OF CORRECTION	IDENTIFICATION NUMBER:				E SURVEY PLETED
	MHL025-045	B. WING		06/	14/2023
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
TREET HOME			1		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
INITIAL COMMEN	rs	V 000			
category: 10A NCA	C 27G .5600C Supervised				
census of 6. The s	urvey sample consisted of				
27G .0202 (F-I) Per	rsonnel Requirements	V 108			
REQUIREMENTS (f) Continuing educ (g) Employee train provided and, at a r following: (1) general organiz (2) training on clier delineated in 10A N 10A NCAC 26B;	cation shall be documented. ing programs shall be minimum, shall consist of the zational orientation; nt rights and confidentiality as ICAC 27C, 27D, 27E, 27F and				
client as specified i plan; and (4) training in infect bloodborne pathogo	n the treatment/habilitation tious diseases and ens.				
.5602(b) of this Sub member shall be av times when a client member shall be tra	ochapter, at least one staff vailable in the facility at all : is present. That staff ained in basic first aid				
to provide cardiopu trained in the Heim techniques such as the American Hear	Imonary resuscitation and lich maneuver or other first aic those provided by Red Cross Association or their				
	INITIAL COMMENT An annual survey w 2023. No deficience actegory: 10A NCA Living for Adults with This facility is licens category: 10A NCA Living for Adults with This facility is licens category: 10A NCA Living for Adults with This facility is licens category: 10A NCA Living for Adults with This facility is licens census of 6. The s audits of 3 current of 27G .0202 (F-I) Per 10A NCAC 27G .02 REQUIREMENTS (f) Continuing educ (g) Employee train provided and, at a to following: (1) general organiz (2) training on clief delineated in 10A N 10A NCAC 26B; (3) training to mee client as specified i plan; and (4) training in infect bloodborne pathogy (h) Except as perm .5602(b) of this Sut member shall be train member shall be train including seizure m to provide cardioput trained in the Heim techniques such as the American Heart	PROVIDER OR SUPPLIER STREET A TREET HOME 313-A HG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An annual survey was completed on June 14, 2023. No deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients. 27G .0202 (F-I) Personnel Requirements 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid	PROVIDER OR SUPPLIER STREET ADDRESS, CITY, S PREET HOME 313-A HOKE STREET NEW BERN, NC 28562 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG INITIAL COMMENTS V 000 An annual survey was completed on June 14, 2023. No deficiencies were cited. V 000 An annual survey was completed on June 14, 2023. No deficiencies were cited. V 000 This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. V 108 This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients. V 108 27G .0202 (F-I) Personnel Requirements V 108 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS V 108 (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (z) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and Itaining in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the f	Initial construction Viscon PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE IREET HOME 313.A HOKE STREET NEW BERN, NC 28562 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF / (EACH CORRECTIVE ACT (CROSS-REFERENCED TO T DEFICIENC INITIAL COMMENTS V 000 V 000 An annual survey was completed on June 14, 2023. No deficiencies were cited. V 000 This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients. V 108 27G .0202 (F-I) Personnel Requirements V 108 10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (I) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 28B; (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be trained in basic first aid including seizure management, currently trained toprovide cardiopulmonary resuscitation and trained in the	Image: construction of the supplication of the su

TATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		MHL025-045	B. WING		06/	14/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
	FREET HOME		DKE STREET RN, NC 28562			
(X4) ID			ID	PROVIDER'S PLAN OF ((X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLE ⁻ DATE
V 108	Continued From pa	ige 1	V 108			
	implement policies reporting, investiga	body shall develop and and procedures for identifying, ting and controlling infectious diseases of personnel and				
	Based on record re interviews the facili trained to meet the	et as evidenced by: views, observation and ty failed to ensure staff were needs of the clients, affecting d staff (#1). The findings are:				
	-50 year old female -Admission date of -Diagnoses include Developmental Dis Disorder, Seizure, I	6/7/94.				
	orders dated 6/7/23	ion (epipen) 0.3 milligrams tion), Inject 1 pen				
	Interview on 6/14/2 -She lived at the fac -She knew how to u -She kept an Epipe	cility a long time.				
		3 staff #1 stated: t the facility about 3 years. ormal training in the use of				

