| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                              | (X2) MULTIPLE CONSTRUCTION |  | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|----------------------------|--|-------------------------------|--|
| ANDIEAN   | SI CONNECTION  | BENTI IGATION NOMBER.   | A. BUILDING:               |  | OOWII EETEB                   |  |
|   |  | MHL059-093  | B. WING                    |  | R<br>01/31/2024               |  |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, STAT          | E, ZIP CODE  |                               |  |
| TAYLOR 2  | ? HOME   |   | E STREET                   |  |                               |  |
|   |  | OLD FOR   | T, NC 28762                |  |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETE                   |  |
| V 000   | INITIAL COMMENTS   | •   | V 000                      |  |                               |  |
|   | An annual, complaint, and follow up survey was completed on January 31, 2024. The complaint was unsubstantiated (Intake #NC00212312). Deficiencies were cited.   |   |                            |  |                               |  |
|   | The facility is licensed for the following service category: 10A NCAC 27G .5600 Supervised Living for Alternative Family Living.   |   |                            |  |                               |  |
|   |  | d for 3 and currently has a<br>vey sample consisted of<br>ents.                 |                            |  |                               |  |
| V 117   | 27G .0209 (B) Medica   | ation Requirements  | V 117                      |  |                               |  |
|   | V 117  27G .0209 (B) Medication Requirements  10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible; (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; (3) The packaging label of each prescription drug dispensed must include the following: (A) the client's name; (B) the prescriber's name; (C) the current dispensing date; (D) clear directions for self-administration; (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the |   |                            |  |                               |  |

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

(X6) DATE TITLE

|                          | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTIPLE       | (X2) MULTIPLE CONSTRUCTION  |           | (X3) DATE SURVEY         |  |
|--------------------------|--|--|---------------------|---|-----------|--------------------------|--|
| AND PLAN (               | AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |  | A. BUILDING: _      |   | COMPLETED |                          |  |
|                          |  |  |                     |   | R         |                          |  |
|                          |  | MHL059-093   | B. WING             |   | 01/3      | 1/2024                   |  |
| NAME OF PI               | ROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY, STA   | TE, ZIP CODE  |           |                          |  |
| TAYLOR 2                 | HOME   |  | LE STREET           |   |           |                          |  |
|                          |  |  | RT, NC 28762        |   |           |                          |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE        | (X5)<br>COMPLETE<br>DATE |  |
| V 117                    | Continued From page  | e 1  | V 117               |   |           |                          |  |
|                          | pharmacy or dispensicenter), and the name practitioner.  | ing location (e.g., mh/dd/sa<br>e of the dispensing  |                     |   |           |                          |  |
|                          | prescriber's name, the for administration, and phone number of the location affecting 1 of #1). The findings are:  Review on 1-29-24 are record revealed: -Admission date: 2-13-13-13-13-13-13-13-13-13-13-13-13-13- | n, record review and ailed to ensure all spensed included a dicate the client's name, the e dispensing date, directions d the name, address and pharmacy or dispensing 3 audited clients (Client and 1-30-24 of Client #1's 3-21.  Intellectual Developmental Mupirocin 2% topical plication topically twice daily d 10-19-23.  24 at 8:40 am of Client #1's and Client #1's a |                     |   |           |                          |  |
|                          | -The ointment did not<br>medication label on the<br>with a prescription me   | ne tube nor was it in a box<br>edication label.  |                     |   |           |                          |  |
|                          | Interview on 1-30-24   | with AFL Provider #1   | 1                   |   |           |                          |  |

Division of Health Service Regulation

STATE FORM B3B011 If continuation sheet 2 of 10

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---|--|--|-------------------------------|--|
|   |  |   |  |  | R                             |  |
|   |  | MHL059-093  | B. WING                                  |  | 01/31/2024                    |  |
| NAME OF PI  | ROVIDER OR SUPPLIER  | STREET ADD  | RESS, CITY, STA                          | TE, ZIP CODE   |                               |  |
| TAYLOR 2  | HOME   | 45 MIDDLE   |  |  |                               |  |
|   |  |   | , NC 28762                               |  |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE COMPLETE                   |  |
| V 117   | Continued From page  | 2   | V 117                                    |  |                               |  |
|   | revealed: -"It (the mupirocin oin but we (the facility) do hasn't come in." -Knew that medication Interview on 1-30-24 revealed: -Did not know where mupirocin creamKnew that medication Interview on 1-31-24 Professional (QP) revenue and the AFL is responsible. Would review medication but not always.  Interview on 1-31-24 revealed: -The QP is responsible.  | tment) does come in a box on't have it. The new one in was for Client #1.  with AFL Provider #2  the box was for the in was for Client #1.  with the Qualified realed: ole for medications. ation sheets on home visits with the Executive Director ile for reviewing medications. cer will look at medications |  |  |                               |  |
| V 118   | 27G .0209 (C) Medica   | ation Requirements  | V 118                                    |  |                               |  |
|   | 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, |   |  |  |                               |  |

