Division of Health Service Regulation

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MUU 044 050	B WING		00/40/004	
MHL044-053	B: 111110		09/12/2024	
CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
5	V 000			
es were cited. ed under the following service c 27G .5600A Supervised				
ed for 6 and currently has a vey sample consisted of				
develop a written fire plan and shall make a copy of elency services agencies upon hall include evacuation es. elemade available to all staff edures and routes shall be drills in a 24-hour facility quarterly and shall be iff. cted under conditions that response to fire	V 114			
	MHL044-053  STREET AL  38 THOM	MHL044-053  STREET ADDRESS, CITY, STA  38 THOMAS PARK DRIVE WAYNESVILLE, NC 2878  TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)  S  A. BUILDING: B. WING  PREFIX TAG  TAG  V 000  AS COMPLETED ON THE FORMATION ON THE FORMATION ON THE PRECEDED BY FULL BE UNDER THE FORMATION ON THE FORMATION ON THE PREFIX TAG  V 000  AS COMPLETED ON THE FORMATION ON THE FORMATI	MHL044-053  STREET ADDRESS, CITY, STATE, ZIP CODE  38 THOMAS PARK DRIVE  WAYNESVILLE, NC 28786  TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL PREFIX TAG  TAG  CROSS-REFERENCE TO 11 HE APPROPR DEFICIENCY)  S  V 000  V 000  S  as completed on September es were cited.  ed under the following service C 27G .5600A Supervised n Mental Illness. ed for 6 and currently has a rvey sample consisted of clients.  TO EMERGENCY PLANS Il develop a written fire plan and shall make a copy of e ency services agencies upon shall include evacuation tes.  To emade available to all staff redures and routes shall be ordfills in a 24-hour facility t quarterly and shall be nift.  Cted under conditions that s response to fire	

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

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S COMPLI		
		MHL044-053	B. WING	B. WING		2/2024
	ROVIDER OR SUPPLIER  TA GROUP HOME		DRESS, CITY, STA			
PARK VIS	TA GROUP HOWE	WAYNESV	ILLE, NC 2878	6		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 114	facility failed to ensure conducted on each stindings are:  Review on 9/11/24 of disaster drill logs reverse A printout of fire-disaster drill logs reverse A printout of following shifts and quality - October - December	as evidenced by: ew and interviews, the e fire and disaster drills were nift at least quarterly. The  the facility's fire and ealed: ster drills completed at the months. if fire drills during the uarters: nber 2023: 1st & 3rd shifts. 2024: 2nd & 3rd shifts. idisaster drills during the uarters: nber 2023: 1st, 2nd, 3rd  2024: 1st, 2nd & 3rd shifts. idisaster drills during the uarters: nber 2023: 1st, 2nd, 3rd  2024: 1st, 2nd & 3rd shifts. idisaster drills during the uarters: nber 2023: 1st, 2nd, 3rd  2024: 1st, 2nd & 3rd shifts. idisaster drills disaster be completed. ind disaster drill log) is what  and 9/12/24 with the I (QP) revealed: for this facility in July 2024. in getting everything up to QP of this facility. for what was done prior to  e and disaster drills) from	V 114			

Division of Health Service Regulation

STATE FORM 6899 WB2X11 If continuation sheet 2 of 14

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			_			
		MHL044-053	B. WING		09/1	2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PARK VIS	TA GROUP HOME		S PARK DRIVE LLE, NC 2878			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From page	2	V 118			
V 118	27G .0209 (C) Medica	ation Requirements	V 118			
	only be administered order of a person autidrugs.  (2) Medications shall clients only when auticlient's physician.  (3) Medications, incluadministered only by unlicensed persons trepharmacist or other leprivileged to prepare (4) A Medication Admall drugs administered current. Medications a recorded immediately MAR is to include the (A) client's name;  (B) name, strength, a (C) instructions for addictions of the control of	stration: n-prescription drugs shall to a client on the written norized by law to prescribe be self-administered by norized in writing by the ding injections, shall be licensed persons, or by ained by a registered nurse, regally qualified person and and administer medications. inistration Record (MAR) of d to each client must be kept administered shall be refler administration. The following: and quantity of the drug; ministering the drug; drug is administered; and person administering the remedication changes or ded and kept with the MAR pointment or consultation				

