Division of Health Service Regulation						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
mhl-059036		mhl-059036	B. WING		07/27/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
NEBO SUI	PERVISED LIVING		LD HWY #10 EAST NC 28761			
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	on July 27, 2023. De This facility is license category: 10A NCAC Living for Adults with The facility is licensed	up survey was completed ficiencies were cited.  d for the following service 27G .5600C Supervised Developmental Disability.  d for 6 and currently has a vey sample consisted of				
	audits of 3 current clie	•				
V 114	AND SUPPLIES  (a) A written fire plan area-wide disaster plashall be approved by authority.  (b) The plan shall be and evacuation proceposted in the facility.  (c) Fire and disaster of shall be held at least repeated for each shi under conditions that	7 EMERGENCY PLANS for each facility and an shall be developed and	V 114			
		ew and interview, the facility and disaster drills quarterly ndings are:				

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

TITLE (X6) DATE Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:	A. BUILDING: _			
mhl-059036		B. WING		07/27/2023		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
NEDO SU	DEDVICED LIVING	2121 OLD	HWY #10 EAS	Г		
NEBU SU	PERVISED LIVING	NEBO, NC	28761			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	D BE COMPLETE	
V 114	Continued From page 1		V 114			
	-There were 2 staff for the facilityThey work 24 hour shifts and alternated 3 days on and 2 days off.  Review on 7/27/23 of the fire and disaster drills from July 2022 through June 2023 revealed: -1 fire drill missing for each of the 4 quarters1 disaster drill missing for each of the 4 quarters.  Interview on 7/27/23 with the Director of Operations and the Human Resources Director revealed: -They were not aware fire and disaster drills needed to be conducted quarterly for each shift.					
		his was corrected to reflect per the rule.				
V 118	27G .0209 (C) Medica	ation Requirements	V 118			
	only be administered order of a person autidrugs.  (2) Medications shall clients only when auticlient's physician.  (3) Medications, incluadministered only by unlicensed persons transfer or other leprivileged to prepare  (4) A Medication Admall drugs administered current. Medications	istration: n-prescription drugs shall to a client on the written horized by law to prescribe be self-administered by horized in writing by the ding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. hinistration Record (MAR) of d to each client must be kept administered shall be a after administration. The				

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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	
		mhl-059036	B. WING		07	/27/2023	
			DRESS, CITY, STA	,			
NEBO SU	PERVISED LIVING	2121 OLL NEBO, N	) HWY #10 EAS <sup>-</sup> C 28761	I			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
V 118	(A) client's name; (B) name, strength, a (C) instructions for ac (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be recor	nd quantity of the drug;	V 118				
	This Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to administer medications as ordered and maintain a current MAR for one of three clients audited (Client #3). The findings are:						
	-Admitted 10/1/91Diagnoses of Modera Developmental Disab Disease Stage IV, Mo Deficiency, Major De						
	medications revealed -Cetirizine (antihistam tablet every night at b	nine) 10 milligrams (mg) - 1 pedtime - dispensed 7/6/23.					

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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 NO.	A. BUILDING: _		OOMI ELTED	
		mhl-059036	B. WING		07/27/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
NEBO SU	PERVISED LIVING		HWY #10 EAS	г		
		NEBO, NC	28761			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
V 118	Continued From page 3		V 118			
	-Claritin 10 mg - 1 tablet every day.					
	Review on 7/27/23 of Client #3's MARs for 5/1/23 through 7/27/23 revealed:  -Cetirizine 10 mg - 1 tablet every night at bedtime - was not initialed to indicate it had been given from 7/1/23 through 7/27/23.  Interview and observation on 7/26/23 at 3:51 p.m. with Client #3 revealed:  -He sat at the kitchen table waiting for surveyor to conduct an interview with him.  -Without any questioning about his Cetirizine he stated "I been sneezing too; I don't feel good."  Interview on 7/26/23 with Staff #1 revealed:  -She hadn't given Client #3's Cetirizine this month because Staff #2 hadn't given it; "She was just following her (Staff #2's) lead."					
	-Client #3 was taken Cetirizine and it shoul re-fill from what she u -Notified her the Cetir	izine was dispensed 7/6/23. answer for that. I don't				
		essional revealed: e for the medication				

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