Division of Health Service Regulation

STATE FORM B3B011 If continuation sheet 3 of 10

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED |   |
|---|--|--|---|---|-------------------------------|---|
|   |  |  | A. BOILDING.                            | 7. Boilbline.   |                               |   |
|   |  | MHL059-093   | B. WING                                 |   | R<br>01/31/2024               |   |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET ADD   | RESS, CITY, STA                         | TE, ZIP CODE  |                               |   |
| TAYLOR 2  | HOME   | 45 MIDDLE  | STREET                                  |   |                               |   |
|   |  | OLD FORT   | , NC 28762                              |   |                               |   |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLETI                   | E |
| V 118   | privileged to prepare (4) A Medication Adm all drugs administered current. Medications a recorded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for ac (D) date and time the (E) name or initials of drug. (5) Client requests for checks shall be recor | egally qualified person and and administer medications. inistration Record (MAR) of d to each client must be kept administered shall be after administration. The following: | V 118                                   |   |                               |   |
|   | facility failed to mainta<br>2 of 3 audited clients<br>administer medication<br>3 audited clients (Clients)<br>Finding #1:<br>Review on 1-29-24 aurecord revealed:<br>-Admission date: 12-3<br>- Diagnosis: Severe ludisability.<br>-Physician's order:<br>-Epidiolex 100 milligra                     | ews and interviews, the ain a current MAR affecting (Clients #1 and #3) and as as ordered affecting 1 of ent #3). The findings are:  |   |   |                               |   |

Division of Health Service Regulation

STATE FORM D3B011 If continuation sheet 4 of 10

|                          | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:   |  | ` '                 |   |                                   | (X3) DATE SURVEY<br>COMPLETED |  |  |
|--------------------------|--|--|---------------------|---|-----------------------------------|-------------------------------|--|--|
|                          |  |  | A. BUILDING:        |   |                                   |                               |  |  |
|                          |  | MHL059-093   | B. WING             |   | 01                                | R<br>I <b>/31/2024</b>        |  |  |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET A   | DDRESS, CITY, STATE | , ZIP CODE  |                                   |                               |  |  |
| TAVLOD                   | LOME   | 45 MIDD  | LE STREET           |   |                                   |                               |  |  |
| TAYLOR 2                 | HOME   | OLD FO   | RT, NC 28762        |   |                                   |                               |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC'<br>CROSS-REFERENCED TO<br>DEFICIEN | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE      |  |  |
| V 118                    | Continued From page  | <del>2</del> 4   | V 118               |   |                                   |                               |  |  |
|                          | 5ml's twice daily there 12-12-23Triamcinolon aceton topically twice daily to cleaning with soap ar Review on 1-30-24 of Client #1 revealed: -Epidiolex 100mg/ml daily 7days, then take | for seven days, then take eafter (via peg-tube), dated  0.1% top (topical): apply of GT (gastrotube) site after and water, dated 10-19-23.  If the Physicians orders for soln ml: take 2ml's twice e 4ml's twice daily for seven twice daily thereafter (via |                     |   |                                   |                               |  |  |
|                          | for Client #1 revealed<br>-Medications are type<br>month.<br>-Epidiolex was handw<br>administration on 12-   | ed onto the MARs for each  |                     |   |                                   |                               |  |  |
|                          | Client #1 revealed: -Medications are type monthEpidiolex had been the Epidiolex had been the Both the handwritten  | the January 2023 MAR for ad onto the MARs for each yped on the MAR. nandwritten on the MAR. and typed sections for narked as if it had been  |                     |   |                                   |                               |  |  |
|                          | typed on the MARHad only been given night.   | with AFL Provider #1  medication (Epidiolex) was  once in the morning and f everything. It wasn't on the   |                     |   |                                   |                               |  |  |