Division of Health Service Regulation

STATE FORM 6899 WB2X11 If continuation sheet 3 of 14

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		COMP		(X3) DATE S		
			A. BUILDING: _			
		MHL044-053	B. WING		09/1	2/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
DVDK //IS	TA GROUP HOME	38 THOMA	S PARK DRIVE	Ē		
PARK VIS	TA GROUP HOWLE	WAYNESV	ILLE, NC 2878	6		
(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 SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
V 118	Continued From page	e 3	V 118			
	Based on record review facility failed to keep	ews and interviews, the the MARs current affecting 3 f1, #2, and #3). The findings				
	Review on 9/10/24 of Client #1's record revealed: -Admission Date: 6/6/24Diagnoses: Schizoaffective Disorder, Bipolar Type; Post Traumatic Stress Disorder (PTSD); Social Anxiety; Unspecified Intellectual Disabilities; Asthma; and ObesityPhysician Orders dated 5/3/24 revealed: -Hydroxyzine 25 milligram (mg) tablet (tab) (anxiety), 2 tabs by mouth (PO) three times daily					
	(TID).	,				
	tabs PO twice daily (Eand 2:00pm.	ng tab (overactive bladder), 2 BID), scheduled at 8:00am				
	1 cap PO every day a	Omg capsule (cap) (antacid), at 4:00PM. g tab (anxiety), 1 tab PO BID.				
	,					
	Review on 9/11/24 of 7/1/24 to 9/11/24 reve	Client #1's MAR dated ealed:				
	-No staff initials to inc administered on the f -July 2024:	licate medication was ollowing dates:				
	7/12/24, 7/17/24-7/18	Omg cap, 7/4/24,7/10/24, 5/24, and 7/24/24. mg tab, 7/26/24, 2:00pm.				
	-Hydroxyzine 25	g tab, 8/30/24, 8:00 PM. mg tab, 8/2/24 2:00pm,				
	2:00pm.	4 2:00pm, and 8/30/24				
	2:00pm, 8/9/24 2:00p -Lansoprazole 30	ng tab, 8/2/24 2:00pm, 8/7/24 m, and 8/30/24 2:00pm. Omg cap, 8/1/24, 8/2/24, 24, 8/2/24-8/23/24, and				

Division of Health Service Regulation

STATE FORM 6899 WB2X11 If continuation sheet 4 of 14

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-053	B. WING		09/12/2024
NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
PARK VISTA GROUP HOME		AS PARK DRIVE VILLE, NC 2878		
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
9/5/24 2:00pm -Imipramine 9/5/24 at 2:00pm Review on 9/10/2 -Admission Date: -Diagnoses: Schi Diabetes; Gastro (GERD); Hyperte Recurrent Genita Pseudo-seizuresPhysician Orders -Aripiprazole PO daily (QD), da -Atorvastatin tab PO in the eve -Bupropion H (Depression), 1 ta -Docusate S 1 cap PO BID, da -Ezetimibe 1 QD, dated 5/17/2 -Famotidine BID, dated 3/21/2 -Linzess 290 (constipation), 1 c -Metoprolol B BID, dated 8/30/2 -Pantoprazol QD, dated 4/10/2 -Psyllium Fib caps PO QHS, da -Risa quad C QD, dated 7/26/2	25mg tab, 9/3/24 2:00pm and 10mg tab, 9/3/24 2:00pm, and 4 of Client #2's record revealed: 6/2/17. zoaffective Disorder; Type 2 esophageal Reflux Disease nsion; Vitamin D Deficiency; I Herpes; Obesity; and s included the following: 15mg tab (antipsychotic), 1 tab ated 12/22/23. 80mg tab (Hyperlipidemia), 1 ning (QHS), dated 4/4/24. ICL SR 150mg tab, ab QD, dated 2/27/24. bdium 100mg cap (constipation), ted 5/17/24. comg tab (cholesterol), 1 tab 4. 20mg tab (GERD), 1 tab PO 4. micrograms (mcg) tap PO, QD, dated 8/7/23. ER 25 mg (anxiety), 1 tab PO 3. e 40mg tab (GERD), 1 tab PO 4. er Capsules (constipation), 2 ated 1/24/22 tapsules (probiotic), 1 cap PO	V 118		

