PRINTED: 02/09/2024 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0411081			(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED 02/08/2024		
			A. BUILDING:			
		B. WING				
IAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
MAXINE D	RIVE GROUP HOME		XINE DRIVE DINT, NC 27265			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
∨ 000	INITIAL COMMENTS		V 000			
	An annual survey was completed on February 8, 2024. A deficiency was cited.					
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.					
		ed for 3 and currently has a vey sample consisted of				
V 119	27G .0209 (D) Medication Requirements		V 119			
	guards against divers (2) Non-controlled su of by incineration, flu system, or by transfe destruction. A record shall be maintained b Documentation shall medication name, str date and method, the disposing of medicati witnessing destructio (3) Controlled substa accordance with the Substances Act, G.S subsequent amendm (4) Upon discharge of remainder of his or h disposed of promptly expected that the pat to the facility and in s	sal: Ind non-prescription lisposed of in a manner that sion or accidental ingestion. Ibstances shall be disposed shing into septic or sewer or to a local pharmacy for of the medication disposal by the program. specify the client's name, rength, quantity, disposal e signature of the person ion, and the person in. Inces shall be disposed of in North Carolina Controlled . 90, Article 5, including any				

6IV011

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0411081			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED 02/08/2024	
		B. WING				
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
MAXINE D	RIVE GROUP HOME		XINE DRIVE INT, NC 27265			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
V 119	Continued From page 1		V 119			
	calendar days after th	ne date of discharge.				
	This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to dispose of expired medications affecting 2 of 3 clients (Clients #1 and #2). The findings are:					
	-Admission date of 12 -Diagnoses: Mild Inter Disability (IDD), Cere Hearing Loss/Deafne Allergies, and Scolios -7/11/23 Physician's of medications-Ear Wax (ear wax removal), O (nausea and vomiting	llectual Developmental bral Palsy, Profound ss, Glaucoma, Seasonal sis. orders for PRN (as needed) & Removal 15 milliliters (ml) ndansetron HCL 4 mg tablet g), Acetaminophen 325 or pain or headache), and				
	-Admission date of 4/ -Diagnoses: Autism, I Language Disorder, A Disorder, and Glauco	Moderate IDD, Expressive Attention-Deficit Hyperactivity ma. order for Benzoyl Peroxide				
	medication bin reveal -2 over-the-counter b with an expiration dat	4 at 10:10 am of Client #1's ed: ottles of Ear Wax Removal e on the 1st bottle of 10/2/21 e on the 2nd bottle of				

STATE FORM

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If continuation sheet 2 of 3

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0411081			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		B. WING	02	02/08/2024			
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE			
	DRIVE GROUP HOME		XINE DRIVE DINT, NC 27265				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
V 119	07/2019. -Benzonatate with an -Ondansetron HCL w 5/24/23. -Acetaminophen with 8/13/23. Observation on 2/8/2- medication bin reveal -Benzoyl Peroxide To expiration date of 9/2 Interview on 2/7/24 w -He took his medicati -He did not know what Interview on 2/7/24 w -He knew his medicati -He had no problem w Interview on 2/8/24 w -She was responsible medications in their b -She planned to send back to the pharmacy -She planned to have	e expiration date of 3/3/23. ith an expiration date of an expiration date of 4 at 10:38 am of Client #2's led: opical Wash with an 9/22. with Client #1 revealed: on every day. at his medications were for. with Client #2 revealed: tions by their colors. with his medications. with the Director revealed: e for checking client boxes. all the expired medications	V 119				

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