Division of Health Service Regulation

STATE FORM D3B011 If continuation sheet 5 of 10

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE  | (X3) DATE SURVEY<br>COMPLETED |  |             |
|---|--|--|-------------------------------|--|-------------|
| AND PLAN  | OF CORRECTION  | IDENTIFICATION NUMBER:   | A. BUILDING: _                |  | COMPLETED   |
|   |  |  | B. WING                       |  | R           |
|   |  | MHL059-093   | B. WING                       |  | 01/31/2024  |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, STA              | TE, ZIP CODE   |             |
| TAYLOR 2  | HOME   |  | E STREET                      |  |             |
|   |  |  | T, NC 28762                   |  |             |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETE |
| V 118   | Continued From page  | 5  | V 118                         |  |             |
|   | MAR initially."  |  |                               |  |             |
|   | Finding #2: Review on 1-29-24 arrecord revealed: -Admission date: 10-2-Diagnoses: Cerebral Developmental Disab-Physician's order for 1/2 tablet each morning and 1 tablet QHS date | een given once in the wo times a day as ble dosed." rovider #1 and #2) fault." and 1-30-24 of Client #3's 20-21. Palsy and Mild Intellectual ilities. Diazepam 5mg tablet, Take g, and ½ tablet each noon ed 8-24-23. Order for changed on 1-3-24 to, Take |                               |  |             |
|   | Client #3 revealed: -Medication was mark   | the January 2023 MAR for the order the order the new order   |                               |  |             |
|   | on 1-3-24The physician's orde reflected on the MAR -Both AFL Providers #   | r dated 1-3-24 was not   |                               |  |             |
|   | look at the book."   |  |                               |  |             |

Division of Health Service Regulation

STATE FORM B3B011 If continuation sheet 6 of 10

| STATEMENT                | of Deficiencies   | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTIPLE             | CONSTRUCTION  | (X3) DATE SURVEY |  |  |
|--------------------------|---|--|---------------------------|---|------------------|--|--|
| AND PLAN (               | AND PLAN OF CORRECTION IDENTIFICATION NUMBER:   |  | A. BUILDING:              |   | COMPLETED        |  |  |
| MHL059-093               |   | B. WING  |                           | R<br>01/31/2024   |                  |  |  |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET A   | ODRESS, CITY, STAT        | E, ZIP CODE   |                  |  |  |
| TAYLOR 2                 | HOME  |  | LE STREET<br>RT, NC 28762 |   |                  |  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE COMPLETE      |  |  |
| V 118                    | Continued From page pharmacy."  -The February pill page the MAR are current with MAR with | ck from the pharmacy and with the new order.  with AFL Provider #2  In the pill pack) because I out the pill with the MAR the ret the new MAR with the new orders til the month runs me to learn."  with the Qualified realed: ble for medications. The part of the pill with the Qualified realed: ble for medications. The provider of the for reviewing medications do visits.  with the Executive Director the for reviewing medications do visits. The provider of the pr | V 118                     |   |                  |  |  |
|                          | and must be correcte  | tutes a re-cited deficiency<br>d within 30 days.   |                           |   |                  |  |  |
| V 289                    | 27G .5601 Supervise   | d Living - Scope   | V 289                     |   |                  |  |  |