Division of Health Service Regulation

-Trintellix 20mg tab (antidepressant), 1 tab

STATE FORM 6899 WB2X11 If continuation sheet 5 of 14

Division of Health Service Regulation

DIVISION	n nealth Service Negu	liation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
			-			
		MHL044-053	B. WING	<del></del>	09/1	2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	ATE ZIP CODE		
TO WILL OF TH	NOVIDER OR GOLF EIER		, ,	,		
PARK VIS	TA GROUP HOME		AS PARK DRIVI			
		WAYNES	/ILLE, NC 2878	36		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
TAG	REGULATORT ORT	EGC IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	MAIL	5,112
V 118	Continued From page	e 5	V 118			
	PO QD, dated 2/28/2	1				
	· ·	ram (Herpes)1 tab PO, every				
	8 hours for 7 days, da					
		00 mcg, tab (low vitamin B), 1				
	tab PO QD, dated 1/2					
		0U tab, (vitamin D				
	deficiency), 1 tab PO	•				
		b (prenatal vitamin), 1 tab				
	QD, dated 1/22/24.	b (prenatai vitaniin), T tab				
	QD, dated 1/22/24.					
	Review on 9/11/24 of	Client #2's MAR dated				
	7/1/24 to 9/11/24 reve					
		icate the medication was				
	administered on the f					
	-July 2024:	onowing dates.				
	•	ng tab, 7/1/24 and 7/7/24.				
		ng tab, 7/7/24 and 7/19/24.				
		SR 150mg tab, 7/1/24.				
		m 100mg cap, 7/1/24				
		om, and 7/19/24 8:00pm.				
	-Ezetimibe 100m					
		ng tab, 7/1/24, 8:00am,				
	7/7/24 8:00PM, and 7					
		crograms (mcg), 7/1/24.				
		25 mg, 7/1/24 9:00am, 7/7/24				
	8:00pm, 7/19/24, 8:00	•				
	-Pantoprazole 40					
	-	Capsules, 7/1/24, 7/7/24 and				
	7/19/24.	5apodios, 77 172 1, 77772 1 dila				
	-Risa quad Caps	sules 7/1/24				
	-Toviaz ER 8mg					
	-Trintellix 20mg t					
	•	ram, 7/26/24 4:00pm and				
	,	24 10:00pm, and 7/30/24,				
	•	m and 7/31/24 10:00pm.				
	-	10 mcg, tab, 7/1/24.				
	-Vitamin D3-500					
	-vvestab Pius Tai	b (prenatal vitamin), 7/1/24.				
	Review on 9/10/24 of	Client #3's record revealed:				
		55.16 // 0 0 1000/d 10 Vodiod.	1	İ		1

Division of Health Service Regulation

STATE FORM 6899 WB2X11 If continuation sheet 6 of 14

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLI			
			A. BUILDING:			
		MHL044-053	B. WING		09/	12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
PARK VIS	TA GROUP HOME		S PARK DRIVE			
			ILLE, NC 2878			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	e 6	V 118			
V 118	-Admission Date: 9/3/ -Diagnoses: Schizop Type 2 Diabetes, Hyp Alcohol Use Disorder Cocaine Use D/OPhysician Orders inc -Ventolin HFA 90 inhale 2 puffs PO, 4 ti 9/19/22B-12 1,000 mcg (injection) (low vitamir -Trulicity 3mg/0.5 sub-q (subcutaneous 8/25/23.  Review on 9/11/24 of 7/1/24 to 9/11/24 reve -No staff initials to ind administered on the fe -July 2024: -B-12 1000 mcg -Ventolin HFA 90 8:00am, 12:00pm, 4:0 12:00pm, 7/4/24-7/5/2 7/10/24 4:00pm, 7/11 4:00pm, 7/18/24-7/19 7/23/24 12:00 and 4:0 -August 2024: -Ventolin HFA 90 4:00pm, 8/7/24 12:00 8/9/24 12:00pm, 8/11 4:00pm, 8/15/24 12:0 8/21/24 4:00pm, 8/23 4:00pm, and 8/30/24 -September 2024:	chrenia, Bipolar Disorder, pertension, GERD, Moderate (D/O), and Moderate (D/O), dated (D/O)	V 118			
	-Ventolin HFA 90 and 4:00pm and 9/6/2					

