STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: MHL059-071			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		B. WING		09/	29/2023	
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE		
VEST M	ARION SUPERVISED	LIVING	IN STREET			
(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 THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMEN	rs	V 000			
	completed on 9/29/	p and complaint survey was 23. The complaint was NC207053). Deficiencies				
	category: 10A NCA	sed for the following service C 27G .5600C Supervised th Developmental Disabilities.				
	census of 2. The s	sed for 4 and currently has a urvey sample consisted of clients and 1 former client.				
V 114	27G .0207 Emerge	ncy Plans and Supplies	V 114			
	AND SUPPLIES (a) A written fire pla area-wide disaster	207 EMERGENCY PLANS an for each facility and plan shall be developed and by the appropriate local				
	and evacuation pro posted in the facility (c) Fire and disaster shall be held at lease repeated for each so under conditions the	e made available to all staff cedures and routes shall be y. er drills in a 24-hour facility st quarterly and shall be shift. Drills shall be conducted at simulate fire emergencies. all have basic first aid supplies				
	This Rule is not me Based on record re facility failed to hold	et as evidenced by: view and interviews, the d fire and disaster drills on quarterly. The findings are:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-071				CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:	A. BUILDING: B. WING		COMPLETED	
		MHL059-071				R 29/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
WEST M	ARION SUPERVISED	LIVING	N STREET NC 28752			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	COMPLETE
V 114	Continued From pa	ge 1	V 114			
	-There was no door been conducted on shift) in the quarter 2022. -There was no door been conducted on	of fire drills revealed: umentation of fire drills having 1st shift (first part of the week from October-December umentation of fire drills having 2nd shift (second part of the uarter from January-March 023.				
	-There was no doct having been condu the week shift) in th 2023, April-June 20 2022. -There was no doct					
	Qualified Professio -Facility staffing wa -They were aware t completed.					
V 118	27G .0209 (C) Med	lication Requirements	V 118			
	only be administere order of a person a drugs.					

Division of Health Service Regulation STATE FORM

6899

If continuation sheet 2 of 6

	of Health Service Re					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE MHL059-071		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NOMBER.				
		MHL059-071	B. WING		R 09/29/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
		145 LUK	IN STREET			
WESTM	ARION SUPERVISED	LIVING MARION	, NC 28752			
(X4) ID			ID			(X5) COMPLET
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	E APPROPRIATE	DATE
V 118	Continued From pa	age 2	V 118			
	clients only when a	uthorized in writing by the				
	client's physician.					
		cluding injections, shall be				
		by licensed persons, or by				
		s trained by a registered nurse,	,			
	 pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administering the 					
	. ,	of person administering the				
	drug.	for modication changes or				
	(5) Client requests for medication changes or checks shall be recorded and kept with the MAR					
		appointment or consultation				
	with a physician.					
	with a physiolari.					
		at an and day of the				
		et as evidenced by:				
)/29/23 for Client #1 revealed:				
	-Date of admission					
		tellectual Developmental abetes, Schizoaffective				
		demia, Hypertension,				
		ic Obstructive Pulmonary				
	Disease.					
		medications dated 5/15/23				
	included:					
)mg (milligrams) (diabetes) - 2				
sion of H	ealth Service Regulation		1			1

Division of Health Service Regulation STATE FORM

1XE511

If continuation sheet 3 of 6

Division	of Health Service Re	egulation			FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-071			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL059-071	B. WING		R 09/29/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
WEST M	ARION SUPERVISED	LIVING 145 LUP	(IN STREET			
	ARION SUPERVISED	MARION	I, NC 28752			
(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 ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From pa	ige 3	V 118			
	tablets twice daily. -Mucus Relief 4 tablets every 12 ho -Carbidopa-leve (Parkinson's)- 1 tab -Diclofenac Soc (anti-inflammatory)- knee 4 times a day -Budesonide 1r nebulizer twice daily -Albuterol Sulfa -use 1 vial in nebuli (as needed). -Asenapine 10r under tongue twice -Zolpidem 10m Review on 9/29/23 MARs revealed: -Metformin was 8/31/23 pm dose. -Mucus Relief v am doses and 8/31 -Carbidopa-leve dose. -Diclofenac Soc for 8pm dose and 7 -Budesonide wa and 8/11/23 4pm do -Albuterol Sulfa 7/2/23 for 8am, 4pr -Asenapine was 7/31/23. (5 doses) Record review on 9	400mg (mucus thinner)- 3 urs. odopa 25-100mg olet 4 times a day. dium topical - Apply 4 grams to affected mg (asthma) -use 1 vial in y. ate 0.63mg (bronchodilator) izer 3 times a day and PRN mg (schizophrenia)- 1 capsule daily. g (sedative)- 1 tab at bedtime of July-September 2023 s blank 7/6/23 am dose, was blank 7/6/23 am dose, was blank 7/3/23 and 7/6/23 /23 pm dose. odopa was blank 7/31/23 noo dium topical was blank 7/23/2 7/31/23 noon dose. as blank 7/12/23 4pm dose ose. ate was blank 7/1/23 and n and 8pm doses. s blank 7/12/23, 7/17/23, 7/29- 0/29/23 for Client #2 revealed:	n 3			
	Disability, Diabetes	- 7/28/21. Itellectual Developmental , Paranoid Schizophrenia, ependence, Alcohol				

If continuation sheet 4 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-071		(X2) MULTIPLE		(X3) DATE SURVEY COMPLETED		
		A. BUILDING:	COM			
		B. WING			R 09/29/2023	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
NEGT M	ARION SUPERVISED	145 LUP	KIN STREET			
	ARION SUPERVISED	MARION	N, NC 28752			
(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 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 118	Continued From pa	age 4	V 118			
	included: -Haloperidol 10 the AM and 1 table		n			
	MARs revealed:	of July-September 2023 as blank on 8/26/23 at noon				
		23 with Client #1 revealed: the wrong medicine." re."				
		3 with Client #2 revealed: morning and night right on				
	-He passed medica -"[Client #1] is a typ doom and gloom."	3 with Staff #1 revealed: ations on time. bical 70 year old man; Mr. He and Client #1 had a (Client #1) takes stories and				
	-"[Client #1] was a grandpa. He lies a	3 with Staff #2 revealed: character; an ornery old lot and is sneaky." Had to e his nebulizer and take his always complains."				
	Professional revea -Client #1 doesn't t medication; he just time. He tells his g -Was also a Regist for medication train	ell the truth. He got the right doesn't like to take it all the juardian the same thing. tered Nurse and responsible				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED R 09/29/2023	
		B. WING				
AME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
/EST M	ARION SUPERVISED		IN STREET , NC 28752			
(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 THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pa	age 5	V 118			
	completed reviews cycle and there had -Had previously tall regarding their doc -Licensee recently system which she h document correctly	stitutes a recited deficiency				