

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL012-147	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/10/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SALEM ALTERNATIVE FAMILY LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 4840 JENKINS ROAD MORGANTON, NC 28655
--	---

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>An annual and follow up survey was completed on April 10, 2024. Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living.</p> <p>The facility is licensed for 2 and currently has a census of 2. The survey sample consisted of audits of 2 current clients.</p>	V 000		
V 108	<p>27G .0202 (F-I) Personnel Requirements</p> <p>10A NCAC 27G .0202 PERSONNEL REQUIREMENTS</p> <p>(f) Continuing education shall be documented.</p> <p>(g) Employee training programs shall be provided and, at a minimum, shall consist of the following:</p> <ol style="list-style-type: none"> (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. <p>(h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction.</p>	V 108		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL012-147	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/10/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SALEM ALTERNATIVE FAMILY LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 4840 JENKINS ROAD MORGANTON, NC 28655
--	---

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 108	<p>Continued From page 1</p> <p>(i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 2 paraprofessional staff (Alternative Family Living (AFL) Provider #1 and #2) and 1 of 1 qualified professional (the Qualified Professional (QP)) was trained in seizure management. The findings are:</p> <p>Review on 4/9/24 of AFL Provider #1's record revealed: -Date of Hire: 3/29/20. -No evidence of training in seizure management.</p> <p>Review on 4/9/24 of AFL Provider #2's record revealed: -Date of Hire: 3/29/20. -No evidence of training in seizure management.</p> <p>Review on 4/9/24 of the QP's record revealed: -Date of Hire: 10/2/23. -No evidence of training in seizure management.</p> <p>Interview on 4/9/24 with AFL Provider #1 revealed: -He was trained in seizure management "years ago" by a previous licensee. -He had not received seizure management training through the current licensee.</p>	V 108		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL012-147	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/10/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SALEM ALTERNATIVE FAMILY LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 4840 JENKINS ROAD MORGANTON, NC 28655
--	---

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 108	Continued From page 2 Interview on 4/9/24 with AFL Provider #2 revealed: -She was "trained in seizure management a long time ago" but could not recall the date. Interview on 4/9/24 and 4/10/24 with the QP revealed: -She could not locate documentation of seizure management training for Staff #1 or Staff #2. -She would be trained in seizure management as soon as possible along with the AFL staff.	V 108		
V 118	27G .0209 (C) Medication Requirements 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 administered; and (E) name or initials of person administering the	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL012-147	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/10/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SALEM ALTERNATIVE FAMILY LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 4840 JENKINS ROAD MORGANTON, NC 28655
--	---

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 3</p> <p>drug.</p> <p>(5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medications were administered as ordered by a physician and failed to keep MARs current for 2 of 2 clients (Client #1 and #2). The findings are:</p> <p>Cross Reference 10A NCAC 27G .0209 Medication Requirements (V119). Based on record reviews, observation and interviews, the facility failed to dispose of medications in a manner that guarded against diversion or accidental ingestion affecting 2 of 2 clients (Client #1 and #2).</p> <p>Review on 4/9/24 of Client #1's record revealed: -Physician's order dated 2/15/24 for ofloxacin 0.3% ophthalmic solution 2 drops in the right eye three times daily for 10 days (for infection). -Physician's order dated 3/8/24 for ofloxacin 0.3% ophthalmic solution 2 drops in the right eye three times daily for 10 days.</p> <p>Review on 4/8/24 and 4/9/24 of Client #1's MARs dated 2/1/24-4/9/24 revealed: -Ofloxacin 0.3% ophthalmic solution was documented as administered three times daily from 2/8/24-2/17/24 (instead of 2/15/24-2/24/24).</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL012-147	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/10/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SALEM ALTERNATIVE FAMILY LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 4840 JENKINS ROAD MORGANTON, NC 28655
--	---

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 4</p> <p>-Ofloxacin 0.3% ophthalmic solution was not listed on the March 2024 MAR.</p> <p>Review on 4/9/24 of Client #2's record revealed: -Physician's orders dated 12/27/23 included: -Adderall 10 mg 1 by mouth (PO) every day for behavior support. -Ciclopirox 8% nail lacquer apply topically to toenails daily as directed for fungus and remove weekly with alcohol. -Polyethylene Glycol 3350 powder dissolve 17 grams in water for constipation.</p> <p>Review on 4/8/24 and 4/9/24 of Client #2's MARs dated 2/1/24-4/9/24 revealed: -No instructions for the dose (# of sprays) of Nayzilam nasal solution. -Adderall was not initialed as having been administered on 3/16/24-3/19/24 and "waiting on script from [local physician]" was handwritten onto the MAR. -No documentation of ciclopirox 8% nail lacquer being removed weekly with alcohol. -No instructions for the route, or frequency of polyethylene glycol powder.</p> <p>Interview on 4/8/24 and 4/9/24 with Alternative Family Living (AFL) Provider #1 revealed: -Prepared MARs each month with the use of a template. "I make sure it's written correctly." -Client #1's "eye was swelled shut, red and like pink eye. He was probably scratching at his eye, and it got infected ...it was last month, I think, but I would have to look at the records. I wrote the medication for the infection on the MAR. I gave it for 10 days and the infection went away." -Removed ciclopirox lacquer from Client #2's toenails every 7 days. "I didn't know to document it." -"I ran out of meds (Client #2's medications) for</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL012-147	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/10/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SALEM ALTERNATIVE FAMILY LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 4840 JENKINS ROAD MORGANTON, NC 28655
--	---

