were no 4/6/23 westh	g dates not initialed: and 3/13/23 for Ciclopirox; //28/23, and 3/13/23 for rapine; d 4/1/22 for Escitalopram. Client #2's record revealed: 5/21 pectrum D/O, Mild IDD, rial Phobia; rided: ab (depression), take ½ tab 15/21; ring tab (seizures), take 1 viritten 3/15/21; tipation), take 1 tab, twice a anxiety), take cap twice 1 4/5/23 of MARs for Client 2023 to April 5, 2023 g date not initialed: Fluvoxamine, enna Lax tab. ith Client #1 revealed: res" to taking medication; restion if he had missed any ith Staff #1 revealed: re MAR system; cream and nose spray potor was aware; ration errors that she was ree months.	V 118			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:	A. BUILDING: _			
			2 1000		R	
MHL011-167		B. WING		04/10	0/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
FARM SC	HOOL ROAD HOME	23 OLD FA	RM SCHOOL F	ROAD		
1 Artin 00	TOOL ROAD HOME	ASHEVILLE	E, NC 28805			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From page	e 3	V 118			
V 118	for February 2023 and #2. -sometimes the interrup the MAR; -clients had received ordered; -if there was a medicate the pharmacy. Interview on 4/5/23 and Professional revealed she reviewed the memonth; -Client #1 was just reand the old prescription the MAR; -there were no medical last three months besomedication for Client which she documented -Client #2 was on a lefebruary 15, 2023 to medical procedure; -she was unsure of with MARs. Due to the failure to a medication administrated termined if clients ras ordered by the physical procedure of the physical procedure of the failure to a medication administrated termined if clients ras ordered by the physical procedure of the failure to a medication administrated the physical procedure of the failure to a medication administrated the physical procedure of the physical procedure of the failure to a medication administrated the physical procedure of the physical proced	d in March 2023 for Client net went down and it messed their medications as ation error, he would contact and 4/6/23 with the Qualified d: edications electronically each -prescribed Escitalopram on was still showing up on ation errors for the facility in sides a PRN (as needed) #2 that was recorded late, ed; eave of absence in from February 28, 2023 for a thy there were blanks on the accurately document ation it could not be received their medications ysician.	V 118			

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