ATEMEN	of Health Service Realth Service Realth Service Realth Services	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 10/11/2023
		MHL047-164			
ME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, S	TATE, ZIP CODE	
			SPIA COURT		
IAT GR	ROUP HOMES 2	RAEFO	RD, NC 28376		
X4) ID REFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE COMPLE HE APPROPRIATE DATE
∨ 000	INITIAL COMMEN	ITS	V 000	an sabetan na mabeba	
	on October 11, 20	mplaint survey was completed 23. The complaint was ntake #NC00206732). A ed.	l	na avanoto cuttolos of su etra city tope box betwee cuttoluenco no Topodologo	
	category: 10A NC Living for Adults w	nsed for the following service AC 27G .5600A Supervised vith Mental Illness. nsed for 6 and currently has a	1		
	census of 5. The audits of 3 curren	survey sample consisted of	V 118	Ali shikarigariya Masariya interior	
	10A NCAC 27G . REQUIREMENTS (c) Medication ac (1) Prescription co only be administed order of a person drugs. (2) Medications si clients only when client's physician (3) Medications, administered onl unlicensed perso pharmacist or ot privileged to pred (4) A Medication all drugs administered on all drugs administered on MAR is to include (A) client's name (C) instructions	0209 MEDICATION S Iministration: or non-prescription drugs shall ered to a client on the written a authorized by law to prescrib shall be self-administered by a authorized in writing by the including injections, shall be y by licensed persons, or by ons trained by a registered nu her legally qualified person ar pare and administer medication Administration Record (MAR stered to each client must be ions administered shall be liately after administration. The le the following:	ne nd ons.) of kept e	RECEIVED By Laura Bryan	nt at 2:29 pm, Oct 16, 20

STATE FORM ACCURATE OF DO 15/2023

If continuation sheet 1 of 5

ivision o	f Health Service Re			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY LETED	
ND PLAN C	OF DEFICIENCIES	IDENTIFICATION NUMBER:	A. BUILDING:				
			B. WING		10/1	10/11/2023	
		MHL047-164					
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA	ILE, ZIF CODE			
		103 CA	SPIA COURT ORD, NC 28376				
AMAT GH	ROUP HOMES 2		ID	PROVIDER'S PLAN OI (EACH CORRECTIVE AC	TION SHOULD DE	(X5) COMPLETE	
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE AFFICOTION	DATE	
V 118	Continued From p	age 1	V 118				
V 118	 (E) name or initial drug. (5) Client request checks shall be refile followed up by with a physician. This Rule is not Based on record facility failed to himmediately after clients (#1). The 	s of person administering the s for medication changes or ecorded and kept with the MA y appointment or consultation ds review and interviews the keep MARs current and recor er administration for 1 of 3 cu	rd rrent				
	revealed: -Admission dat -Diagnoses of S Type; Panic Dis Disability; Unsp Unspecified Ar Anxiety. -Discharge pal Hospital indica from 8/27/23 tr for Homicidal -Physician's o -Escitalop mouth once a -Vitamin B once a day. -Atorvast	e of 11/29/22. Schizoaffective Disorder, Bipo sorder; Unspecified Intellectur becified Depressive Disorder; ixiety Disorder; Type I Diabete berwork from Cape Fear Valle ting that Cl #1 was hospitalize to 8/29/23. Cl #1 was hospitalize o 8/29/23. Cl #1 was hospitalized o 8/29/23	olar al es; ed ized n. et by uth			continuation sheet 2	