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 5</p> <p>Adderall over the weekend (3/16/24) ...and I couldn't give him something I didn't have ...I called to get it refilled and the pharmacy tried to fill it but could not get it refilled until the next week. The number of refills went to zero. I guess I will have to start calling ahead of time."</p> <p>-Discussed MARs and medications with the Qualified Professional (QP) "every now and then."</p> <p>"I turn in the records (MARs) and the nurses can check them if they want to."</p> <p>Interview on 4/9/24 and 4/10/24 with the QP revealed:</p> <p>-Had been providing facility oversight since the end of November 2023.</p> <p>-Received MARs from the facility at the end of each month and reviewed each MAR "to make sure it matches with physician orders."</p> <p>"I have asked [AFL Provider #1] numerous times to give me a copy if new medications have been ordered, and when I have seen a new med (medication) on the MARs, I have called the doctor myself ..."</p> <p>-Would begin having more communication with facility staff about medications, giving more reminders of the importance "to not let a medication run out" and ensuring copies of all medication prescriptions are "on hand" at the facility and the Abound Health, LLC (licensee) office.</p> <p>Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.</p> <p>Review on 4/10/24 of a Plan of Protection completed and submitted by the QP and the Program Director (PD) revealed:</p> <p>"What immediate action will the facility take to</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL012-147	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/10/2024
--	---	---	--

NAME OF PROVIDER OR SUPPLIER SALEM ALTERNATIVE FAMILY LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 4840 JENKINS ROAD MORGANTON, NC 28655
--	---

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 6</p> <p>ensure the safety of the consumers in your care?</p> <ol style="list-style-type: none"> Contractors will be signed up to take RN (Registered Nurse) training Seizure overview, Rescue Meds (medications) & VNS (Vagus Nerve Stimulation) immediately. Contractors will repeat the full Medication Administration training immediately. All expired and D/C (discontinued) medications will be properly disposed of and documented by the end of business day 4/12/24. Medication Administration Record will be updated to reflect all current medications including dose, route, time, and frequency. Describe your plans to make sure the above happens. <ol style="list-style-type: none"> QP/PD will conduct site reviews per policy. During site reviews medication orders, MARs and medications will be reviewed to monitor medication management. Any medication errors will be properly documented on the MAR, reported to the QP timely, and appropriate level in incident report completed. QP/PD and contractors will communicate any changes in medications in real time. Contractor will obtain any changes to or new medications (medications) orders from the prescribing doctor immediately following the appointment." <p>Client #1 and Client #2 had diagnoses which included Profound Intellectual Disability, Seizure Disorder, Major Neurocognitive Disorder due to Traumatic Brain Injury without Behavioral Disturbance, Pica, Schizophreniform Disorder, Chronic Constipation, gastroesophageal reflux disease, Hypertension, and Benign Prostatic Hypertrophy. Client #1's daily multivitamins expired over 5 ½ years ago (August 2018) and his twice daily ophthalmic gel expired over 7</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL012-147	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/10/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SALEM ALTERNATIVE FAMILY LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 4840 JENKINS ROAD MORGANTON, NC 28655
--	---

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 118	<p>Continued From page 7</p> <p>years ago (March 2017). Client #2's Nayzilam for seizures was also expired as of November 22, 2023. Client #1's physician ordered ofloxacin ophthalmic solution to be administered for 10 days to treat an eye infection on February 15, 2024, but ofloxacin was documented on Client #1's MAR as being administered February 8-17, 2024. Client #1 was prescribed ofloxacin again on March 8, 2024, to be administered for another 10 days but ofloxacin was not listed on Client #1's MAR for the month of March 2024. Client #2 did not receive his daily Adderall for behavior support March 16th - 19th 2024 due to the facility running out of medication. Client #2's MARs did not include instructions for the dose of Nayzilam to administer during a seizure and did not include instructions for the frequency of polyethylene glycol powder to administer for constipation. Additionally, there was no documentation of Client #2's topical ciclopirox for toenail fungus having been removed with alcohol every 7 days as ordered by the physician.</p> <p>This deficiency constitutes a Type B rule violation which is detrimental to the health, safety and welfare of the clients and must be corrected within 45 days.</p>	V 118		
V 119	<p>27G .0209 (D) Medication Requirements</p> <p>10A NCAC 27G .0209 MEDICATION REQUIREMENTS (d) Medication disposal: (1) All prescription and non-prescription medication shall be disposed of in a manner that guards against diversion or accidental ingestion. (2) Non-controlled substances shall be disposed of by incineration, flushing into septic or sewer system, or by transfer to a local pharmacy for</p>	V 119		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL012-147	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/10/2024
--	---	---	--