Division of Health Service Regulation

STATE FORM 6899 WB2X11 If continuation sheet 7 of 14

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
			A. BOLLBING.		
		MHL044-053	B. WING		09/12/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
PARK VISTA GROUP HOME 38 THOMA			S PARK DRIVE	<b>!</b>	
	TA GROOT TIGHTE	WAYNESV	ILLE, NC 2878	66	
(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 APPROPF DEFICIENCY)	BE COMPLETE
V 118	Continued From page		V 118		
	-The facility had medi Qualified Professional being hired in July 20 trying to get things who -"When I got here (hir messed up" -Client #2 frequently and may be related to -On 7/724, Client #2 smedicationCould not locate an inthose missing signature #2 in July 2024.  Interview on 9/12/24 shadministered medical shiftDid not know about roughly 2024 MARs, "[in and just didn't documents."	cation issues prior to current I/House Manager (QP/HM) 24 and staff had worked on here they should be. red) a lot of meds were  went to the emergency room to the missing signatures. Islept late and missed her Incident report related to here on the MAR for Client  with Staff #2 revealed: Incident staff #2 revealed: Incident staff #2 revealed: Incident staff #3 revealed: Incident staff #4 revealed: Incident staff *4 reve			
	"didn't give meds."	the clients bowling and			
	Interview on 9/12/24 with the Qualified Professional (QP) revealed: -Had worked at the facility since the middle of July 2024Was responsible for medication oversight at the facility"Haven't looked at MARs yet for when they (medications) are late." -The nurse "hadn't been on site" since she was hired"I didn't realize how bad they (MARs) looked until I printed them out."				
	Due to the failure to a medication administra determined if the clier				

Division of Health Service Regulation

STATE FORM 6899 WB2X11 If continuation sheet 8 of 14

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		MHL044-053	B. WING		09	0/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE		
PARK VIS	TA GROUP HOME		MAS PARK DRIVE			
	CUMMARY CT		SVILLE, NC 28786	DDOVIDEDIC DI ANI OF (	CORRECTION	
(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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 118	Continued From page	e 8	V 118			
	as ordered by the phy	ysician.				
V 123	27G .0209 (H) Medica	ation Requirements	V 123			
	and significant advers reported immediately pharmacist. An entry and the drug reaction	Drug administration errors se drug reactions shall be				
	facility failed to ensur immediately reported affecting 3 of 3 audite The findings are:	as evidenced by: ews and interviews, the e all medication errors were to a pharmacist or physician ed clients (#1, #2, and #3).				
	-Admission Date: 6/6, -Diagnoses: Schizoaf Type; Post Traumatic Social Anxiety; Unspe Disabilities; Asthma; a -Physician Orders da -Hydroxyzine 25 (anxiety), 2 tabs by m (TID)Imipramine 10m	/24. ffective Disorder, Bipolar Stress Disorder (PTSD); ecified Intellectual and Obesity.				

Division of Health Service Regulation

STATE FORM 6899 WB2X11 If continuation sheet 9 of 14

Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		MHL044-053	B. WING		09/	12/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
		38 THOM	IAS PARK DRIVE			
PARK VIS	TA GROUP HOME		VILLE, NC 28786			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	)RRECTION	(YE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 123	Continued From page	9	V 123			
	and 2:00pm.					
	•	Omg capsule (cap) (antacid),				
	1 cap PO every day a					
		tab (anxiety), 1 tab PO BID.				
	D : 0/40/04 f					
	-Admission Date: 6/2	Client #2's record revealed:				
		fective Disorder; Type 2				
		phageal Reflux Disease				
		n; Vitamin D Deficiency;				
	Recurrent Genital He	_				
	Pseudo-seizures.	.p.c., 0.200.sy, aa				
	-Physician Orders inc	luded the following:				
	-	ng tab (antipsychotic), 1 tab				
	PO daily (QD), dated					
	-Atorvastatin 80n	ng tab (Hyperlipidemia), 1				
	tab PO in the evening	g (QHS), dated 4/4/24.				
	-Bupropion HCL					
	(Depression), 1 tab C					
		m 100mg cap (constipation),				
	1 cap PO BID, dated					
		g tab (cholesterol), 1 tab				
	QD, dated 5/17/24.	(0555) 50				
		g tab (GERD), 1 tab PO				
	BID, dated 3/21/24.	arama (mag)				
	-Linzess 290 mid	PO, QD, dated 8/7/23.				
		90, QD, dated 6/7/25. 5 mg (anxiety), 1 tab PO				
	BID, dated 8/30/23.	.5 mg (anxiety), i tab FO				
		mg tab (GERD), 1 tab PO				
	QD, dated 4/10/24.	omg tab (GEND), 1 tab 1 G				
		Capsules (constipation), 2				
	caps PO QHS, dated					
	•	ules (probiotic), 1 cap PO				
	QD, dated 7/26/23.	(F), . 33F . 3				
		tab (incontinence), 1 tab PO,				

Division of Health Service Regulation

QD, dated 2/28/24.

