MHL04         AME OF PROVIDER OR SUPPLIER         SLAZINGWOOD         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECI (EACH DEFICIENCY MUST BE PRECI REGULATORY OR LSC IDENTIFYING         V 000       INITIAL COMMENTS         An annual and follow up survey was on March 15, 2024. Deficiencies w         This facility is licensed for the follow category: 10A NCAC 27G .5600C	STREET. 824 BL/ GREEN FICIENCIES CEDED BY FULL S INFORMATION) as completed vere cited. wing service Supervised	A. BUILDING: B. WING ADDRESS, CITY, STATE SBORO, NC 27406 PREFIX TAG V 000	, ZIP CODE	CORRECTION TON SHOULD BE THE APPROPRIATE	/15/2024 (X5) COMPLET DATE
AME OF PROVIDER OR SUPPLIER SLAZINGWOOD (X4) ID PREFIX TAG V 000 INITIAL COMMENTS An annual and follow up survey wa on March 15, 2024. Deficiencies w This facility is licensed for the follow category: 10A NCAC 27G .5600C	STREET. 824 BL/ GREEN FICIENCIES CEDED BY FULL S INFORMATION) as completed vere cited. wing service Supervised	ADDRESS, CITY, STATE AZINGWOOD DRIVE SBORO, NC 27406 ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	CORRECTION TON SHOULD BE THE APPROPRIATE	(X5) COMPLET
SLAZINGWOOD         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFINITION (EACH DEFICIENCY MUST BE PRECI REGULATORY OR LSC IDENTIFYING         V 000       INITIAL COMMENTS         An annual and follow up survey was on March 15, 2024. Deficiencies w         This facility is licensed for the follow category: 10A NCAC 27G .5600C	824 BL/ GREEN FICIENCIES CEDED BY FULL 3 INFORMATION) as completed vere cited. wing service Supervised	AZINGWOOD DRIVE SBORO, NC 27406	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE THE APPROPRIATE	COMPLET
(X4) ID PREFIX TAG         SUMMARY STATEMENT OF DEFINITION (EACH DEFICIENCY MUST BE PRECONDUCTION REGULATORY OR LSC IDENTIFYING           V 000         INITIAL COMMENTS           An annual and follow up survey was on March 15, 2024. Deficiencies w           This facility is licensed for the follow category: 10A NCAC 27G .5600C	GREEN FICIENCIES CEDED BY FULL S INFORMATION) As completed vere cited. wing service Supervised	SBORO, NC 27406	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE THE APPROPRIATE	COMPLET
(AT) FREFIX TAG         (EACH DEFICIENCY MUST BE PREC REGULATORY OR LSC IDENTIFYING           V 000         INITIAL COMMENTS           An annual and follow up survey wa on March 15, 2024. Deficiencies w           This facility is licensed for the follow category: 10A NCAC 27G .5600C	CEDED BY FULL S INFORMATION) as completed vere cited. wing service Supervised	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE THE APPROPRIATE	COMPLET
An annual and follow up survey wa on March 15, 2024. Deficiencies w This facility is licensed for the follow category: 10A NCAC 27G .5600C	vere cited. wing service Supervised	V 000			
on March 15, 2024. Deficiencies w This facility is licensed for the follow category: 10A NCAC 27G .5600C	vere cited. wing service Supervised				
category: 10A NCAC 27G .5600C	Supervised				
Living for Adults with Development					
The survey sample consisted of au current clients.	udits of 3				
V 118 27G .0209 (C) Medication Require	ements	V 118			
<ul> <li>10A NCAC 27G .0209 MEDICATIC REQUIREMENTS</li> <li>(c) Medication administration:</li> <li>(1) Prescription or non-prescription only be administered to a client on order of a person authorized by law drugs.</li> <li>(2) Medications shall be self-admir clients only when authorized in writ client's physician.</li> <li>(3) Medications, including injection administered only by licensed pers unlicensed persons trained by a re pharmacist or other legally qualifier privileged to prepare and administer (4) A Medication Administration Re all drugs administered to each client current. Medications administered recorded immediately after administ MAR is to include the following:</li> <li>(A) client's name;</li> <li>(B) name, strength, and quantity of (C) instructions for administering th (D) date and time the drug is administ (E) name or initials of person administ</li> </ul>	n drugs shall the written w to prescribe histered by ting by the as, shall be sons, or by egistered nurse, d person and er medications. ecord (MAR) of nt must be kept shall be stration. The f the drug; he drug; nistered; and				
drug. (5) Client requests for medication of	changes or				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: MHL0411235			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
		B. WING		03	/15/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
		824 BLA	ZINGWOOD DRIVE			
BLAZING	WOOD	GREEN	SBORO, NC 27406			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	F CORRECTION	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	) THE APPROPRIATE	COMPLETI
V 118	Continued From page 1		V 118			
		rded and kept with the MAR opointment or consultation				
	failed to ensure the c	ew and interview, the facility lients' MARs were kept 3 clients (Client #1 and				
	record revealed: -Admission date of 4, -Diagnoses of : Seve Developmental Disat Disorder, History of 0 Deficiency. -Physician order date -Desmopressin Ace milligram (mg), 1 tab	re Intellectual bility (IDD), Autism Spectrum Constipation, and Vitamin D ed 12/20/23 for: etate Tablet (Tab) 0.1 at bedtime (bedwetting).				
	(depression). -Clozapine 100 mg (aggressive behavior -Clozapine 200 mg (aggressive behavior -Divalproex Sodium	g, 1-2 tabs at bedtime , 1 tab at bedtime //mood). , 1 tab every morning //mood). n 500 mg, 1 tab three times a				
	(excessive salvia/eps -Physician order date	late 1 mg, 1 tab twice daily				