Division of Health Service Regulation

STATE FORM D3B011 If continuation sheet 7 of 10

PRINTED: 02/19/2024 FORM APPROVED

Division of Health Service Regulation

| DIVISION      | of Health Service Regu                        | liation  |                   |   |                  |  |
|---------------|---|--|-------------------|---|------------------|--|
|               | OF DEFICIENCIES                               | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTIPLE     | CONSTRUCTION  | (X3) DATE SURVEY |  |
| AND PLAN (    | AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | A. BUILDING: _    |   | COMPLETED        |  |
|               |   |  |                   |   |                  |  |
|               |   | MUU 050 003  | B. WING           |   | R                |  |
|               |   | MHL059-093   | D. WIIVO          |   | 01/31/2024       |  |
| NAME OF P     | ROVIDER OR SUPPLIER                           | STREET A   | DDRESS, CITY, STA | TE, ZIP CODE  |                  |  |
|               |   | 45 MIDD  | LE STREET         |   |                  |  |
| TAYLOR 2      | HOME  |  | RT, NC 28762      |   |                  |  |
|               |   |  | (1, NC 20702      | T   |                  |  |
| (X4) ID       |   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL   | ID                | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD | ()               |  |
| PREFIX<br>TAG | •   | LSC IDENTIFYING INFORMATION)   | PREFIX<br>TAG     | CROSS-REFERENCED TO THE APPROPI                             |                  |  |
|               |   |  |                   | DEFICIENCY)   |                  |  |
|               |   |  |                   |   |                  |  |
| V 289         | Continued From page                           | e 7  | V 289             |   |                  |  |
|               | 10A NCAC 27G .560                             | 1 SCOPE  |                   |   |                  |  |
|               |   | is a 24-hour facility which  |                   |   |                  |  |
|               |   | ervices to individuals in a  |                   |   |                  |  |
|               | •   | here the primary purpose of  |                   |   |                  |  |
|               | these services is the                         |  |                   |   |                  |  |
|               |   | duals who have a mental  |                   |   |                  |  |
|               |   | ntal disability or disabilities,   |                   |   |                  |  |
|               | ·   | e disorder, and who require  |                   |   |                  |  |
|               | supervision when in t                         | •  |                   |   |                  |  |
|               | •   | ng facility shall be licensed if   |                   |   |                  |  |
|               | the facility serves eith                      |  |                   |   |                  |  |
|               | •   | e minor clients; or  |                   |   |                  |  |
|               |   | e adult clients.   |                   |   |                  |  |
|               | ` '   |  |                   |   |                  |  |
|               |   | ts shall not reside in the   |                   |   |                  |  |
|               | same facility.                                | living facility about be   |                   |   |                  |  |
|               | (c) Each supervised                           |  |                   |   |                  |  |
|               | licensed to serve a sp                        | becilic population as  |                   |   |                  |  |
|               | designated below:                             | At a second and a second a second and a second a second and a second a second and a second and a second and a |                   |   |                  |  |
|               |   | tion means a facility which  |                   |   |                  |  |
|               |   | primary diagnosis is mental  |                   |   |                  |  |
|               |   | nave other diagnoses;  |                   |   |                  |  |
|               | ` '   | tion means a facility which  |                   |   |                  |  |
|               |   | primary diagnosis is a   |                   |   |                  |  |
|               | •   | lity but may also have other   |                   |   |                  |  |
|               | diagnoses;                                    |  |                   |   |                  |  |
|               |   | tion means a facility which  |                   |   |                  |  |
|               |   | primary diagnosis is a   |                   |   |                  |  |
|               | •   | lity but may also have other   |                   |   |                  |  |
|               | diagnoses;                                    |  |                   |   |                  |  |
|               |   | ition means a facility which   |                   |   |                  |  |
|               | serves minors whose                           |  |                   |   |                  |  |
|               |   | endency but may also have  |                   |   |                  |  |
|               | other diagnoses;                              | ,.   |                   |   |                  |  |
|               |   | tion means a facility which  |                   |   |                  |  |
|               | serves adults whose                           |  |                   |   |                  |  |
|               | -   | endency but may also have  |                   |   |                  |  |
|               | other diagnoses; or                           |  |                   |   |                  |  |
|               |   | tion means a facility in a   |                   |   |                  |  |
|               | private residence, wh                         | ich serves no more than  |                   |   |                  |  |

