Division of Health Service Regula STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R 09/27/2024	
		IDENTIFICATION NUMBER.				
		MHL043-090				
AME OF PRO	VIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
MARTIN			MAS DICKENS I TON, NC 2754			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 000 IN	INITIAL COMMENTS		V 000			
	An annual and follow up survey was completed on September 27, 2024. A deficiency was cited.					
ca Li	This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living Alternative Family Living in a Private Residence.					
Ce		eed for 2 and has a current irvey sample consisted of clients.				
V 118 27	7G .0209 (C) Med	ication Requirements	V 118			
Ri (c (1 or or dr (2 cli cli cli cli cli cli cli cli cli cli	Aly be administered ader of a person at augs. Medications shat ients only when at ient's physician. Medications, includent's Medications, includent Medications, includent Medications, includent Medications, includent Medication Ad I drugs administered arrent. Medication A Medication Ad I drugs administered AR is to include th Corded immediate AR is to include th Corded immediate AR is to include th Corded immediate (Corded immed	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				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED R 09/27/2024	
		MHL043-090					
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE			
MARTIN			IAS DICKENS FON, NC 2754				
(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 DEFICIENC	ON SHOULD BE COMPL HE APPROPRIATE DATE		
V 118	drug. (5) Client requests checks shall be rec	ge 1 for medication changes or orded and kept with the MAR appointment or consultation	V 118				
	facility failed to ensu current affecting on findings are:	views and interviews, the ure the MARs were kept e of two clients (#2). The of client #2's record revealed: '18. und Intellectual					
	Review on 9/26/24 orders dated 5/6/24 -Simvastatin 40 mg						
	Review on 9/26/24 7/1/24 - 9/26/24 rev -No documentation administered from 7	Simvastatin 40 mg					
	client #2's medicati	within a blister packet of					
	Attempted on 9/26/ revealed he was no ealth Service Regulation	24 to interview client #2 n verbal.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHI 043-090	B. WING		R 09/27/2024		
			DDRESS, CITY, SI		03/		
			AS DICKENS				
MARTIN			TON, NC 2754				
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 118	Continued From pa	age 2	V 118				
	-The pharmacy cre -Client #2 was pres -It was a pharmacy not on the MAR. -She would add Sin MARs. Interview on 9/26/2 Provider stated: -Client #2 was pres -She reviewed the I -The pharmacy con facility. -She had not notice not on the MAR.	npleted the MARs for the ed the Simvastatin 40 mg was stitutes a re-cited deficiency					

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