| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED |                          |  |  |
|---|--|---|---|---|-------------------------------|--------------------------|--|--|
|   |  |   | 7.1. 20125.1.10.                        |   |                               |                          |  |  |
|   |  | MHL041-975  | B. WING                                 |   | 04/2                          | 8/2023                   |  |  |
| NAME OF I   | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE   |   |   |   |                               |                          |  |  |
| SERVAN  | T'S HEART III  |   | ISE PEN CRI<br>BORO, NC 2               | EEK ROAD, APT 1B<br>7410  |                               |                          |  |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>( MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE                        | (X5)<br>COMPLETE<br>DATE |  |  |
| V 000   | INITIAL COMMENT  | rs  | V 000                                   |   |                               |                          |  |  |
|   | This facility is licens category: 10A NCA Living for Adults wit This facility is licens census of 2. The su  | sed for the following service<br>C 27G .5600C Supervised<br>h Developmental Disabilities.<br>sed for 3 and currently has a<br>urvey sample consisted of |   |   |                               |                          |  |  |
| V 118   | census of 2. The survey sample consisted of audits of 2 current clients.  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 administering the |   | V 118                                   |   |                               |                          |  |  |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   |        | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|---|--|---|--------|-------------------------------|--|
|   |   |   | A. BOILDING.                             |   |        |                               |  |
|   |   | MHL041-975  | B. WING                                  |   | 04/2   | 8/2023                        |  |
| NAME OF   | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S                           | STATE, ZIP CODE   |        |                               |  |
| SERVANT'S HEART III 3317 HORS GREENSB               |   |   |  | EEK ROAD, APT 1B<br>7410  |        |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY) | JLD BE | (X5)<br>COMPLETE<br>DATE      |  |
| V 118   | (5) Client requests checks shall be rec file followed up by a with a physician.  This Rule is not me  | for medication changes or corded and kept with the MAR appointment or consultation et as evidenced by:  | V 118                                    |   |        |                               |  |
|   | facility failed to ens administered on the affecting 1 of 2 clie  Review on 4/24/23 -Date of admission -Diagnoses: Mild In Disability; Prader V Depression; -Physician orders for ginger mixture, Wu jin san, Vitamin Do Recept/Focus drop-Pyridoxal 1, 2, 3 or before any meal the weeks, then off for -Symptoyogurt 10 r daily for two weeks -Ginger mixture 2 or before any two mears -Wu jin san, castor strength to area of daily followed by her -"Wu jin san 2 ounce away from food for ginger mixture and | atellectual Development Villi Syndrome; and Major  or Pyridoxal, Symptoyogurt, i jin san, castor oil salve, Wu drops 2,000 dated 11/3/22, and is dated 7/29/22; ine from each bag 10 minutes iree days per week for four one week; iminutes before any meal twice in then off two weeks; incompared to the purchase of the salve apply Wu jin san full panniculus bilaterally twice |  |   |        |                               |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  | COMPLETED |                          |
|--|--|--|--|--|-----------|--------------------------|
|  |  | MHL041-975   | B. WING                                  |  | 04/2      | 8/2023                   |
|  | PROVIDER OR SUPPLIER   | 3317 HOR   |  | ETATE, ZIP CODE<br>EEK ROAD, APT 1B<br>7410  |           |                          |
| (X4) ID<br>PREFIX<br>TAG                         | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUI<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE     | (X5)<br>COMPLETE<br>DATE |
| V 118  | any meal; -Nutritional supplem who specializes in haraditional/alternative Review on 4/26/23 2023 revealed: -Pyridoxal was not of administered prior to 4/26/23; -Symptoyogurt was administered prior to dinner on 4/7/23, -Wi jin san castor of away from food was administered on 4/3-Focus drops were administered at 8:0 on 4/7/23, and 4/25  Review on 4/26/23 January, February, -Pyridoxal was not of administered prior to 1/23/23, 1/26/23, and 3/29/2-Symptoyogurt was administered prior to and 2/24/23; -Wi jin san castor of being administered and 2/24/23; -Recept/Focus drop being administered and 2/24/23; -Vitamin D drops were and to be a supplementation of the supp | ooo IU daily by mouth after nents prescribed by a doctor nomeopathy using non-re medications.  of client #1's MAR for April of documented as being o dinner on 4/25/23 and  not documented as being o breakfast on 4/3/23 or prior and 4/25/23; il and Wi jin san 2 ounces ont documented as being 3/23; not documented as being 0 am on 4/3/23 and 8:00 pm 1/23.  of the MARs for the months of and March of 2023 revealed: documented as being o dinner on 1/9/23, 1/11/23, and 1/30/23, 2/15/23, 2/22/23, | V 118                                    |  |           |                          |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   |           | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|--|---|-----------|-------------------------------|--|
|   |  | MHL041-975  | B. WING                                  |   | 04/2      | 28/2023                       |  |
| NAME OF   | PROVIDER OR SUPPLIER   |   |  | STATE, ZIP CODE   |           |                               |  |
| SERVAN  | IT'S HEART III   |   | RSE PEN CR<br>BORO, NC 2                 | EEK ROAD, APT 1B<br>27410   |           |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETE<br>DATE      |  |
| V 118   | Interview on 4/26/23 -Staff #1, staff #2, a medicine every day  Interview on 4/26/23 -"The only errors (medication does not or [client #1] does not medication."  Interview on 4/26/23 Coordinator reveals -"If the medication was given on the weeke mother; -If it (medication) was medication) was medication." | 3 with client #1 revealed: and fill-in staff give her  3 with staff #1 revealed: nedication) are if the at arrive on time to the facility not make (prepare) her  3 with the Medication | V 118                                    |   |           |                               |  |

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