PRINTED: 05/02/2024 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		MHL0411115	B. WING		04/15/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
J GEE'S HOUSE			JONES ROAD	•		
	OLIMAN DV OT		ORO, NC 2740		N	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
V 000	INITIAL COMMENTS		V 000			
	An annual survey was 2024. A deficiency was	s completed on April 15, as cited.				
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disability.				
	The facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.					
V 118	27G .0209 (C) Medica	ation Requirements	V 118			
	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 administering the drug.					

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

(X6) DATE TITLE

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			A. BUILDING: _		
		MHL0411115	B. WING		04/15/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
J GEE'S H	IOUSE	2006 OLD	JONES ROAD		
JULESI	IOU3E	GREENSB	ORO, NC 2740	06	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 118	Continued From page	e 1	V 118		
	(5) Client requests for checks shall be recor	r medication changes or ded and kept with the MAR pointment or consultation			
	facility failed to keep of 3 clients (#1, #2, and Review on 4/11/24 of -An admission date of -Diagnoses of Intellect Disability, Bipolar Dis	ews and interview, the the MARs current affecting 3 and #3). The findings are:  client #'1 record revealed: f 9/1/2015.			
	-She was 36 years ol	d.			
	orders dated 3/28/24 -Clindamycin PH 1% times daily (antibiotic - Divalproex SOD (so 500 mg(milligram), ta times daily (bipolar)Risperidone 0.5 mg to mouth two times daily -Topiramate 100 mg to mouth two times daily - Fluphenazine Dec 1 ml IM(intramuscular) (schizophrenia).	Solution apply topically two ). dium) DR (delayed release). ke two tablet by mouth two tablet, take one tablet by / (mood). tablet, take one tablet by / (bipolar). 25 mg/5, MI (milliliter) give 2 every 4 weeks mg, take one tablet by			

Division of Health Service Regulation

STATE FORM SQ4M11 If continuation sheet 2 of 7

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL0411115	B. WING		04/15/	/2024
J GEE'S HOUSE 2006 OLD			DRESS, CITY, STA JONES ROAD ORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	MHL0411115  PROVIDER OR SUPPLIER  STREET ADD  2006 OLD  GREENSB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		V 118			

Division of Health Service Regulation

STATE FORM SQ4M11 If continuation sheet 3 of 7

DIVISION	n nealth Service Negu	ialion				
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
		MHL0411115	B. WING		04/4	5/2024
		WITEO411113			04/1	5/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
J GEE'S H	IOUSE	2006 OLD	JONES ROAD			
JULESH	1003E	GREENS	BORO, NC 274	06		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	KIAIE	DATE
				,		
V 118	Continued From page	e 3	V 118			
	-April 12, 2024-No sta	aff initials to document				
	administration of follo	wing medications:				
	Clindamycin PH 1% o	on 4/8, Divalproex SOD DR.				
	500mg on 4/8, Topira	mate 100mg tablet on 4/8,				
	Ferrous Sulfate 325 n	ng on 4/8, Metformin HCL				
	ER 500mg on 4/8, Or	neprazole Dr. 20mg on 4/8,				
	Amantadine 100mg o	n 4/8, GNP one Daily				
	Essential on 4/8, Vita	min C 1000 IU on 4/8, 4/9.				
	Review on 4/11/24 of	client #2's record revealed:				
	-An admission date of	f 12/4/2017.				
	-Diagnoses of Bipolar	Disorder, Autism Spectrum				
	Disorder, Attention De	eficit Hyperactivity Disorder,				
	Mild Intellectual Deve	lopmental Disability, Seizure				
	Disorder.					
	-She was 33 years old.					
	Review on 4/11/24 of	Client #2's physician's				
	orders dated 1/17/24	revealed:				
		mg/3.2ml, inject 960mg in				
	gluteal every two mor	` '				
	- Aimovig 140mg/ml,					
	subcutaneously every					
	_	blet, take one tablet by				
	mouth at night (antac	•				
		rochloride) 20mg, take one				
	tablet by mouth daily(					
		ce one tablet by mouth daily				
	(contraceptive).	taka ana tahlat hu mauth				
		, take one tablet by mouth				
	at bedtime (seizures)	take one capsule by mouth				
	- Magnesium 400mg, daily (deficiency).	take one capsule by mouth				
		eam, apply a thin layer to				
	affected area on the f					
	(eczema).	ace two times daily				
		%, brush once daily in place				
		(prevent tooth decay).				
		ab, take one tablet by mouth				
	Tophaniate rooming to	as, take one tablet by mount	1			

Division of Health Service Regulation

two times daily (seizure).

