PRINTED: 02/29/2024 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY PLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NOWIBER.	A. BUILDING:		COMPLE	ILD	
	MHL0411177		B. WING		02/23/2024		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
QUALITY	CARE III, LLC/SHIRLEY'	S HOUSE 1596 CAN	DACE RIDGE D	RIVE			
	, -	GREENSE	BORO, NC 2740				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)) BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENTS	INITIAL COMMENTS					
	An annual survey wa 2024. A deficiency wa	s completed on February 23, as cited.					
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.						
	_	d for 3 and currently has a vey sample consisted of ents.					
V 118	V 118 27G .0209 (C) Medication 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, 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 drug.						

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

(X6) DATE TITLE

Division of Health Service Regulation

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:		3) DATE SURVEY COMPLETED	
		MHL0411177	B. WING		02	2/23/2024	
	ROVIDER OR SUPPLIER	1596 (T ADDRESS, CITY, STATE				
QUALITY	CARE III, LLC/SHIRLEY'	GREE	NSBORO, NC 27406				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 118	Continued From page 1		V 118				
	checks shall be recor	r medication changes or ded and kept with the MAR pointment or consultation					
	current affecting 2 of Review on 2/21/24 of -Admission date of 5/ -Diagnoses of Mild-M Disability, Bipolar Dis Hyperactivity Disorde	n, record reviews and failed to keep the MARs 2 audited clients (#1, #2). client #1's record revealed: 17/2019.					
	medicationsMontelukast Sodium (mg), take one tablet -Fish Oil (supplement capsule by mouth ever-Olanzapine (antipsyotablet by mouth after -Thera-M tablet (mult mouth every morning -Olanzapine 5 mg, tall the afternoon.	ted, 9/27/23 for the following (allergies) 10 milligrams by mouth every morning. (a) 1200 mg, take one ery morning. chotic) 10 mg, take one breakfast. i-vitamin), take one tablet by					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		SURVEY PLETED		
			A. BUILDING.				
МН		MHL0411177	B. WING		02/	02/23/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
OHALITY	CARE III, LLC/SHIRLEY'S	S HOUSE 1596 CAN	IDACE RIDGE D	RIVE			
QUALITI	CARE III, EEC/GIIIREET	GREENSI	BORO, NC 2740)6			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
V 118	Continued From page	2	V 118				
	by mouth every dayClonidine Hcl (hydrotablet by mouth at bee-Guanfacine (ADHD) by mouth at bedtimeOlanzapine 20 mg, ta-Lamotrigine (bipolar) tablets by mouth ever-Staff did not docume codes when clients w 1-27-24, 1-28-24, 1-2 2-16-24. Interview on 2/22/24 v-Has taken medicatio is with his family at the Review on 2/21/24 of -Admission date of 9/-Diagnoses of Autism Sunflower Syndrome,	chloride) 0.1 mg, take one dtime. (Hcl 2 mg, take one tablet ake one tablet by mouth. 100 mg tab, take two ry evening. In the correct charting ere awry from the facility on 9-24,2-14-24, 2-15-24, and with Client #1 revealed: In every day, even when he eir home. client #2's record revealed: 2/22. Spectrum Disorder,					
	-Physician's order data medicationsSertraline (anxiety) Hamouth every dayXcopri (seizure) 100 mouth every dayClobazam (depressa by mouth at bedtimeQc Melatonin (vitami daily at bedtimeQuetiapine Fumarate take one tablet by mo	uary 22, 2024 revealed: ted, 9/27/23 for the following dcl 50mg, take one tablet by mg, take one tablet by int) 10 mg, take one tablet n) 5 mg, take one tablet e (antipsychotic) 100 mg,					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			
AND PLAN OF CORRECTION			
	02/23/2024		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, (
QUALITY			
(X4) ID PREFIX TAG	E (X5) COMPLETE ATE DATE		
V 118			

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