NAME OF PROVIDER OR SUPPLIER SALEM ALTERNATIVE FAMILY LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 4840 JENKINS ROAD MORGANTON, NC 28655
--	---

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 119	<p>Continued From page 8</p> <p>destruction. A record of the medication disposal shall be maintained by the program. Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person disposing of medication, and the person witnessing destruction.</p> <p>(3) Controlled substances shall be disposed of in accordance with the North Carolina Controlled Substances Act, G.S. 90, Article 5, including any subsequent amendments.</p> <p>(4) Upon discharge of a patient or resident, the remainder of his or her drug supply shall be disposed of promptly unless it is reasonably expected that the patient or resident shall return to the facility and in such case, the remaining drug supply shall not be held for more than 30 calendar days after the date of discharge.</p> <p>This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to dispose of medications in a manner that guarded against diversion or accidental ingestion affecting 2 of 2 clients (Client #1 and #2). The findings are:</p> <p>Review on 4/9/24 of Client #1's record revealed: -Date of Admission: 3/29/20. -Diagnoses: Major Neurocognitive Disorder due to Traumatic Brain Injury (TBI) without Behavioral Disturbance; Hypertension; Benign Prostatic Hypertrophy; Gastroesophageal Reflux Disease (GERD). -Physician orders dated 2/1/23 included: -Adult multivitamin 1 tablet by mouth (PO)</p>	V 119		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL012-147	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/10/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SALEM ALTERNATIVE FAMILY LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 4840 JENKINS ROAD MORGANTON, NC 28655
--	---

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 119	<p>Continued From page 9</p> <p>every morning for nutrition.</p> <p>-GenTeal 0.3 % ophthalmic gel 2 drops in each eye twice daily (BID) for dry eyes.</p> <p>Review on 4/9/24 of Client #2's record revealed:</p> <p>-Date of Admission: 3/15/20.</p> <p>-Diagnoses: Abdominal Distension; Chronic Constipation; Edentulous; GERD, Pica; Profound Intellectual Disability; Regurgitation and Rechewing; Schizophreniform Disorder; Seizure Disorder.</p> <p>-Physician's order dated 12/27/23 for Nayzilam 5 milligram (mg)/0.1 milliliter (ml) nasal solution as needed (PRN) for seizure greater than 3 minutes. May repeat after 10 minutes.</p> <p>Observation on 4/8/24 at approximately 12:00 pm - 12:50 pm of Client #1's medications revealed:</p> <p>-Adult multivitamins expired August 2018.</p> <p>-GenTeal 0.3% ophthalmic gel expired March 2017.</p> <p>Observation on 4/8/24 at approximately 12:00 pm - 12:50 pm of Client #2's medication revealed:</p> <p>-Nayilam 5 mg/ml nasal solution expired 11/22/23.</p> <p>Interview on 4/9/24 with the local pharmacist revealed:</p> <p>-Expired medications could not "be administered legally ...If expired Nayzilam was used, it would not cause direct harm, but it can lose effectiveness. Expired GenTeal ointment would not cause harm but being that old it wouldn't be doing a lot except lubricating with minimal effectiveness. Expired multivitamins would be the same. Not causing direct harm, but minimally effective."</p> <p>Interview on 4/8/24 with Client #1 revealed:</p>	V 119		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL012-147	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/10/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER SALEM ALTERNATIVE FAMILY LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 4840 JENKINS ROAD MORGANTON, NC 28655
--	---

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 119	<p>Continued From page 10</p> <p>-His medications were administered by facility staff.</p> <p>Interview on 4/8/24 with Client #2 revealed: -He was unable to provide information regarding the administration of medications.</p> <p>Interview on 4/9/24 with Alternative Family Living (AFL) Provider #1 revealed: -Client #2 "had seizures before ...he used to be on meds (medications) that didn't work. Now he's on Keppra, it controls the seizures. He hasn't had one (seizure) in 2 years." - "I just left them (expired medications) in there. I should have took them out. It's just sloppy behavior."</p> <p>Interview on 4/9/24 with AFL Provider #2 revealed: -"I don't give medications. It's easier to just have one person (AFL Provider #1) doing that. I'm trained in case there's an emergency or something like that. [Client #2] hasn't had a seizure in over 2 years."</p> <p>Interview on 4/9/24 and 4/10/24 with the Qualified Professional revealed: -She was responsible for facility oversight. -She had not been reviewing the bottles of clients' medications during her on-site visits to the facility. -"I am going to make sure monthly that I look at the medication bottles to make sure they are in date ..."</p> <p>This deficiency is cross referenced into 10A NCAC 27G .0209 Medication Requirements (V118) for a Type B rule violation and must be corrected within 45 days.</p>	V 119		