Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL043-084 02/21/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **54 RIPLEY ROAD** FOREST HILLS FAMILY CARE FACILITY CAMERON, NC 28326 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual survey was completed on February 21, 2024. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. The facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients. V 117 27G .0209 (B) Medication Requirements V 117 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (b) Medication packaging and labeling: (1) Non-prescription drug containers not dispensed by a pharmacist shall retain the manufacturer's label with expiration dates clearly visible: (2) Prescription medications, whether purchased or obtained as samples, shall be dispensed in tamper-resistant packaging that will minimize the risk of accidental ingestion by children. Such packaging includes plastic or glass bottles/vials with tamper-resistant caps, or in the case of unit-of-use packaged drugs, a zip-lock plastic bag may be adequate; RECEIVED (3) The packaging label of each prescription drug dispensed must include the following: MAR 2 0 2024 (A) the client's name; (B) the prescriber's name; (C) the current dispensing date: **DHSR-MH Licensure Sect** (D) clear directions for self-administration: (E) the name, strength, quantity, and expiration date of the prescribed drug; and (F) the name, address, and phone number of the pharmacy or dispensing location (e.g., mh/dd/sa

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

center), and the name of the dispensing

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

(X4) ID PREFIX TAG	VIDER OR SUPPLIER LS FAMILY CARE SUMMARY STA (EACH DEFICIENCY N	FACILITY CAMERO TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)		STATE, ZIP CODE 26 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	02/	21/2024
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY N REGULATORY OR LS	FACILITY FACILITY CAMERO TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	DRESS, CITY, Y ROAD DN, NC 2832 ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		21/2024
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY N REGULATORY OR LS	FACILITY CAMERO TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	N	
PRÉFIX TAG V 117 Co	(EACH DEFICIENCY N REGULATORY OR LS	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	N	
		ge 1	1	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETE	
			V 117	The facility will ensure each client's medication(s) is labeled as required in accordance with physician's orders. For clients #1, Novolog Flex pen will b a labeled bag and stored in the refrigera physician' orders.	tor per	4/22/24
Revision - 10 Portion - 10 Port	sed on record reverviews, the facilitedications for admeled as required. view on 2/21/24 of year old male actingnoses of Interritism Disorder; Solvere Intellectual Effux; Diabetes. 2 signed and date view on 2/21/24 of the detection of the ders: Novolog short refrigeratorIt is labeled bag and of the ders and of the ders of the deriving of the ders of the ders of the deriving	mittent Explosive Disorder; hizoaffective Disorder; hizoaffective Disorder; Disability; Asthma; Acid ed 5/8/23- f client #1's signed physician 3 revealed: Novolog Flexpen Unit (s) every day- PRN ould be kept in labeled bag in recommended to store in in the refrigerator after each /24 at approximately 's medications revealed a filled insulin syringe that was yellow plastic bag without a ne Novolog flex pen prefilled the CEO/Licensee stated: dications for administration		The QP will conduct an in-service trains medication storage—and labeling for all assigned to the home. The QP will monitor once a week in the ensure appropriate labeling and storage medications. The Quality Management Director will in the home once monthly to ensure applabeling and storage of all medications.	staff- home to of all	4/22/24

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: MHL043-084 B. WING 02/21/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **54 RIPLEY ROAD** FOREST HILLS FAMILY CARE FACILITY CAMERON, NC 28326 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE. REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) The facility will ensure that the group home is 4/22/24 V 736 Continued From page 2 V 736 maintained in such a manner to ensure a safe, clean, attractive, odorless, and an orderly environment V 736 27G .0303(c) Facility and Grounds Maintenance V 736 through implementation of cleaning, repairs, and ongoing monitoring. 10A NCAC 27G .0303 LOCATION AND **EXTERIOR REQUIREMENTS** The group home will be cleaned thoroughly to ensure (c) Each facility and its grounds shall be that it is free of dirt, odor, stains and is maintained in maintained in a safe, clean, attractive and orderly an attractive manner. manner and shall be kept free from offensive odor. 4/22/24 The globe will be secured for celling light in the laundry room. This Rule is not met as evidenced by: Based on observation and interview, the facility The light ceiling in the den will be repaired. was not maintained in a safe, attractive and orderly manner. The findings are: The microwave will be replaced, the oven will be cleaned. Observation on 02/21/24 at approximately 4/22/24 12:15pm revealed: The blinds in the dining room will be replaced. -The ceiling light in the laundry room had no globe. Client #1's bedroom and bathroom will be cleaned, -The den had a 4 light ceiling and 3 lights had not and the bathroom ceiling will be painted. worked. -The microwave had areas on the inside that were peeling and rusty... Client #3's comforter with a large hole will be -The oven had black spills. replaced. The headboard of the bed that is peeling -The dining area window had a blind that had 8 will be repaired or replaced. Torn clothing hamper 4/22/24 slats broken in half. will be replaced. -Client #1's bedroom had clothing scattered on the floor; his bathroom had paint peeling from the Client #2's clothing hamper will be replaced. The ceiling above the shower and the toilet had not window blinds will be replaced as well. been flushed. -Client #3's bed had a comforter with a large hole, The hall bathroom will be thoroughly cleaned, and the bed brown covering on the headboard of the repairs made to the baseboard of flooring behind 4/22/24 bed was peeling, the clothes hamper was torn, bathroom door, and toilet tank top will be replaced. various sized brown stains were on the wall above the headboard. The living room in the front of the home will be -Client #2' clothes hamper had broken handles cleaned to also include removal of shoe molding and and the window blind had broken slats. nails on the floor near double window to ensure an -The hall bath had approximately 2 feet of the orderly environment. baseboard missing from the floor behind the bathroom door; the toilet in the hall bath had a

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	MHL043-084		B. WING			02/21/2024	
	PROVIDER OR SUPPLIER HILLS FAMILY CARE	FACILITY 54 RIPLE		STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY I	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE		
V 736	brown stain on the t tank top was broker -The living room at shoe molding with n double window. Interview on 02/21/2 the maintenance per molding in the living understood the facil	op behind the seat. The toilet	V 736	The QP/Residential Manager will conduct week inspections of the home to ensure appropriate cl repairs, and attractiveness of the facility. The Director of Quality Management will monit home monthly to ensure continued compliance.	eaning,	4/22/24	

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