STATEMEN	of Health Service Re T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		MHL025-045	B. WING		06/14/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE	
HOKE ST	REET HOME		OKE STREET RN, NC 28562		
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF C	ORRECTION (X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE COMPLET LE APPROPRIATE DATE
V 108	Continued From pa	ge 2	V 108		
	client #1's epipen.				
		3 the Residential Manager			
	stated:	ure staff #1 was trained in the			
		bipen. She understood staff			
	needed training to r	meet the needs of the clients.			
V 117	27G .0209 (B) Med	ication Requirements	V 117		
	10A NCAC 27G .02	209 MEDICATION			
	REQUIREMENTS	REQUIREMENTS b) Medication packaging and labeling:			
	1) Non-prescription drug containers not				
	dispensed by a pha	rmacist shall retain the			
	manufacturer's labe visible;	el with expiration dates clearly			
		edications, whether purchased			
	or obtained as sam	ples, shall be dispensed in			
		ckaging that will minimize the gestion by children. Such			
		plastic or glass bottles/vials			
		nt caps, or in the case of			
		ed drugs, a zip-lock plastic bag	3		
	may be adequate; (3) The packaging	label of each prescription			
	drug dispensed mu	st include the following:			
	(A) the client's nam				
	(B) the prescriber's(C) the current disp				
		for self-administration;			
		ngth, quantity, and expiration			
	date of the prescrib	ed drug; and ess, and phone number of the			
		nsing location (e.g., mh/dd/sa			
	center), and the nar	me of the dispensing			
	practitioner.				
ivision of He	ealth Service Regulation				

GF2I11

If continuation sheet 3 of 9

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		MHL025-045	B. WING		06/	14/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
HOKE S	TREET HOME		OKE STREET RN, NC 28562	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 117	Continued From pa	nge 3	V 117			
	Based on record re interviews, the facil packaging labels as prescription drug di audited clients (#1) -50 year old female -Admission date of -Diagnoses include Developmental Dis Disorder, Seizure, I	ispensed for one of three . The findings are: e. 6/7/94.	,			
	orders dated 6/7/23 -Epinephrine Injecti (mg), (allergic react intramuscularly as -Albuterol Aerosol	ion (epipen) 0.3 milligrams tion), Inject 1 pen needed. Hydrofluoroalkane (AER HFA) CG) Inhale 1-2 puffs by mouth				
	of client #1's medic -An epipen with no pharmacy label in a #1. -An albuterol aeros	4/23 at approximately 1:12pm ation revealed: manufactures box or a sandwich bag kept by client ol spray with no manufactors bel in a sandwich bag kept by				
	Interview on 6/14/2 -She lived at the face ealth Service Regulation					

STATE FORM

GF2I11

If continuation sheet 4 of 9

Division	of Health Service Re	egulation			FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		SURVEY PLETED
		MHL025-045	B. WING		06/14/202	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
HOKE S	FREET HOME		DKE STREET RN, NC 28562	2		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	ΓΙΟΝ	(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETE DATE
V 117	Continued From pa	ge 4	V 117			
	-She knew how to u -She kept an epiper times.	ise the epipen. n and albuterol with her at all				
	stated: -Client had an orde					
		e facility was required to packaging labels as required n drug dispensed.				
V 119	27G .0209 (D) Med	ication Requirements	V 119			
	medication shall be guards against dive (2) Non-controlled s of by incineration, fl system, or by transf destruction. A recor shall be maintained Documentation sha medication name, s date and method, th disposing of medica witnessing destruct (3) Controlled subst accordance with the Substances Act, G. subsequent amend (4) Upon discharge remainder of his or disposed of prompt expected that the p to the facility and in	osal: and non-prescription disposed of in a manner that rsion or accidental ingestion. substances shall be disposed ushing into septic or sewer fer to a local pharmacy for d of the medication disposal by the program. Il specify the client's name, thrength, quantity, disposal he signature of the person ation, and the person ion. cances shall be disposed of in a North Carolina Controlled S. 90, Article 5, including any				

