STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL023-219	B. WING		05/1	8/2023
				STATE, ZIP CODE	1	
				RINGS ROAD		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	TS .	V 000			
	An annual up surve A deficiency was cit	y was completed on 5/18/23. ed.				
	This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Individuals of all Disability Groups/Alternative Family Living.					
		sed for 2 and currently has a urvey sample consisted of clients.				
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	only be administered order of a person a drugs.  (2) Medications shat clients only when a client's physician.  (3) Medications, included administered only builties only builties only builties only builties on their privileged to prepare (4) A Medication Acall drugs administer current. Medication recorded immediate MAR is to include the (A) client's name;  (B) name, strength, (C) instructions for	inistration: non-prescription drugs shall ad to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by a trained by a registered nurse, legally qualified person and le and administer medications. Iministration Record (MAR) of red to each client must be kept administered shall be lely after administration. The line following:  and quantity of the drug; administering the drug;				
	(D) date and time the	administering the drug; ne drug is administered; and of person administering the				

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL023-219	B. WING		05/1	8/2023
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	03/1	0/2023
	ER HOME			RINGS ROAD		
WICERA	TER HOME	SHELBY,	NC 28150			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
V 118	drug. (5) Client requests checks shall be red file followed up by a with a physician.  This Rule is not me Based on record refacility failed to ensadministered on the and failed to keep to clients (Clients #1,  Observation on 5/1 Client #1's medicate Furosemide tablets dispensed on 4/17/Client #2's medicate Dispill medication peach medication we pack.  Record review on 5-Date of Admission-Diagnosis: Severe Disability, Anxiety Disorder, Seizure Dereview of physicial revealed:	for medication changes or corded and kept with the MAR appointment or consultation  et as evidenced by: eviews and interviews, the ure medications were et written order of a physician the MARs current for 2 of 2 #2). The findings are:  8/23 at approximately 10am of ion revealed: is in bubble pack card 23. ion revealed: AM and PM backs dispensed on 5/1/23. as listed on the back of each tablet was in the AM and PM  6/18/23 for Client #1 revealed: 10/30/10. Intellectual/Developmental Disorder, Autism Spectrum	V 118			
	Review on 5/18/23	of Client #1's MAR revealed:				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL023-219	B. WING		05/1	8/2023	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
MCBRAYER HOME			BRAYER SPE NC 28150	RINGS ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
V 118	-Furosemide was and was not docum Record review on 5 -Date of Admission -Diagnosis: Profour Disability, Anxiety Disability, An	not listed on the April MAR nented as administered.  i/18/23 for Client #2 revealed: : 5/1/13. Ind Intellectual/Developmental Disorder, Hyperlipidemia, Cy, Hypokalemia, Chronic ions. In's orders dated 2/28/23  i.1% ointment (topical steroid) of affected area for 7 days. Sician's order for Docusate her) twice daily.  of MARs from 3/1/23-5/18/23 ed: I was not written on the March documented as administered indered. I wrinted on the MAR in 2 dinitialed as administer on 18/23.  2 with Staff #1 revealed: In the the printed MARs each int. Medications that were would not have been printed got to add the Furosemide for rash cream (for Client #2) on susate was written on the MAR inly received 1 dose of it was packed in the dispill ack. I promise I won't miss	V 118				

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ZI2P11 If continuation sheet 3 of 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
MHL023-219		B. WING		05/	05/18/2023		
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
MCBRAY	MCBRAYER HOME 1805 MCBRAYER SPRINGS ROAD SHELBY, NC 28150						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 118	Professional reveal -Reviewed the MAF	ed:	V 118				

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