STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	COMPLETED		
		B. WING		R		
MHL068-101		B. WING		02/0	9/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
RSI-OLE	ANDER		ANDER DRIV RO, NC 275			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
V 000	0 INITIAL COMMENTS		V 000			
	An annual, complaint and follow up survey was completed on February 9, 2024. The complaint was unsubstantiated (intake #NC00212261). Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.  This facility is licensed for 6 and currently has a census of 5. The survey sample consisted of audits of 3 current clients.					
V 114	27G .0207 Emerge	ncy Plans and Supplies	V 114			
	10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES  (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority.  (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility.  (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies.  (d) Each facility shall have basic first aid supplies accessible for use.  This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure that fire and disaster drills were completed at least quarterly on each shift. The findings are:					

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL068-101			(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER:	A. BUILDING:			
		B. WING		R <b>02/09/2024</b>		
					1 02/0	3/2024
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RSI-OLE	ANDER		NDER DRIV RO, NC 275 <sup>,</sup>			
(VA) ID	CLIMMA DV CTA			PROVIDER'S PLAN OF CORRECT	ON	(VE)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
V 114	Continued From page 1		V 114			
	book for the last 12 -There were no fire and 2nd (night) shift through June) of 20 -There were no fire (night) shift for the 3 September) of 2023 Review on 2/8/24 o book for the last 12 -There were no disc (night) shift for the 3 June) of 2023There were no disc (day) and 2nd (night through September) Interview on 2/8/24 Services revealed: -Facility operated ureshe was aware the been conducted last-She confirmed states.	drills conducted for 1st (day) its for the 2nd quarter (April 123. drills conducted for 2nd 3rd quarter (July through 3.  If the facility's disaster drills log months revealed: aster drills conducted for 2nd 2nd quarter (April through aster drills conducted for 1st 1t) shift for the 3rd quarter (July 1) of 2023.  with the Supervisor of Support 11 nder two shifts. at some of the drills had not				
\/ 11.0	-	each shift on each quarter.	V 118			
V 110	10A NCAC 27G .02 REQUIREMENTS (c) Medication adm (1) Prescription or r only be administered order of a person a drugs. (2) Medications shall		V 110			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BUILDING.		R		
MHL068-101		B. WING		02/09/2024		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RSI-OLE	ANDER		NDER DRIV RO, NC 275			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118			V 118			
	medications as orde	view, interview, and cility failed to administer ered by the physician and the MAR affecting 1 of 2 current				
	Review on 2/8/24 of client #2's record revealed: -Admission date of 5/13/14Diagnoses of Autism; Moderate Intellectual or Developmental Disabilities; Cerebral Palsy; Spinal Stenosis.					

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DIVISION	of Health Service Re	egulation				1
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
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		MHL068-101	B. WING		R 02/09/2024	
		WITIL000-101			02/0	3/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		203 OLEA	NDER DRIV	E		
RSI-OLE	ANDER	CARRBOI	RO, NC 275	10		
()(4) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION		()(5)
(X4) ID PREFIX		MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
\/ 110	Cantinuad Francisa	2	V 118			
V 118	Continued From pa	ge 3	V 110			
	Review on 2/8/24 o	f client #2's physician's orders				
	dated 12/15/23 reve					
	-Daily-Vite- take on					
		nit- chew one tablet daily.				
	-	nilligrams (mg)- chew one				
	tablet four times a					
		5 mg- take one tablet every				
	other day.	o mg- take one tablet every				
	-Earwax Solution Removal- instill five 5 drops in both ears every FridayDocusate Sodium 100 mg- take one capsule once dailyCetaphil liquid cleanser- wash face twice a dayValproic acid 250/5ml- take 7.5 ml every morningFolic Acid 1 mg- take one tablet dailyErythromycin 250 mg- take one tablet three					
	times a day.					
	Observation on 2/8/24 at 10:25 am of Client #2's medications revealed: -All medications mentioned were available.					
	-All medications me	iniloned were available.				
	Poviow on 2/8/24 o	f Client #2's MAR for the				
		er 1, 2023 through February 8,				
		ollowing omissions on the medication had been				
		medication had been				
	administered:					
	-January: -Daily-Vite- 1/2	1				
	,					
		00 unit- 1/5-1/7, 1/9.				
	-Simethicone 1 @8a; 1/28-1/31 @1	25 mg- 1/7-1/10 @4p; 1/15				
		e 325 mg- 1/20.				
		on Removal- 1/3, 1/8.				
		ium 100 mg- 1/15.				
		cleanser- 1/1-1/3 @8p; 1/8-				
		sa,8p; 1/16-1/17 @8p, 1/23-				
	1/24 @8p; 1/30-1/3	1@8p.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
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		MHL068-101	B. WING		02/09/2024	
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NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RSI-OLE	ANDER		ANDER DRIV			
		CARRBO	RO, NC 275	10		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
170		,	IAG	DEFICIENCY)		
\/ 440	0	1	V 440			
V 118	Continued From pa	ge 4	V 118			
	-Valproic acid 2	50/5ml- 1/3,1/4, 1/7, 1/15;				
	1/19, 1/21, 1/26-1/3					
	-Folic Acid 1 mg					
	-February:					
	-Simethicone 1	25 mg- 2/6 @12p and 4p, 2/7				
	@12p.					
	-Earwax Solution	on Removal- 2/1.				
	-Cetaphil liquid	cleanser- 2/5 @8p.				
	-Folic Acid 1 mg- 2/3.					
	-Erythromycin 2	250 mg- 2/6 @3pm.				
	Review on 2/8/24 of www.webmd.com revealed: -Daily-Vite- was used as a supplement.					
	-Dairy relief 9000 unit- was used to prevent gas,					
	diarrhea and bloating from lactose intolerance					
	-Simethicone was used to relieve the painful					
	• •	uch gas in the stomach and				
	intestines.					
	to treat iron-deficier	as used as an iron supplement				
		emoval was used to loosen				
	wax from ears.	emoval was used to loosen				
		was used as a stool softener.				
		inser was used as a face				
	cleanser.					
		used to treat bipolar disorders				
		ere used to treat epilepsy.				
		d to treat or prevent folate				
	deficiency anemia.	,				
		used to treat chest infections.				
		with the Supervisor of Support				
	Services revealed:					
		ne staff had not been marking				
	the MAR according					
		f Client #2 had been out of the				
	facility when the sta					
	administration of he					
		the facility failed to				
administer medications as ordered by the						

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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MHL068-101		B. WING 02/09/2024			9/2024	
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V 118	V 118 Continued From page 5		V 118			
	physician and main	tain an accurate MAR.				
	Due to the failure to accurately document medication administration, it could not be determined if Client #2 received her medications as ordered by the physician.					
	This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.					

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