STATEMEN	of Health Service Re NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		MHL025-045	B. WING		06/	14/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
HOKE S	TREET HOME		KE STREET RN, NC 28562			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETI DATE
V 119	Continued From pa	ge 5	V 119			
	calendar days after	the date of discharge.				
	interview the facility medications that ha a manner that guar	et as evidenced by: view, observations, and failed to ensure prescription ad expired were disposed of in ds against diversion or n for one of three client (#1).				
	-50 year old female -Admission date of -Diagnoses include Developmental Disa Disorder, Seizure, E Gastroesophageal and Anxiety. Signed physician or	6/7/94. d Mild Intellectual ability, Asthma, Tourette's Environmental Allergies, Reflux Disease, High Lipid rders dated 6/7/23 revealed- on (epipen) 0.3 milligrams tion), Inject 1 pen				
	of client #1's medic -A box containing o mg with a dispense	4/23 at approximately 1:12pm ations revealed: ne Epinephrine Injection 0.3 date of 6/9/22 and an 2/8/22 on the pharmacy label.				
	Interview on 6/14/2 -She lived at the fac -She knew how to u -She kept an epiper -She had no emerg epipen. ealth Service Regulation	cility a long time. use the epipen.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		MHL025-045	B. WING		06/*	14/2023
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
IOKE S	TREET HOME		OKE STREET RN, NC 28562			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 119	Continued From pa	ige 6	V 119			
V 120	stated: -Client #1 used the -Staff did not know -She would order a -The facility normal expired medication pharmacy would se medication to be re 27G .0209 (E) Med 10A NCAC 27G .02 REQUIREMENTS (e) Medication Stor (1) All medication s (A) in a securely loo well-lighted, ventilai and 86 degrees Fa (B) in a refrigerator degrees and 46 degrees fa (B) in a refrigerator degrees and 46 degrees fa (B) in a securely loo well-lighted, ventilai and 86 degrees fa (B) in a refrigerator degrees and 46 degrees fa (C) separately for e (D) separately for e (E) in a secure mar for a client to self-m (2) Each facility tha controlled substance registered under th	the epipen was expired. refill for the epipen. ly completed a return form for , call the pharmacy and the end a shipping label for the turned tothe pharmacy. ication Requirements 209 MEDICATION age: hall be stored: cked cabinet in a clean, ted room between 59 degrees hrenheit; , if required, between 36 grees Fahrenheit. If the for food items, medications eparate, locked compartment each client; external and internal use; nner if approved by a physiciar nedicate. t maintains stocks of ces shall be currently e North Carolina Controlled S. 90, Article 5, including any	V 120			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		MHL025-045	B. WING		06/	14/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
HOKE S	TREET HOME		OKE STREET RN, NC 28562			
()()))		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 120	Continued From pa	ige 7	V 120			
	interview the facility	ion, record review and / failed to ensure medications cked container for one of three				
	Disorder, Seizure, I	6/7/94.				
	of client #1's medic -An epipen with no	4/23 at approximately 1:12pm ation revealed: manufactures box or a sandwich bag kept by client				
	box or pharmacy la client #1. -A small backpack medications were k	ol spray with no manufactors bel in a sandwich bag kept by without a lock, that both tept in when in client #1's away from the facility inside n.				
	orders dated 6/7/23 -Epinephrine Injecti (mg), (allergic react intramuscularly as -Albuterol Aerosol	ion (epipen) 0.3 milligrams tion), Inject 1 pen needed. Hydrofluoroalkane (AER HFA) CG) Inhale 1-2 puffs by mouth				
	Interview on 6/14/2 -She lived at the fac -She knew how to u -She kept an epipe ealth Service Regulation	cility a long time.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			
		MHL025-045	B. WING		06/	14/2023
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
	FREET HOME		OKE STREET RN, NC 28562			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 120	Continued From pa	ge 8	V 120			
		andwich bags and in her that was unable to be locked.				
	Interview on 6/14/2 stated:	3 the Residential Manager				
	-She understood th	order to self-medicate. e facility was required to and would obtain a lock box cations.				