AND PLAN OF CORRECTION IDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING		10/11/2023	
		MHL047-164			10/11/2023	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	STATE, ZIP CODE		
AMAT G	ROUP HOMES 2		SPIA COURT RD, NC 28376	A34.8		
			ID	PROVIDER'S PLAN OF CORREC	CTION (X5)	
(X4) ID PREFIX TAG	(EACH DEELCIENC)	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE	
V 118	Continued From pa		V 118			
		ng- 1 capsule by mouth once a				
	day at bedtime.					
	-Buspirone 10 times a day.) mg- 1 tablet by mouth three		and the second second second second	ALL CARLENDER STORE	
	-Physician's orders	rs dated 7/14/23:		the program of the second second second	Contract for the Co	
	-Levothyroxine	e 25 mg- 1 tablet by mouth		Villet Honderen ge echninetere	(status) expression (status)	
	once a day in the I	morning and on an empty				
	stomach.	mg- 1 tablet by mouth once a		himmer wat analt H4 terrested. Nearlin	AC CHARGEN AND A CONTRACT	
	day at bedtime.			A madematication terret where the	State and a state	
	-Trazodone 50	60 mg- 1 tablet by mouth once a	£		Sources and a second	
	day at bedtime.			en elde side ede om slottig ede o		
		0.5 mg- 1 tablet by mouth twic	,e	a nategian na tantanya ana	200 - 200 - 200 - 200 (200 - 200 (200 - 200 (200 - 200 (200 - 200 (200 - 200 (200 - 200 (200 - 200 (200 - 200 (200 - 200 (200 - 200 - 200 (200 - 200 (200 - 200 (200 - 200 (200 - 200 (200 - 200 (200 - 200 (200 - 200 (200 - 200 (200 - 200 - 200 (200 - 200 (200 - 200 (200 - 200 - 200 (200 - 200 (200 - 200 - 200 (200 - 200 - 200 (200 - 200 - 200 (200 - 200 - 200 (200 - 200 - 200 - 200 - 200 (200 - 200 - 200 - 200 - 200 - 200 (200 - 20	
	a day. Physician's orders	s dated 8/30/23:		e Barana da Barana da Barana ang Ba	established protocol	
	-Janumet 50-	-1000 mg- 1 tablet by mouth		i blood sugar kevels svare head	No.61 apropriedant	
	twice a day after f	food. o 100 unit/ml- Inject 5 units				
	under the skin thr	ree times a day with meals and	t	en la serie compare a la serie de la s		
	ner sliding scale	before meals and at bedtime.		gent stratilitaria some crastvertion	-Sina sedanake	
	Sliding scale for h	blood sugar 61-150 0 units, 15	1-	Entransie Die Kustikom-ougen	odubient telefondente	
	200 2 units, 201-2 -350 8 units, 351-	-250 4 units, 251-300 6 units, 30	JT	nas pro 83 Judić (1811) o baskadovo vez milačno pro 1		
				na a sen celastican art de la sen	Imp	
	Review on 10/6/2	23 of CI #1's MARs for August		Contraction and a second se	acu	
	2023 through Oc	ctober 6, 2023 revealed:		- cr trainil	na will belio	
	-August 2023: -Staff marked	ed their initials on all of CI #1's		· Staff	19 000011	
	medications as a	administered from 8/28/23-		· Staff trainin implemented o documentat	nd Woker	
	8/29/23 even tho	ough she was out of the facility	on	1 anno atat	-ion.	
	those days.	oro 100 unit/ml- 8/1-8/31- Facilit	tv	documeran		
	recorded medica	ation as given once daily (8 am	i).	ur Brita Justicanasco francesco activitado		
	Did not record th	he number of times given, but		to any pay require the		
	only once a day	that to indicate as administered	J.	a advert 1,20 State (1920) taken a state (1920)		
	September:			 Magnetiki usi si dang 		
	-Insulin Lisp	pro 100 unit/ml- 9/1-9/30- Facilit	ty	standampo anyonariana distang noo		
	recorded medica	ation as given once daily (8 am	·)·			
Division	Did not record the Did service Regulat	the number of times given, but	·		If continuation sheet 3 o	