Division of Health Service Regulation

STATE FORM D3B011 If continuation sheet 8 of 10

| Division c    | of Health Service Regu  | ilation  |                            |  |                  |                  |
|---------------|-------------------------|--|----------------------------|--|------------------|------------------|
|               | OF DEFICIENCIES         | (X1) PROVIDER/SUPPLIER/CLIA                          | (X2) MULTIPLE CONSTRUCTION |  | (X3) DATE SURVEY |                  |
| AND PLAN C    | OF CORRECTION           | IDENTIFICATION NUMBER:                               | A. BUILDING:               |  | COMPLETED        |                  |
|               |                         |  |                            |  |                  |                  |
|               |                         | 1 250 202  | B. WING                    |  | R                |                  |
|               |                         | MHL059-093   | D. WING                    |  | 01/3             | 1/2024           |
| NAME OF PR    | ROVIDER OR SUPPLIER     | STREET A   | DDRESS, CITY, STA          | TE, ZIP CODE   |                  |                  |
|               |                         | 45 MIDD  | LE STREET                  |  |                  |                  |
| TAYLOR 2      | HOME                    |  | RT, NC 28762               |  |                  |                  |
|               |                         |  | ·                          |  |                  |                  |
| (X4) ID       |                         | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL | ID                         | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD |                  | (X5)<br>COMPLETE |
| PREFIX<br>TAG |                         | LSC IDENTIFYING INFORMATION)                         | PREFIX<br>TAG              | CROSS-REFERENCED TO THE APPROPR                              |                  | DATE             |
|               |                         |  |                            | DEFICIENCY)  |                  |                  |
| : / 000       |                         |  | 1                          |  |                  |                  |
| V 289         | Continued From page     | e 8  | V 289                      |  |                  |                  |
|               | three adult clients wh  | ose primary diagnoses is                             |                            |  |                  |                  |
|               | mental illness but ma   |  |                            |  |                  |                  |
|               |                         | adult clients or three minor                         |                            |  |                  |                  |
|               | clients whose primary   |  |                            |  |                  |                  |
|               |                         | ilities but may also have                            |                            |  |                  |                  |
|               | •                       | live with a family and the                           |                            |  |                  |                  |
|               |                         | ervice. This facility shall be                       |                            |  |                  |                  |
|               | * *                     | wing rules: 10A NCAC 27G                             |                            |  |                  |                  |
|               | .0201 (a)(1),(2),(3),(4 | •  |                            |  |                  |                  |
|               |                         | ); (8); (11); (13); (15); (16);                      |                            |  |                  |                  |
|               |                         | AC 27G .0202(a),(d),(g)(1)                           |                            |  |                  |                  |
|               |                         |  |                            |  |                  |                  |
|               |                         | 0203; 10A NCAC 27G .0205                             |                            |  |                  |                  |
|               |                         | 7G .0207 (b),(c); 10A NCAC                           |                            |  |                  |                  |
|               |                         | A NCAC 27G .0209[(c)(1) -                            |                            |  |                  |                  |
|               |                         | lications only] (d)(2),(4); (e)                      |                            |  |                  |                  |
|               |                         | and 10A NCAC 27G .0304                               |                            |  |                  |                  |
|               |                         | cility shall also be known as                        |                            |  |                  |                  |
|               | •                       | ng or assisted family living                         |                            |  |                  |                  |
|               | (AFL).                  |  |                            |  |                  |                  |
|               |                         |  |                            |  |                  |                  |
|               |                         |  |                            |  |                  |                  |
|               |                         |  |                            |  |                  |                  |
|               |                         |  |                            |  |                  |                  |
|               |                         |  |                            |  |                  |                  |
|               |                         |  |                            |  |                  |                  |
|               | This Rule is not met    | as evidenced by:                                     |                            |  |                  |                  |
|               | Based on interviews a   | and record reviews, the                              |                            |  |                  |                  |
|               | facility management f   | failed to ensure minor and                           |                            |  |                  |                  |
|               | ,                       | eside within the same facility.                      |                            |  |                  |                  |
|               | The findings are:       | -  |                            |  |                  |                  |
|               |                         |  |                            |  |                  |                  |
|               | Review on 1-29-24 ar    | nd 1-30-24 of Client #1's                            |                            |  |                  |                  |
|               | record revealed:        |  |                            |  |                  |                  |
|               | -Admission date: 2-13   | 3-21.  |                            |  |                  |                  |
|               | -Age: 16.               | J = 1.   |                            |  |                  |                  |
|               | _                       | ntellectual Developmental                            |                            |  |                  |                  |
|               | Disabilities.           | nonocidal Bovolepinonia.                             |                            |  |                  |                  |
|               | Dioadiiitioc.           |  |                            |  |                  |                  |
|               |                         |  | ,                          |  |                  |                  |

Division of Health Service Regulation

Review on 1-29-24 and 1-30-24 of Client #2's

STATE FORM B3B011 If continuation sheet 9 of 10

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | ` '   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED |                          |
|--|---|---|---|---|-------------------------------|--------------------------|
|  |   | MHL059-093  | B. WING                                 | B. WING   |                               | 1/2024                   |
| NAME OF P  | ROVIDER OR SUPPLIER   | STREET AL   | DRESS, CITY, STA                        | TE, ZIP CODE  | •                             | -                        |
| TAYLOR 2   | HOME  |   | E STREET                                |   |                               |                          |
| IATLUR 2   | HOWE  | OLD FOR   | T, NC 28762                             |   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETE<br>DATE |
| V 289  | Continued From page   | 9   | V 289                                   |   |                               |                          |
| V 200  | record revealed: -Admission date: 12-2 -Age: 26Diagnosis: Profound Disabilities.  Review on 1-29-24 ar record revealed: -Admission date: 10-2 -Age: 34Diagnoses: Mild Interview on 1-30-24 of -There was no curren 2024 licensure year.  Interview on 1-31-24 of Professional (QP) revert was her responsibility request. | 23-2019. Intellectual Developmental and 1-30-24 of Client #3's 24-21. Illectual Developmental al Palsy. Ithe facility folder revealed: t waiver or request for the with the Qualified | V 200                                   |   |                               |                          |

Division of Health Service Regulation

STATE FORM D3B011 If continuation sheet 10 of 10