STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
						R
		MHL067-100	B. WING			01/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
COURTL	AND		IRTLAND DRIV NVILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMEN	TS	V 000			
	An annual and follow up survey was completed on March 1, 2024. Deficiencies were cited.					
	This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living: Alternative Family Living in a Private Residence.					
	The survey sample consisted of audits of 3 current clients.					
V 118	27G .0209 (C) Medication Requirements		V 118			
	 only be administered order of a person a drugs. (2) Medications shat clients only when a client's physician. (3) Medications, ind administered only built unlicensed persons pharmacist or other privileged to prepare (4) A Medication Act all drugs administered current. Medication frecorded immediat MAR is to include t (A) client's name; (B) name, strength (C) instructions for (D) date and time t 	inistration: non-prescription drugs shall ed to a client on the written nuthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by a trained by a registered nurse r legally qualified person and re and administer medications dministration Record (MAR) of red to each client must be kep as administered shall be ely after administration. The				

	of Health Service Re					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		MHL067-100	B. WING			R 01/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
COURTL		113 COU	RTLAND DRIV	Έ		
COURTE	AND	JACKSO	NVILLE, NC 2	8546		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETI DATE
V 118	Continued From pa	ge 1	V 118			
	checks shall be rec	for medication changes or orded and kept with the MAR appointment or consultation				
	facility failed to adm ordered by the phys MARs for 2 of 3 cur #4). The findings a Finding #1:	views and interviews, the ninister medications as sician and maintain accurate rent clients (clients #1 and				
	-55 year old male a - Diagnoses of Mod					
	orders revealed: 2/12/24	f client #1's signed physician 25mcg (asthma) - inhale 1				
	-Olanzapine 5mg (b	ng (allergies) - take 1 daily. bipolar)- take 1 daily. pression)- 20mg- take 1 every				
	morning. -Betamethasone (d apply twice daily.	ermatitis) 0.05% Ointment-				
	Cream- apply spari	nate (dermatitis) 0.05% ngly twice daily. ty)- 10mg- take 1 three times				

Division of Health Service Regulation STATE FORM

6899

5WZZ11

If continuation sheet 2 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL067-100	B. WING			R 01/2024
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
COURTL	AND		IRTLAND DRIV			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	COMPLET DATE
V 118	Continued From pa	ge 2	V 118			
	MARs revealed: February 2024 -Anoro Ellipta- no s administration on 2 -Cetirizine- no staff administration on 2 -Olanzapine- no sta administration on 2 -Fluoxetine - no sta administration on 2 -Betamethasone - n administration on 2 -Clobetasol Propior indicate administrat -Propranolol - no st administration on 2 Finding #2: Review on 3/1/24 o -31 year old male a -Diagnoses of Autis Review on 3/1/24 o orders revealed: 2/14/24 -Debrox 6.5% ear of drops each ear am 02/22/24 -Multivitamin (suppl -Vitamin D 3 1000 to daily. -Divalproex Sodium (ER) (seizures)- 50 -Diazepam (anxious	initials to indicate /23/24 at 8am. aff initials to indicate /23/24 at 8am. ff initials to indicate /23/24 at 8am. no staff initials to indicate /22/24 at 8am. nate - no staff initials to tion on 2/22/24 at 8am. aff initials to indicate /22/24 at 8am and 8pm. f client #3's record revealed: dmitted 9/15/23. tic Disorder. f client #3's signed physician frops (wax removal) - instill 4 and pm for 1 week. lement) - take 1 daily. Jnits (supplement) take 1 n (SOD) Extended Release				

STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		BERTH TOX TOT TOMBER.	A. BUILDING:				
		MHL067-100	B. WING		R 03/01/2024		
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
COURTL	AND		RTLAND DRIV NVILLE, NC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 118	Continued From pa	ge 3	V 118				
	8pm. -Multivitamin- no sta administration on 2/ -Vitamin D 3- no sta administration on 2/ -Divalproex SOD El administration on 2/ -Diazepam- no staff administration on 2/ Interviews on 3/1/24 stated they received Interview on 3/1/24	21/24 and 2/22/24 at 8am and aff initials to indicate 24/24 and 2/29/24 at 8am. aff initials to indicate 24/24 and 2/29/24 at 8am. R- no staff initials to indicate 24/24 and 2/29/24 at 8am. initials to indicate 24/24 and 2/29/24 at 8am. initials to indicate 24/24 and 2/29/24 at 8am. initials to indicate 24/24 and 2/29/24 at 8am. it with client #'s 1 and #2 d their medications daily. staff # 3 stated:					
	-Blanks should not -If she noticed a bla confirm with staff th administered and w required. -She understood the	nk in the MAR, she would at the medication was ould have then initial as e requirement to administer ered by the physician and					
	This deficiency cons and must be correc	stitutes a re-cited deficiency ted within 30 days.					
V 119	27G .0209 (D) Med	ication Requirements	V 119				
	10A NCAC 27G .02 REQUIREMENTS (d) Medication dispo (1) All prescription a						

