PRINTED: 06/28/2023 FORM APPROVED

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING | | (X3) DATE SURVEY COMPLETED 06/21/2023 | |
|---|---|---|---|--|---|--|
| | | MHL020-009 | | | | |
| NAME OF PI | ROVIDER OR SUPPLIER | I | DDRESS, CITY, STATE | | | |
| | | 33 GEN | LE DOVE LANE | | | |
| LEASAN | IT VALLEY GROUP HOM | MURPH | Y, NC 28906 | | | |
| (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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE COM THE APPROPRIATE D | |
| ∨ 000 | INITIAL COMMENTS | | V 000 | | | |
| | An annual and complaint survey was completed on June 21, 2023. The complaint was unsubstantiated (intake #NC00202296). | | | | | |
| | This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. | | | | | |
| | | d for 6 and currently has a vey sample consisted of ents. | | | | |
| V 118 | 27G .0209 (C) Medic | ation Requirements | V 118 | | | |
| | 10A NCAC 27G .020 REQUIREMENTS | 9 MEDICATION | | | | |
| | (c) Medication administration: | | | | | |
| | | n-prescription drugs shall | | | | |
| | | 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 aut | horized in writing by the | | | | |
| | client's physician. | | | | | |
| | | iding injections, shall be licensed persons, or by | | | | |
| | | rained by a registered nurse, | | | | |
| | | egally qualified person and | | | | |
| | • | and administer medications. | | | | |
| | | iinistration Record (MAR) of | | | | |
| | 5 | d to each client must be kept | | | | |
| | current. Medications | | | | | |
| | recorded immediately after administration. The | | | | | |
| | MAR is to include the following: | | | | | |
| | (A) client's name; (B) name, strength, and quantity of the drug: | | | | | |
| | (B) name, strength, and quantity of the drug;(C) instructions for administering the drug; | | | | | |
| | | drug is administered; and | | | | |
| | | f person administering the | | | | |
| | alth Service Regulation | . 5 | 1 | | | |

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| Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL020-009 | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|---|--|--|-------------------------------|--|
| | | B. WING | 06 | 06/21/2023 | | | |
| AME OF P | ROVIDER OR SUPPLIER | | DDRESS, CITY, STATE | 1 00 | | | |
| LEASAN | T VALLEY GROUP HON | 1E | LE DOVE LANE Y, NC 28906 | | | | |
| (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 DEFICIENC | ACTION SHOULD BE TO THE APPROPRIATE | | |
| V 118 | checks shall be reco | e 1 or medication changes or rded and kept with the MAR opointment or consultation | V 118 | | | | |
| | interviews, the facility medication was adm | ews, observation and / failed to ensure a inistered as ordered by a of 3 audited clients (Client | | | | | |
| | -Date of Admission: & -Diagnoses: Develop Scholastic Skills; Arm Autistic Disorder; Ce Localization-Related Epilepsy and Epilepti Partial Seizures, Not Epilepticus; Constipa Hyperactivity Disorder Congenital Hydrocep Severe Intellectual D Status; Malignant Hy Anesthesia, Initial En Compulsive Disorder | mental Disorder of hold-Chiari Syndrome; rebral Palsy; (focal) (partial) Symptomatic ic Syndromes with Complex Intractable, without Status ation; Attention-Deficit er; Allergic Rhinitis; bhalus; Anxiety Disorder; isabilities; Bee Allergy perthermia due to acounter; Obsessive | | | | | |
| | 24 milliliters (ml's) by insomnia. | mouth at bedtime for | | | | | |
| sion of Use | am of Client #2's me | /23 at approximately 10:00 dication revealed: | | | | | |

KLCC11

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|--|--|---|---|--|---|--|
| | | B. WING | | 06 | 06/21/2023 | |
| | ROVIDER OR SUPPLIER | E 33 GENT | DDRESS, CITY, STATE, LE DOVE LANE (, NC 28906 | ZIP CODE | | |
| (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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | CTION SHOULD BE COMPL D THE APPROPRIATE DATE | |
| V 118 | -A bottle of melatonin ml's labeled with instr mouth at bedtime. Review on 6/21/23 of 4/1/23 through 6/21/2 -Melatonin 2.5 mg/ml MAR with instructions bedtime. Interview on 6/21/23 · Manager revealed: -The Qualified Profes Director (ED) was resourced oversight to client MA Interview on 6/21/23 · -He was responsible client MARs. -He misread the adm Client #2's melatonin -He had typed 10 ml's ml's. -The error was corrected -He would ensure that MAR instructions mate every month. | 2.5 milligrams (mg) per 10 ructions to take 24 ml's by 7 Client #2's MARs dated 23 revealed: was transcribed on the s to take 10 ml's by mouth at with the Group Home asional (QP)/Executive sponsible for providing ARs. with the QP/ED revealed: for ensuring accuracy of inistration instructions for s on the MAR instead of 24 cted today. It all medication labels and tched the physician's orders | V 118 | | | |

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