PO QD, dated 2/28/24.

-Trintellix 20mg tab (antidepressant), 1 tab

-Valacyclovir 1 gram (Herpes)1 tab PO, every

STATE FORM 6899 WB2X11 If continuation sheet 10 of 14

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		MHL044-053	B. WING		09	9/12/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
PARK VIS	TA GROUP HOME		IAS PARK DRIVE SVILLE, NC 28786			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 123	8 hours for 7 days, d -Vitamin B-12 50 tab PO QD, dated 1// -Vitamin D3-500 deficiency), 1 tab PO -Westab Plus Ta QD, dated 1/22/24.  Review on 9/10/24 o -Admission Date: 9/3 -Diagnoses: Schizor Type 2 Diabetes, Hyl Alcohol Use Disorde Cocaine Use D/OPhysician Orders inc -Ventolin HFA 90 inhale 2 puffs PO, 4 9/19/22B-12 1,000 mcg (injection) (low vitam -Trulicity 3mg/0.	ated 7/25/24.  20 mcg, tab (low vitamin B), 1 26/24.  30 U tab, (vitamin D 30 QD, dated 4/26/24.  3b (prenatal vitamin), 1 tab  4 Client #3's record revealed:  4/16.  5 bhrenia, Bipolar Disorder,  5 pertension, GERD, Moderate  4 (D/O), and Moderate  5 uncg (inhaler/asthma),  6 times a day (QID), dated  5 intramuscular every month	V 123			
	dated 6/1/24 to 9/11/ -A minimum of 9 med 8/30/24, 8/29/24, 8/2 8/11/24, 7/10/24, 7/7	f the facility's incident reports 24 revealed: dication (med) errors dated 3/24, 8/17/24, 8/16/24, /24, and 7/5/24 with no macist or physician was				
	-The facility had med Qualified Professiona hired in July 2024 an to get things where the -Staff would contact to med errors.	with Staff #1 revealed: I issues prior to current al/House Manager (QP/HM) Id staff had worked on trying they should be. Ithe pharmacy if there was Incident report related to				

Division of Health Service Regulation

STATE FORM 6899 WB2X11 If continuation sheet 11 of 14

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MHL044-053	B. WING		09/1	2/2024
	ROVIDER OR SUPPLIER  TA GROUP HOME	38 THOMA	PRESS, CITY, STA S PARK DRIVE	E		
(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
V 123	#2 in July 2024.  Interview on 9/12/24 v -Had to do an inciden late in the evening an -Did not contact the p the above noted med -She has been instruct for med errors and the by the current QP/HM  Interview on 9/12/24 v -Was responsible for -A staff meeting was I medication administra -Had been over the fa was still catching up of medicationSaw how the MARs	with Staff #2 revealed: t report if meds were given d why. harmacist or physician for ication errors. cted to contact the pharmacy e correct window for dosing 1. with the QP/HM revealed: med oversight. held on 9/11/24 regarding	V 123			
V 736	10A NCAC 27G .0303 EXTERIOR REQUIRI (c) Each facility and it maintained in a safe, manner and shall be odor.  This Rule is not met Based on observation failed to be maintained orderly manner. The face of the same of the sa	EMENTS s grounds shall be clean, attractive and orderly kept free from offensive as evidenced by: n and interviews, the facility d in a safe, clean, and	V 736			

Division of Health Service Regulation

STATE FORM 6899 WB2X11 If continuation sheet 12 of 14

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED							
AND FLAN OF CORRECTION		ISERTIN ISTRICTION NECES	A. BUILDING:		00111112							
		MHL044-053	B. WING		09/1	2/2024						
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
PARK VIS	TA GROUP HOME		S PARK DRIVE									
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	T .	PROVIDER'S PLAN OF CORRECTIO	N	(VE)						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE						
V 736	Continued From page	e 12	V 736									
	-Client #2's bedroom items, trash, and had -Trash was on the top-A trash can beside the and had an incontine outBlankets and clothing-Empty snack bags well-The closet had clothe bedroom and there we a point of egress that chair and all of the closet in hygiene properties and no toilet paper in their care appliances.  Interview on 9/11/24 vell-Had been at the facility-She was working town independent."  Interview on 9/10/24 vell-He came to the facility is "unacceptable."	was cluttered with food an odor of urine. of the dresser. he dresser was overflowing ince pad folded over sticking g covered the floor. here on the bed. hes overflowing out into the as desk beside the window, has partially blocked by a bothing items. had a double sink that was roducts, clothing on the floor the holder. here of the were plugged in by the sink.  with Client #2 revealed: hity for 7 years. had a double work on some be addressed. he physical state was  with Staff #1 revealed:										
	-He was the sole male clients and tried not to to maintain profession	eeping her room clean. e staff with the all-female o go in their bedrooms alone nal boundaries. that she needed to clean up										
	Interview on 9/12/24 v -Staff and clients were cleanliness of the faci	•										