Division of Health Service Regulation STATE FORM

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL0411235			B. WING		03	/15/2024
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	ZIP CODE		
BLAZING	WOOD		AZINGWOOD DRIVE SBORO, NC 27406			
(X4) ID PREFIX TAG			LL PREFIX (EACH CORRECTI) DN) TAG CROSS-REFERENCE		N OF CORRECTION () E ACTION SHOULD BE COM D TO THE APPROPRIATE DJ CIENCY)	
V 118	Continued From page	e 2	V 118			
	(constipation). -Physician order date mg, 1 tab daily (high	ed 3/20/23 for Lisinopril 10 blood pressure).				
	Review on 3/14/24 of Client #1's February 2024 MAR revealed: -No documentation Desmopressin Acetate					
		-				
	administered on 2/28 -No documentation C	3/24 and 2/29/24 at 8 pm. Clozapine 200 mg				
	administered on 2/21 -No documentation E administered on 2/20	-				
	MAR revealed:	f Client #1's March 2024				
	administered on 3/6/2	Desmopressin Acetate 24 and 3/7/24 at 8 pm. orazepam administered on				
	-No documentation N 3/6/24 and 3/7/24 at					
	-No documentation C administered on 3/6/2 -No documentation E	24 and 3/7/24 at 8 pm.				
	administered on 3/1/2 -No documentation E administered on 3/1/2	ocusate Sodium				
	-No documentation L 3/1/24 at 8 am. -No documentation E	isinopril administered on				
	administered on 3/1/2					
		with Client #1 revealed: vable about medications due				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL0411235					(X3) DATE SURVEY COMPLETED	
		B. WING		03	8/15/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE		
	WOOD					
			SBORO, NC 27406			
(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) COMPLET DATE
V 118	Continued From page	e 3	V 118			
	-Client #1 had no pro	with Staff #1 revealed: blem taking his medications. ent's MAR when a client took				
	Interview on 3/15/24 with Staff #3 revealed: -There were no medications issues with Clients #1, #2 and #3. -He never forgot to give the clients any of their medications.					
	medications every da that the MAR was no blanks. -He would follow up v					
V 736	27G .0303(c) Facility	and Grounds Maintenance	V 736			
	-	EMENTS				
		as evidenced by: n and interview, the facility n an attractive manner. The				
	pm of the facility reve -There were 2 holes i	24 between 1:35 pm 2:15 ealed: n the living room wall. One ide the office that was				

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL0411235			B. WING		03	/15/2024
IAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,			
BLAZING	WOOD		ZINGWOOD DRIVE SBORO, NC 27406			
(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 ) THE APPROPRIATE	(X5) COMPLET DATE
V 736	Continued From page 4		V 736			
	second hole was bes about 1 inch by 1 incl -Two holes were in th (bathroom used by C located near the toile approximately 2-3 incl the second hole was size. -There were 2 white- unpainted areas on th -The kitchen ceiling fi hanging light fixture a discolored and patter 1/2-4 feet. -The kitchen food par side that was about 1 Interview on 3/14/24 -There was maintena and made repairs to of anything that need Interview on 3/14/24 -Maintenance worker repairing the holes in -No response about to walls.	he upstairs client bathroom clients #1 and #2) and t and sink. One hole was ches by 2 inches in size and about 1 inch by 1 inch in colored plastered and he kitchen wall. rom the air vent to past the and to the blinds had a rned area of approximately 3 htry had a crack on the left i inch by 1 ½ inch in size. with Client #2 revealed: ince people who came in the facility. He did not know led to be fixed. with Client #3 revealed: rs were upstairs and				
	he was frustrated or v -They were working t for Client #1 and to g	oward a new behavior plan et another one-on-one o address his behaviors that				
		1 and 3/15/24 with the				

STATE FORM

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         MHL0411235					(X3) DATE SURVEY COMPLETED	
		B. WING		03/15/2024		
	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
BLAZING	WOOD		SBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 736	Continued From page 5		V 736			
	from Client #1's pund were working to add -Confirmed the main the holes and paintir -The ceiling discolora leak 3-4 months ago kitchen ceiling neede take care of this.	tenance staff was repairing ng the walls. ation was from a water pipe that had been fixed but the ed to be painted. He would titutes a re-cited deficiency				
ivision of He	alth Service Regulation		6899	5411	lf.com	tiouz