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL067-100	B. WING		R 03/01	1/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, ST	ATE, ZIP CODE		
COURTL	AND		RTLAND DRIV			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID FREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD TAG			ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 119	guards against dive (2) Non-controlled s of by incineration, fi system, or by trans destruction. A recor- shall be maintained Documentation sha medication name, s date and method, the disposing of medicat witnessing destruct (3) Controlled subs accordance with the Substances Act, G. subsequent amend (4) Upon discharge remainder of his or disposed of prompt expected that the p to the facility and in drug supply shall no	e disposed of in a manner that ersion or accidental ingestion. substances shall be disposed lushing into septic or sewer fer to a local pharmacy for rd of the medication disposal l by the program. Ill specify the client's name, strength, quantity, disposal he signature of the person ation, and the person ion. tances shall be disposed of in e North Carolina Controlled S. 90, Article 5, including any	V 119			
	interview the facility medications that ha a manner that guar	view, observations, and a failed to ensure prescription ad expired were disposed of in ds against diversion or n for two of three client (#1 and				
	Review 3/1/24 of cl -55 year old male. -Admission date of	ient #1's record revealed: 3/3/03.				

AME OF PROVIDER OR SUPPLIER		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
AME OF PROVIDER OR SUPPLIER	MHL067-100	B. WING		03/	01/2024
		DRESS, CITY, ST			
OURTLAND		RTLAND DRIV NVILLE, NC 2			
PREFIX (EACH DEFICIENCY MUST	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
V 119 Continued From page 5		V 119			
 -Diagnoses included Modipisabilities; Pedophilia; IPICA by History -Signed physician orders Ipratropium 0.03% Spratine each nostril three time Observation on 3/1/24 a of client #1's medication -1 container of Ipratropiu of 3/16/21 and an expiration -1 container of Ipratropiu of 7/19/21 and an expiration -1 container of Ipratropiu of 7/19/21 and an expiration -1 container of Ipratropiu of 7/19/21 and an expiration -1 container of Ipratropiu of 7/19/21 and an expiration -1 container of Ipratropiu of 7/19/21 and an expiration -1 container of Ipratropiu of 7/19/21 and an expiration -1 container of Ipratropiu of 7/19/21 and an expiration -1 container of Ipratropiu of 7/19/21 and an expiration -2 container of Ipratropiu of 7/19/21 and an expiration -3 container of Ipratropiu of 7/19/21 and an expiration -3 container of Ipratropiu of 7/19/21 and an expiration -43 year old male. -43 year old male. -44 mission date of 8/1/0 -Diagnoses included Scl Mild Intellectual Disabilit Hyperlipidemia-Unspecifi Reflux. -Signed physician orders Hydrocortisone 2.5% creation -1 tube of Hydrocortison <l< td=""><td>derate Intellectual Impulse Control Disorder; s dated 2/12/24 revealed- y (asthma)- Instill 1 spray es daily. PRN. t approximately 11:20am s revealed: un with a dispense date ation date of 3/16/22. un with a dispense date ation date of 7/19/22. n client #'s 1 and #2 ir medications daily. nt #2's record revealed: 07. hizoaffective Disorder; ies; Seizure Disorder; ies; Seizure Disorder; fied; Gastro-esophageal s dated 11/3/22 revealed- eam (skin conditions)- owel movements to t approximately 10:45am s revealed: e cream with a dispense scard after date of House Manager stated:</td><td></td><td></td><td></td><td></td></l<>	derate Intellectual Impulse Control Disorder; s dated 2/12/24 revealed- y (asthma)- Instill 1 spray es daily. PRN. t approximately 11:20am s revealed: un with a dispense date ation date of 3/16/22. un with a dispense date ation date of 7/19/22. n client #'s 1 and #2 ir medications daily. nt #2's record revealed: 07. hizoaffective Disorder; ies; Seizure Disorder; ies; Seizure Disorder; fied; Gastro-esophageal s dated 11/3/22 revealed- eam (skin conditions)- owel movements to t approximately 10:45am s revealed: e cream with a dispense scard after date of House Manager stated:				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NOMIDER.	A. BUILDING:			
		MHL067-100	B. WING			R 01/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
COURTL	AND		RTLAND DRIV			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	COMPLET
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736			
	10A NCAC 27G .03 EXTERIOR REQU	03 LOCATION AND REMENTS				
	 (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview, the facility was not maintained in a clean, safe, attractive and orderly manner. The findings are: 					
	12:45pm during a ta -The living room has lights not working of the other; the fabrica- The downstairs has fixture with one ligh -The upstairs hall be light not working. -Client #2's bedroom closet that was miss in the closet was m	ath had a 2 bulb light with 1 m had a wall receptacle by the sing the cover; the ceiling light issing a cover; various				
	paper, Q-tips and s the floor.	hroughout the floor; candy nack wrappers scattered on				
	stated she understo	the Qualified Professional bod the facility was required to clean, safe, attractive and				