Division of Health Service Regulation

STATE FORM 6899 WB2X11 If continuation sheet 13 of 14

Division of Health Service Regulation

MALE OF PROMIDER OR SUPPLIER  PARK VISTA GROUP HOME  STREET ADDRESS, CITY, STATE. JIP CODE  38 THOMAS PARK DRIVE WAYNESVILLE, NC 28786   [X4) ID PRETTY 1AG  V 736  Continued From page 13  -"Some staff are better with following up than others." -Client #2 was independent and will say that she's cleaned her roomWould check on Client #2's sister and Client #2's sister told Client #2 to keep their rooms clean.  Interview on 91/12/24 with the Qualified Professional revealed: -Staff #1 contacted Clients #2 to keep their rooms clean.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
PARK VISTA GROUP HOME  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 736  Continued From page 13  -"Some staff are better with following up than others."  -Client #2 was independent and will say that she's cleaned her room.  -Would check on Client #2's room more often.  Interview on 9/12/24 with the Qualified Professional revealed:  -Staff #1 contacted Client #2's sister and Client #2's sister told Client #2 to clean her room, and she did on 9/11/24.  -Worked with Clients #1 and #2 to keep their			MHL044-053	B. WING		09	9/12/2024	
CX4) ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDER'S PLAN OF CORRECTION (X5)   COMPLETE   TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   TAG   COntinued From page 13   V 736   Continued From page 13   V 736   Continued From page 13   V 736   Client #2 was independent and will say that she's cleaned her room.   -Would check on Client #2's room more often.   Interview on 9/12/24 with the Qualified   Professional revealed:   -Staff #1 contacted Client #2's sister and Client #2's sister told Client #2 to clean her room, and she did on 9/11/24.   -Worked with Clients #1 and #2 to keep their	NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE			
(X4) ID PREFIX TAG    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG     V 736   Continued From page 13	PARK VIS	TA GROUP HOME						
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 736  Continued From page 13  -"Some staff are better with following up than others."  -Client #2 was independent and will say that she's cleaned her room.  -Would check on Client #2's room more often.  Interview on 9/12/24 with the Qualified Professional revealed:  -Staff #1 contacted Client #2's sister and Client #2's sister told Client #2 to clean her room, and she did on 9/11/24.  -Worked with Clients #1 and #2 to keep their	040.15	CLIMMADVCT				ORRECTION	2/5	
-"Some staff are better with following up than others."  -Client #2 was independent and will say that she's cleaned her room.  -Would check on Client #2's room more often.  Interview on 9/12/24 with the Qualified Professional revealed:  -Staff #1 contacted Client #2's sister and Client #2's sister told Client #2 to clean her room, and she did on 9/11/24.  -Worked with Clients #1 and #2 to keep their	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	N SHOULD BE E APPROPRIATE	COMPLETE	
others." -Client #2 was independent and will say that she's cleaned her roomWould check on Client #2's room more often.  Interview on 9/12/24 with the Qualified Professional revealed: -Staff #1 contacted Client #2's sister and Client #2's sister told Client #2 to clean her room, and she did on 9/11/24Worked with Clients #1 and #2 to keep their	V 736	Continued From page 13		V 736				
	V 736	-"Some staff are bette others." -Client #2 was indeper cleaned her roomWould check on Clied. Interview on 9/12/24 of Professional revealedStaff #1 contacted C #2's sister told Client she did on 9/11/24Worked with Clients.	er with following up than endent and will say that she's ent #2's room more often. with the Qualified d: lient #2's sister and Client #2 to clean her room, and	V 736				

Division of Health Service Regulation

STATE FORM 6899 WB2X11 If continuation sheet 14 of 14