STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
MHL091-087		IDENTIFICATION NOMBER.	A. BUILDING:			
		B. WING			R 03/2024	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ESTHER	'S PLACE		RLES STREET SON, NC 275			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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 000	INITIAL COMMENT	S	V 000			
		w up survey was completed ficiencies were cited.				
	category: 10A NCA	eed for the following service C 27G .5600C Supervised h Developmental Disability.				
	This facility is licensed for 6 and has a current census of 5. The survey sample consisted of audits of 2 current clients and 1 former client.					
V 118	27G .0209 (C) Medication Requirements		V 118			
	<ul> <li>only be administered order of a person and drugs.</li> <li>(2) Medications shat clients only when and client's physician.</li> <li>(3) Medications, inclient's physicians, inclient's physician.</li> <li>(3) Medications, inclient's physicians, incliented only builticensed persons pharmacist or other privileged to prepare (4) A Medication Ad all drugs administered current. Medication and all drugs administered mAR is to include th (A) client's name;</li> <li>(B) name, strength, (C) instructions for a (D) date and time the current of the strength and the strength of the strength</li></ul>	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 cluding injections, shall be y licensed persons, or by trained by a registered nurse, legally qualified person and e and administer medications. ministration Record (MAR) of red to each client must be kep s administered shall be ely after administration. The				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL091-087			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING			R 03/2024	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ESTHER	'S PLACE		RLES STREET RSON, NC 275			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From pa	ge 1	V 118			
	checks shall be rec	for medication changes or orded and kept with the MAR appointment or consultation				
	failed to ensure the 3 audited clients (# Review on 7/3/24 o - Admitted 5/1/07	view and interview, the facility MAR was kept current for 1 o 5). The findings are: f client #5's record revealed:				
	Developmental Disa Disorder, Obsessiv Autism - A Physician's o blood sugar (BS) or - June & July 202 instructions:	ability, Generalized Anxiety e Compulsive Disorder, & rder dated 6/14/24: check nce daily (Diabetes) 24 MARs with the following ugar once a week before				
	Interview on 7/3/24 - Staff checked h	client #5 reported: nis BS everyday				
	client #5 ate breakf - The Executive	#5's BS every morning before				
	Interview on 7/3/24 (CA) reported: ealth Service Regulation	the Compliance Assistant				

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	of Health Service Re				I		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL091-087		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		B. WING	07/	R 07/03/2024			
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S <sup>-</sup>	TATE, ZIP CODE			
ESTHER	'S PLACE		RLES STREET SON, NC 275				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C		(X5)	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIN CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETE	
V 118	Continued From pa	ge 2	V 118				
	<ul> <li>The Executive Director/Nurse was responsible for updating the clients' MARs</li> <li>Staff were supposed to notify the Executive Director/Nurse of any medication changes so she could update the MARs</li> <li>"Someone didn't update [Executive Director/Nurse]" of client #5's new physician order to check his BS</li> <li>Interview on 7/3/24 the Qualified Professional (QP) reported: <ul> <li>"Management (QP, CA, &amp; the Executive Director/Nurse)" could update the clients' MARs, but the Executive Director/Nurse had to approve the changes on the MAR</li> <li>Saw client #5's MARs weren't updated last night (7/2/24)</li> <li>Her not updating client #5's MARs was an "oversight"</li> </ul> </li> </ul>						
	reported: - Was the facility "routine for checkin - Was responsibl MARs once she wa changes - Hired a nurse th	the Executive Director/Nurse nurse, but she didn't have a g anything (client records)" le for updating the clients' s notified of medication nat will be responsible for weekly visits in the facility to					
V 291	27G .5603 Supervis	sed Living - Operations	V 291				
	six clients when the developmental disa on June 15, 2001, a	03 OPERATIONS illity shall serve no more than clients have mental illness or bilities. Any facility licensed and providing services to more nat time, may continue to					

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If continuation sheet 3 of 6

Division	of Health Service Re	equlation			FORM APPROVED	
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
МН		MHL091-087	B. WING		R 07/03/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ESTHER	'S PLACE		RLES STREET SON, NC 275			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BECOMPLETEHE APPROPRIATEDATE	
V 291	Continued From pa	ige 3	V 291			
	<ul> <li>/ 291 Continued From page 3 provide services at no more than the facility's licensed capacity.</li> <li>(b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management.</li> <li>(c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals.</li> <li>(d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan. Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.</li> </ul>					
	failed to coordinate	et as evidenced by: view and interview, the facility with other agencies to meet audited clients (#5). The				
ivision of H	<ul> <li>Admitted 5/1/07</li> <li>Diagnoses of M Developmental Disc</li> </ul>	f client #5's record revealed: 7 Aoderate Intellectual ability, Generalized Anxiety e Compulsive Disorder, &				

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Division	of Health Service Re	egulation			FORM	APPROVED
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
	MHL091-087		B. WING			R 03/2024
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
ESTHER	'S PLACE	270 CHA	RLES STREE	т		
2011121		HENDER	SON, NC 275	536		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 291	Continued From pa	ge 4	V 291			
		rder dated 6/14/24: check nce daily (Diabetes)				
	MARs revealed: - 14 missed BS of June 14, 2024-June	f client #5's June & July 2024 checks out of 16 days from e 30, 2024 d BS check for July 1, 2024				
	Observation on 7/3, - 1 documented 7/2/24 was handwri - 1 documented	/24 at 11:20am revealed: BS check for client #5 dated itten on a 3 x 3 inch sticky note BS check for client #5 dated itten on a torn sheet of paper				
	Interview on 7/3/24 - Staff checked h	client #5 reported: nis BS everyday				
		ger of the facility #5's BS every morning before				
	client #5's BS result - Supposed to do	ocument client #5's BS check				
		ut the "sheets (client #5's BS up and we (staff) been writing				
	client #5's BS result - Couldn't recall	what happened to client #5's				
	completed BS form Interview on 7/3/24	s the Compliance Assistant				
	reported: - Was unaware o weren't documente	client #5's BS check results d daily on his MAR				
	- Staff were train the client #5's MAR	ed to document BS results on s				
	ealth Service Regulation	y staff were documenting				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL091-087		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING			R 07/03/2024	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ESTHER	'S PLACE		RLES STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 291	Continued From pa	ge 5	V 291			
		eces of paper Professional (QP) and staff #1 or ensuring the clients' MARs				
	checks until June 2 - Was responsib MARs to ensure it w - BS checks wer on the clients' MAR - She informed th were to be docume daily 2-3 weeks ago - Saw sticky note BS results last wee	't have an order for daily BS 024 le for checking the clients' was documented correctly e supposed to be documented the facility staff that BS results nted on the clients' MARs				
	reported: - Client #5's BS of 2024 - The QP and ma ensuring the clients - The QP was re staff to ensure staff on the clients' MAR - Was informed b checks and docume	by management client #5's BS entation were completed client #5's BS results weren't				

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