STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				R-C		
	MHL080-168		B. WING		09/05/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CADADE	RUS COUNTY GROUP	355 HUMI	MINGBIRD C	IRCLE		
CABARA	COUNTY GROUP	SALISBU	RY, NC 2814	46		
(X4) ID PREFIX TAG			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	S	V 000			
	completed on Septe was unsubstantiate Deficiencies were complete. This facility is licens category: 10A NCA	nt and follow up survey was ember 5, 2023. The complaint d (Intake #NC002055449). ited.  sed for the following service C 27G .5600C Supervised h Developmental Disabilities.				
	census of 6. The su	sed for 6 and currently has a urvey sample consisted of clients and 1 former client.				
V 119	27G .0209 (D) Med	ication Requirements	V 119			
	medication shall be guards against dive (2) Non-controlled sof by incineration, fl system, or by transf destruction. A recorshall be maintained Documentation shamedication name, so date and method, the disposing of medica witnessing destruction (3) Controlled substances Act, G. substances Act, G. subsequent amend (4) Upon discharge remainder of his or disposed of prompt	osal: and non-prescription disposed of in a manner that disposed disposed disposed disposed by the medication disposal by the program. Il specify the client's name, disposed of the person disposed of the person disposed of in disposed o				

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	IMPED:   ` ´		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
,	0. 00.1.1.20.1.0.1	.52	J	A. BUILDING:				
		MHL080-168		B. WING			R-C <b>05/2023</b>	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
CABARE	CABARRUS COUNTY GROUP HOME 9 355 HUMMINGBIRD CIRCLE SALISBURY, NC 28146							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 119	to the facility and in	age 1 a such case, the remain ot be held for more tha the date of discharge	an 30	V 119				
	Based on record re interviews, the facil prescription and no disposed of in a ma accidental ingestion	et as evidenced by: eviews, observations, a lity failed to ensure all en-prescription medical anner that guards agai n affecting 3 out of 3 a #3). The findings are:	tion was nst udited					
	-Date of Admission -Diagnoses: Moder Anxiety, and Hyper -Physician order da	rate Intellectual Disabil tension; ated 6/15/23 for Antifur cted area twice daily P	ity, ngal 1%					
	-Date of Admission -Diagnoses: Mild In Respiratory Failure muscle weakness ( -Physician order da Dimetapp/Robituss -Physician order da 600-30 milligrams ( twice a day PRN fo -Physician order da Meclizine 25 mg 3	ntellectual Disability, s, Hypokalemia, Ileus, a (generalized); ated 7/25/23 for sin PRN for cough; ated 9/1/22 for Mucines (mg), take one tablet b	and  x DM ER y mouth nue zziness.					
	-Date of Admission		vealeu.					

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	` ′		L, COMBLE	
					R-	C
		MHL080-168	B. WING		1	5/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
		355 HUMI	MINGBIRD C			
CABARE	RUS COUNTY GROUP	PHOME 9	RY, NC 2814			
(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 119	Continued From page 2		V 119			
	-Diagnosis: Mild Intellectual Disability; -Physician order dated 8/1/23 for Tylenol 325 mg, take 2 tablets by mouth three times a day PRN for knee pain.					
	of client #1's medic -Antifungal 1% spra -No evidence Antifu					
		and 8/30/23 of client #1's rough 8/30/23 revealed: ray had not been				
	Observation on 8/30/23 at approximately 3:58 pm of client #2's medications revealed: -Robitussin expired 12/31/22; -Mucinex DM ER 600-30 mg expired 1/11/23; -Meclizine 25 mg expired 10/11/22.					
	through 8/30/23 rev -Robitussin was add through 8/5/23, and -Mucinex DM ER 60 twice daily 8/1/23 th morning of 8/8/23;	ministered twice daily 8/1/23 I the morning of 8/7/23; 00-30 mg was administered arough 8/7/23, and the				
	Observation on 8/30 of client #3's medical-Tylenol 325 mg ex					
	2023 revealed:	of client #3's MAR for August				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
,		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R.	.c
MHL080-168		B. WING		R-C <b>09/05/2023</b>		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY. S	STATE, ZIP CODE		
		355 HUMN	INGBIRD C	•		
CABARR	US COUNTY GROUP	PHOME 9 SALISBU	RY, NC 2814	16		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 119	Continued From pa	ge 3	V 119			
	from 8/9/23 through 8/29/23, and the morning of 8/30/23.					
	revealed:	3 and 8/31/23 with staff #1				
	-He was unaware the medications were expired; -Client #2 had not hardly ever taken her PRN					
	medicationsClient #3 was adm pain;	inistered Tylenol daily for knee				
	-"The [Office Assistant (OA)] does all the MARs (reviews), medication (re-ordering), and takes the clients to their medical appointments. If I see					
	something then I br	ing it to [OA's] attention; son (go to person) for all				
	Interview on 8/31/23 & 9/5/23 with the Administrator revealed: -"I check the medication quarterly and go through everything on the MAR. That's on me;"					
	one thing that I did	ing medication dates) was not think about;" essional admitted client #3 into should have seen the Tylenol				
	Interview on 9/1/23					
	checking the MARs -The (OA) did the c	of who was responsible for and medications; oordination of appointments ordering) for the facility. She				

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