STATE FORM SQ4M11 If continuation sheet 4 of 7

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MULTIPLE	CONSTRUCTION	I/V2) DATE O	·IID\/EV
	OF DEFICIENCIES  OF CORRECTION	IDENTIFICATION NUMBER:	` '		COMPLETED	
			A. BUILDING: _			
			R WING		]	
		MHL0411115	B. WING		04/1	5/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
J GEE'S H	IOUSE	2006 OLD	JONES ROAD			
J GLL J II	003L	GREENSE	30RO, NC 2740	06		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
1710		,	1,7,6	DEFICIENCY)	04/1	
V 118	Continued From page	. 1	V 118			
V 110	Continued From page	<del>; 4</del>	V 110			
		nd 4/12/24 of MARs dated				
		hrough April 12, 2024, for				
	client #2 revealed:	staff initials to document				
	-	staff initials to document following medications:				
		et on 2/23, Pimecrolimus				
	1% cream on 2/22, 2/					
	-March 2024- No staf	f initials to document				
	administration of the following medications:					
	_	g on 3/31, Kuvela 28 tab on				
	3/31, Lorazepam 1mg					
	•	n 3/31, Pimecrolimus 1%				
		Fluoride 0.2% on 3/31,				
	Topiramate 100mg ta	b on 3/30, 3/31.				
	-April 2024. No staff i	nitials to document				
	•	following medications:				
		on 4/5, Topiramate 100 mg				
	tab on 4/8					
		client #3's record reveled:				
	-An admission date o					
	-Diagnoses of Bipolai					
	•	Post Traumatic Stress				
	Oppositional Defiant	Development Disorder,				
	-She was 24 years of					
	5.10 Mas 24 yours or	<b>u.</b>				
	Review on 4/11/24 of	client #3's physician's order				
	dated 3/1/24 revealed					
		take one teaspoon of				
	· ·	e or coffee once a day				
	(probiotic).					
	•	n, take one tablet by mouth				
	daily (deficiency).	m dalca ana dablat burus sudi				
		g, take one tablet by mouth				
	daily (antihistamine).	DP 10mg take one tab by				
	- wontelukast Sodium	n DR 10mg, take one tab by				

Division of Health Service Regulation

STATE FORM SQ4M11 If continuation sheet 5 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
		MHL0411115	B. WING		04/1	5/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE. ZIP CODE		
			JONES ROAD	,		
J GEE'S H	OUSE	GREENS	BORO, NC 2740	06		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
	by mouth daily (hearti-Oxcarbazepine 300 two times daily (seizu-Pantoprazole Sodiumby mouth 2 times dail minutes before meals-Prazosin 2mg, take of (nightmares).  - Sertraline HCL 100rd daily (depression).  - Slynd 4mg, take one (contraception).	ng, take one capsule (cap) burn). mg, take one tab by mouth re). m DR 40 mg, Take one tab y on a empty stomach 30 c (reflux). one cap by mouth at bedtime mg, take one tab by mouth e tab by mouth daily				
	- Sucralfate 1mg, take one tab by mouth 2 times daily on an empty stomach (antiacid).  - Valacyclovir 500mg, take one tablet by mouth (antiviral).  - Vitamin D3 125 microgram (mcg), take one cap by mouth daily (supplement).  - Vitamin B-12 250mcg, take one cap by mouth daily(supplement).  - Vraylar 4.5, take one cap by mouth daily (Bipolar).					
	MARs dated from Fet 12, 2024 revealed: -February 2024- No s administration of the 1 Benefiber Prebiotic of Sodium DR 40mg on 300mg on 2/12, 2/22April 2024-No staff in administration of the 1 Oxcarbazepine 300m Sodium DR 40mg on	2/22, Oxcarbazepine  nitials to document following medications: g on 4/3, Pantoprazole				

Division of Health Service Regulation

revealed:

STATE FORM SQ4M11 If continuation sheet 6 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL0411115	B. WING		04/1	5/2024
NAME OF PR	ROVIDER OR SUPPLIER		RESS, CITY, STA		, ,,,,	<u></u>
J GEE'S HOUSE 2006 OLD J			JONES ROAD			
		GREENSB	ORO, NC 2740	06		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From page	÷ 6	V 118			
		their medications every day, to take their medication.				
		with Staff #1 revealed: s all the time when I give out on."				
	Interview on 4/12/24 with the House Manager revealed: -Clients received their medications every day.					
	-"no reason why they MARs."	(staff) did not sign off on the				
	-Knew who the staff the MARs.	nat was not initialing the				
	-"I look over the MAR Professional (QP)."	s and the Qualified				
	-The QP will give ano					
	Administration Training to the staffShe agreed that staff did not initial the MARs to have them to be current.  Interview on 4/12/24 with the QP revealed: -" I look over them, but the House Manger should be monitoring them."					
	MARs.	the missing initials on the w the MARs for February 24.				
	, , ,					

Division of Health Service Regulation

STATE FORM SQ4M11 If continuation sheet 7 of 7