STATEMENT	THEATTIN DELIVICOTION				
AND PLAN OF		FICIENCIES (X1) PROVIDER/SOLITICAL MILLIMBER		LE CONSTRUCTION	COMPLETED
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	B:	
					10/11/2023
		MHL047-164	B. WING		10,11
			DDRESS, CITY	, STATE, ZIP CODE	
NAME OF PR	OVIDER OR SUPPLIER		PIA COURT		
	UD HOMES 2	DAFEOF	RD, NC 2837	76	
AMAT GRU	OUP HOMES 2		ID	DED'S DIAN ()FUL	ORRECTION (X5) COMPLETE
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	E APPROPRIATE DATE
PREFIX	(EACH DEFICIENC	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	
TAG	NLOOD			0 0 11 0 00	the t Imple
	a timed From D	202 3	V 118	The op will ensu staff clocumer	We That pate
V 118	Continued From p	age o		staff clocumer	it in the 10/6/23
	only once a day th	at to indicate as administered.		MATZ each ti medication has	me 9 1'
				medicipan has	s peen
	October:	100 unit/ml- 10/1-10/5- Facilit	TY .	administered	·Staff
	1-1-madicat	ion as diver unue uairy (o arriv		daministered	
		number (1) IIIES UIVOIL MAR		training Im	1 pleinented
	only once a day th	nat to indicate as administered			
	Interview on 10/6	/23 with Staff #4 revealed:			
	-CI #1 received in	Cl #1's blood sugar levels up to)		
		and site was aver	0		
	read the sugar b	lood levels via an application of			
	-She administer	ed the Humalog Kwikpen to Cl s blood sugar levels were high			
	-She followed in	r, she would not administer the)		
	17 11				
	ol admouter	iged that there were many day	S		
	that she had to	administer the Kwukper more			
	than once a day	y to CI #1.	/AR		
	-She acknowled	dged only marking on Cl #1's N Istered the medication once a d	day.		
	Interview on 10	0/6/23 and 10/11/23 with the Ov	wner		
	revealed:				
	10/0/00.	had b	000		
	-She understoo	od how confusing it may had b	een		
	to follow the ph	hysician's order and what was			
	being done at	lowing the sliding scale per Do	ctor's		
	i contra ann				
	-Staff administ	tered the Kwikpen only when C			
	11.11	are about 1/11			
	Staff was only	v recording it once a day, but i	nay		
	I image it made	are than once a uay.			
	-Cl wore the s	sensor patch and was constant			1
	being monitor of Health Service Reg	eu.			If continuation sheet 4

Division of	of Health Service Re	egulation		CONSTRUCTION	(X3) DATE SURVEY
STATEMEN'	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COMPLETED
		MHL047-164	B. WING		10/11/2023
	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE	
			PIA COURT		
AMAT GH	ROUP HOMES 2		D, NC 28376	PROVIDER'S PLAN OF CORRECT	ION (X5)
(X4) ID PREFIX TAG	(EACH DEEICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE COMPLETE
V 118	Continued From pa	age 4	V 118		
	10/11/23: -She was not awar continued to mark	e that staff at the facility Cl #1's medications as e days that she was at the			
Division o	f Health Service Regulati	ion	6899	X44R11	If continuation sheet 5 o



ROY COOPER · Governor KODY H. KINSLEY · Secretary MARK PAYNE · Director, Division of Health Service Regulation

October 12, 2023

Ibilola Aridegbe Amat Group Homes, LLC 5519 Plainview Hwy Dunn, NC 28334

JUMAN

NC DEPARTMENT OF **IEALTH AND**

Annual & Complaint Survey completed October 11, 2023 Re: Amat Group Homes 2, 103 Caspia Court, Raeford, NC 28376 MHL # 047-164 E-mail Address: amatpek@gmail.com (Intake #NC00206732)

Dear Ms. Aridegbe:

Thank you for the cooperation and courtesy extended during the annual & complaint survey completed October 11, 2023. The complaint was unsubstantiated.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

Tag cited is a standard level deficiency.

Time Frames for Compliance

Standard level deficiency must be corrected within 60 days from the exit of the survey, which is . 12/10/23.

What to include in the Plan of Correction

- Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to prevent the problem from occurring again. .
- Indicate who will monitor the situation to ensure it will not occur again.
- Indicate how often the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603 MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718 www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

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