STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
				A. BUILDING:		
		MHL077-082	B. WING		R 05/31/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
DILIGEN	T CARE GROUP HOM	AF #11	ELE STREET IGHAM, NC 28	370		
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
V 000	INITIAL COMMEN	rs	V 000			
	An annual and follow up survey was completed on May 31, 2024. A deficiency was cited.					
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.					
		eed for 4 and currently has a urvey sample consisted of clients.				
V 118	27G .0209 (C) Med	lication Requirements	V 118			
	 only be administered order of a person a drugs. (2) Medications shat clients only when a client's physician. (3) Medications, ind administered only builticensed persons pharmacist or other privileged to prepare (4) A Medication Act all drugs administered current. Medication frecorded immediate MAR is to include the (A) client's name; (B) name, strength (C) instructions for (D) date and time to the formation of the formation of the current of the	inistration: non-prescription drugs shall ed to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by trained by a registered nurse r legally qualified person and re and administer medications dministration Record (MAR) of red to each client must be kep s administered shall be ely after administration. The				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED	
			A. BUILDING:			
		MHL077-082	B. WING			R 31/2024
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
DILIGEN	IT CARE GROUP HOM	VIF #11	ELE STREET GHAM, NC 28	379		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	CORRECTION	- ()	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE DAT	
V 118	Continued From pa	Continued From page 1				
	checks shall be red	for medication changes or corded and kept with the MAR appointment or consultation				
	This Rule is not met as evidenced by: Based on observation, records reviews and interview, the facility failed to keep the MAR current affecting two of two audited clients (#1 and #3). The findings are:					
	-Admission date of -Diagnoses of Inter Moderate Intellectu Anxiety Disorder; C Abuse of an Adult Hypertension; Majo -Physician orders of	rmittent Explosive Disorder; ual Disorder; Generalized Central Sleep Apnea; Sexual Victim; Morbid Obesity; or Depression; Mood Disorder. dated 3/7/24 discontinuing 00 milligrams (mg)- Give two				
	Client #1's medicat	81/24 at about 10:30 am of tions revealed: 00 mg was not available.				
	1, 2024 through Ma -Carbamazepine 2	of Client #1's MARs for March ay 31, 2024 revealed: 00 mg was marked as 5/1/24 through 5/31/24.				
vision of H	-Carbamazepine w	of www.webmd.com revealed vas used to treat certain types rtial seizures, tonic-clonic	:			

3ZXL11

If continuation sheet 2 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL077-082 B. WING			R 05/31/2024		
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	T CARE GROUP HOM	418 STE	ELE STREET			
JEIGEN	T CARE GROUP HOW	ROCKIN	GHAM, NC 28	379		
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
V 118	Continued From pa	ige 2	V 118			
	seizures) and bipol	ar disorder.				
	-Admission date of -Diagnoses of Seve Thrombocytopenia, Non Compulsive Ep Contact Dermatitis; Palsy; Hyperlipidem -Physician's orders medications: -Divalproex Sou three times daily. -Risperidone 2 times daily. Observation on 5/3 revealed:	ere Intellectual Disorder; Unspecified; Generalized pilepsy; Allergic Rhinitis; Ace hyperkalemia; Cerebral nia. dated 8/1/23 for the following dium 250mg- Give one tablet mg- Give 1/2 tablet three 1/24 of Client #3's medication: n 250mg- Was available.				
	1, 2024 through Ma not initial the medic dates: -March 2024: -Divalproex Soc @ 2pm.	of Client #3's MARs for March ay 31, 2024 revealed staff did ation as given on the following dium 250mg- 3/8 @ 2pm. 3/28 mg- 3/8 @ 2pm. 3/28 @ 2pm	3			
	-Divalproex So 4/17-4/19 @ 2pm, 4 -Risperidone 2 @ 2pm, 4/22-4/26 @ -May 2024: -Divalproex So 5/4 @ 2pm, 5/6-5/7 5/13-5/17 @ 2pm, 5 @ 2pm.	mg- 4/4-4/5 @ 2pm, 4/17-4/19	9			

STATE FORM

3ZXL11

If continuation sheet 3 of 5

	of Health Service Re					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED	
						П
		MHL077-082	B. WING			R 31/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
DILIGEN	T CARE GROUP HON	AF #11		070		
			GHAM, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
V 118	Continued From page 3		V 118			
	2pm, 5/6-5/7 @ 2pm, 5/9-5/10 @ 2pm, 5/13-5/17 @ 2pm, 5/22-5/23 @ 2pm, 5/29- 5/30 @ 2pm.					
	-Divalproex Sodium and as a mood stat -Risperidone was u	of www.webmd.com revealed: n was used to treat seizures bilizer. Ised to treat schizophrenia, irritability associated with				
	Assistant revealed: -Medication came i not always review t -Staff did not realize Carbamazepine ha showed on the MAI -She was supposed	n bubble packs and staff may he med pack with the MAR. e that Client #1's d been discontinued, but still				
	-Client #3 did get hi program daily and a 2pm. -Staff may had forg as the electronic fili -Staff had been cor be hard on some of	is medications at his day at his home on weekends at otten to mark the MAR as well ing on Therap. ntinuously trained, but it may f them to mark the medication				
	medication would b	tilling a system so that the 2pm le logged appropriately. ly on the paper MAR.	ו			
	-He was not aware Carbamazepine ha	that Client #3's d continued to be marked as it was discontinued in March				

Division of Health Service Regulation STATE FORM

3ZXL11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		ENCIES (X1) PROVIDER/SUPPLIER/CLIA TION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		мн	L077-082	B. WING			R 31/2024	
PROVIDER	OR SUPPLIER	R	STRE	ET ADDRESS, CITY, S	STATE, ZIP CODE			
TCARE	GROUP HO	ME #II		STEELE STREET KINGHAM, NC 2				
(EAG	CH DEFICIENC	CY MUST BE P	DEFICIENCIES PRECEDED BY FULL (ING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2024. -He ack		d that facilit	ty staff failed to or Clients #1 and	#3.				

3ZXL11