STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
	or connection			A. BUILDING:			
		mh1082-042	B. WING		R 08/28/2023		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
SAMPSC	ON GROUP HOME		OBS STREET N, NC 28328				
(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 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
V 000	INITIAL COMMENT	ſS	V 000				
		w up survey was completed . 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 5 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.						
V 118	27G .0209 (C) Medication Requirements		V 118				
	 only be administered order of a person a drugs. (2) Medications shat clients only when at client's physician. (3) Medications, inclient's physician. (4) A Medication Additional drugs administered only builtieged to prepare (4) A Medication Additional drugs administered current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for (D) date and time the full drugs administered for the physician of the physician of	inistration: non-prescription drugs shall ed 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 r legally qualified person and re and administer medications liministration Record (MAR) of red to each client must be kep s administered shall be ely after administration. The					

		egulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		mhl082-042	B. WING			R 28/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
SAMPSC	ON GROUP HOME		OBS STREET N, NC 28328			
(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) COMPLE DATE
V 118	Continued From pa	ge 1	V 118			
	checks shall be rec	for medication changes or orded and kept with the MAR appointment or consultation				
	facility failed to kee	et as evidenced by: views and interviews, the p the MARs current affecting (client #1 and client #3). The				
	-60 year-old male. -Admission date of	d moderate intellectual				
	orders dated 2/1/23 -Alprazolam (treats Take one tablet by -Fexofenadine (treat capsule by mouth of -Chlorhexidine (treat Rinse with 1/2 output	anxiety) 0.5 milligrams (mg) - mouth twice daily. ats allergies) 180mg - Take 1 laily at bedtime. ats inflammation) 0.12% - ce by mouth twice daily. s allergies) 50mg - Take 1				
	revealed the follow -Hydroxyzine 50mg	of client #1's July 2023 MARs ng blanks: I, Chlorhexidine 0.12%, ng, and Alprazolam 0.5mg -				

STATE FORM

JXYN11

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED R 08/28/2023	
		mhl082-042	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
SAMPSO	ON GROUP HOME		DBS STREET			
(X4) ID			ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
V 118	Continued From pa	ge 2	V 118			
	 -57 year-old male. -Admission date of -Diagnoses included developmental disa disorder. Review on 8/28/23 d 4/25/23 revealed: -Metformin (treats of tablet by mouth twide -Paliperidone (antip capsule by mouth dailed -Review on 8/28/23 d -Ketoconazole Created - Spread topically to -Simvastatin (treats tablet by mouth dailed Review on 8/28/23 d revealed the followite -Metformin 1000mg Ketoconazole Created - 7/31/23 at 8:00pm Interviews on 8/28/23 stated they received not missed any mediated stated she would er documented correct Due to the failure to medication administ determined if client 	d moderate intellectual bility and schizoaffective of client #3's FL2 form dated liabetes) 1000mg- Take one ce daily. sychotic) 3/9mg - Take 1 laily at bedtime. am (treats fungal infection) 2% o affected area twice daily. cholesterol) 40mg - Take 1 ly at bedtime. of client #3's July 2023 MARs ng blanks: I, Paliperidone 3/9mg, m 2%, and Simvastatin 40mg 23, client #1 and client #3 d meds as ordered and had dications. 3 the Qualified Professional nsure that MARs were				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: mhl082-042		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED R 08/28/2023		
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		08/	20/2023
	ON GROUP HOME	300 JAC	OBS STREET I, NC 28328			
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLET DATE
V 736	Continued From pa	ige 3	V 736			
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736			
	10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor.					
	This Rule is not met as evidenced by: Based on observation and interviews, the facility was not maintained in a safe, clean, attractive manner. The findings are:					
	12:00pm of the fac -The kitchen stove' -The carpet through stained and bubble causing a tripping h -The laminate floor was bubbled up are tripping hazard.	s bottom drawer was broken. hout the facility was worn, d in several large areas hazard. ing in the hall bathroom #1 bund the toilet causing a				
	in bathroom #1 had -The fabric from the back approximately	n hallway and bathroom vent d dust visible on the slats. e sectional sofa was peeling / 3 x 6 inches on the arm and on the seat cushions.				
	stated: -She was aware of the home and had association which is responsible for the	repairs of the facility. ue to report concerns to the				
	This deficiency con and must be correc ealth Service Regulation	stitutes a re-cited deficiency cted within 30 days.				

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If continuation sheet 4 of 5

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		mhl082-042	B. WING			R 28/2023
AME OF PI	ROVIDER OR SUPPLIER	•	DDRESS, CITY, ST			
	N GROUP HOME	300 JAC	OBS STREET			
			N, NC 28328			
(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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE

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