STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED			
					R		
		MHL032-267	B. WING		05/15/2024		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
DIXON R	DIXON ROAD GROUP HOME 3520 DIXON ROAD DURHAM, NC 27707						
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)		
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE		
V 000	INITIAL COMMENT	-s	V 000				
		w up survey was completed deficiency was cited.					
	category: 10A NCA	sed for the following service C 27G .5600C Supervised h Developmental Disability.					
		sed for 5 and has a current urvey sample consisted of clients.					
V 118	27G .0209 (C) Med	ication Requirements	V 118				
	10A NCAC 27G .02 REQUIREMENTS (c) Medication adm (1) Prescription or r only be administere order of a person and rugs. (2) Medications shad clients only when and client's physician. (3) Medications, incompation administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Administered immediate MAR is to include the (A) client's name; (B) name, strength, (C) instructions for a (D) date and time the	inistration: non-prescription drugs shall d to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the sluding injections, shall be y licensed persons, or by trained by a registered nurse, legally qualified person and e and administer medications. Iministration Record (MAR) of led to each client must be kept s administered shall be ely after administration. The					

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			R	
		MHL032-267	B. WING			15/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
DIXON R	OAD GROUP HOME	3520 DIXO DURHAM	ON ROAD , NC 27707				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AID DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
V 118	Continued From particles (5) Client requests checks shall be recipile followed up by a with a physician.  This Rule is not me Based on observation interview, the facility available for administering three of three client ensure medications licensed person trapharmacist or other privileged to prepare affecting one of three to keep an MAR curaudited clients (#1)  The following is evicensure MARs were medication.  Review on 5/14/24 - Admission date of -Diagnoses of Mod Breast Cancer, Hyp Diverticulosis, and	for medication changes or corded and kept with the MAR appointment or consultation  et as evidenced by: ion and record reviews and y failed to ensure MARs were istered medication affecting is (#1, #2 and #3); failed to is were administered by a ined by a registered nurse, regally qualified person the and administer medications are audited staff (#1) and failed in the findings are:  dence the facility failed to available for administered  of client #1's record revealed: 4/12/18. erate Intellectual Disability, pertension, History of Obesity,	V 118				
	Review on 5/14/24 #1 revealed: Order dated 1/31/2	of physician's orders for client					

Division of Health Service Regulation

STATE FORM 5699 Z90E11 If continuation sheet 2 of 6

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 t. BOILBING.		l F	٦
		MHL032-267	B. WING			5/2024
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
DIXON R	OAD GROUP HOME	3520 DIXO DURHAM,	NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 2	V 118			
	-Nutritional Suppler	ment, drink once daily				
	Order dated 12/13/23: -Exemestane 25 milligrams (mg) (Breast Cancer), one tablet daily					
	tablet daily -Daily Gummy Mult one tablet daily -Fiber well Gummy movements), take of	e 10-12.5 mg (Diuretic), one ivitamin (Vitamin deficiency), 2.5 gram (gm) (Bowel				
	Observation on 5/14/24 at approximately 2:40 pm of the medication box for client #1 revealed: -The above medications and/or supplements were available.					
	-Admission date of -Diagnoses of Dow Disability, Opposition Dementia, Psychos	of client #2's record revealed: 6/15/07. n's Syndrome, Mild Intellectual onal Defiant Disorder, iis, Sleep Apnea and Gout. umentation of a March 2024				
	Review on 5/14/24 #2 revealed:	of a physician's order for client				
	(mg) (Dementia), o -Risperidone 0.5 m morning and one ta -Divalproex Sodium	ed Relief (ER) 28 milligrams ne capsule daily g (Schizophrenia), ½ tablet in ablet at night n Delayed Release (DR) 250 er), one tablet in the morning				

Division of Health Service Regulation

STATE FORM 5899 Z90E11 If continuation sheet 3 of 6

	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BOILDING.		R	
	MHL032-267	B. WING			5/2024
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DIXON ROAD GROUP HOME	3520 DIXO DURHAM	ON ROAD , NC 27707			
PREFIX (EACH DEFICIENCY MUST	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
V 118 Continued From page 3  -Metamucil powder 3.4 growith full glass of water -Prevident 5000 plus (Debefore bedtime -Allopurinol 100 mg (Gouthirtazapine 15 mg (Deputedtime) -Famotidine 40 mg (Acidibedtime) -Citalopram 30 mg (Depritablet and one 10 mg tabelitation and page of the medication box for the medication box for the above medications of the medication box for the above medications of the medication date of 8/14/8 -Diagnoses of Moderate Seizure Disorder, Scoliose HypertensionThere was no document 2024 MARs.  Review on 5/14/24 of a pillagraphic for the morning and the folial forms of the morning and the folial fol	ntal caries), brush teeth  it), two tablets daily ression), one tablet at  Reducer), one tablet at ression), one 20 mg let at bedtime ementia), one patch to  00 mg, 2 tablets at  at approximately 3:10 pm client #2 revealed: were available.  ant #3's record revealed: 31. Intellectual Disability, sis, Allergies and ration of March and April hysician's order for client  ure Disorder), ½ tablet in blet daily tablet at bedtime Seizure Disorder), 3	V 118			

Division of Health Service Regulation

STATE FORM 5899 Z9OE11 If continuation sheet 4 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		,	₹
		MHL032-267	B. WING			5/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DIXON R	OAD GROUP HOME	3520 DIXO DURHAM	ON ROAD , NC 27707			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
V 118	capsule two times of -Keppra 500 mg (State of Academic	mg (Seizure Disorder), one daily eizure Disorder), 3 tablets Overactive Bladder), one g (Depression), one tablet daily g (High Cholesterol), one digh Blood Pressure), one digh Blood Pressure), one 4/24 at approximately 2:53 pm ox for client #3 revealed: tions were available.  dence the facility failed to trained in medication  of the personnel record for define Manager umentation of medication	V 118			
	May 2024:					

Division of Health Service Regulation STATE FORM

ATE FORM 290E11 If continuation sheet 5 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING		R		
		MHL032-267	B. WING		05/1	5/2024
NAME OF PROVIDER OR	SUPPLIER		, ,	STATE, ZIP CODE		
DIXON ROAD GROU	P HOME	3520 DIXO DURHAM	ON ROAD , NC 27707			
PREFIX (EACH [	DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118 Continued	From pa	ige 5	V 118			
No staff in medication -Caltrate G-Nutritiona Interview of revealed: -The facility reorganized -She was not the file calcular -Staff #1 to training with -Staff #1 however the certificated -Staff #2 who for client #1 -She confined completed -She confined padminister -She confined for client #1 -She confined padminister -She confi	itials as a a/suppler summy be I Suppler on 5/14/2 by got new document on the agrad the coand never as working and the mad the mad the med the consequence on primed the trunch as a consequence on 5/6/6/6/10 comment the consequence on 5/6/6/6/10 comment the consequence on 5/6/6/10 comment the consequence of 5/6/6/10 comment the consequence of	administered for the following nent: ite on 5/11 ment on 5/11  4 with the Assistant Director of the paperwork. Ite older MAR's were not in nedication administration ency Nurse. Ite opy of her medication training or gave it back to them. In gon 5/11/24 and possibly those medications were given or ewas no documentation staff or administered medications. If #1 had no documentation y persons trained by a harmacist or other legally vileged to prepare and	V 118			

6899

Division of Health Service Regulation STATE FORM

Z90E11 If continuation sheet 6 of 6