Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(2) MULTIPLE CONSTRUCTION (X3) D		
			A. BUILDING:			
		MHL007-076	B. WING		R 10/17/20	24
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
COUNTE	RY LIVING GUEST HO	MF #6	TAYLOR ROASTON, NC 27			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE CO	(X5) MPLETE DATE
V 000	INITIAL COMMEN	тѕ	V 000			
	on October 17, 202 This facility is licens category: 10A NCA Living for Adults with This facility is licens census of 6. The su	urvey sample consisted of				
V 118	This facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients. 27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the					

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	1 ` ' CC			DATE SURVEY COMPLETED	
,	0. 002011011		A. BUILDING:				
		MHL007-076	B. WING		I	R 17/2024	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE			
COUNTR	RY LIVING GUEST HO	MF #6	TAYLOR ROAGTON, NC 27				
(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
V 118	(5) Client requests checks shall be rec file followed up by a with a physician.	for medication changes or corded and kept with the MAR appointment or consultation	V 118				
	Based on record refacility failed to administration order of a publication of the facility failed to administration order of a publication of the facility failed by the facility failed to administration of the facility failed by the faile	sm Spectrum Disorder, order, Intermittent Explosive pyramidal and Movement					
	client #1 dated 03/2 - Benzoyl peroxide daily Clonidine (treats I milligrams (mg) - ta - Divalproex (treats tablets twice daily Lacosamide (treat twice daily Lorazepam (treats twice daily.	4 of medication orders for 20/24 revealed: (treats acne) - apply twice high blood pressure) 0.1 ake 2 tablets twice daily. s seizures) 500mg - take 2 ts seizures) 200mg - take s anxiety) 0.5mg - take 1 tablet rpsychotic) 3mg - 1 tablet twice					

Division of Health Service Regulation

STATE FORM 6899 72HO11 If continuation sheet 2 of 5

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				O) DATE SURVEY COMPLETED	
			A. BUILDING:				
		MHL007-076	B. WING		I	R 17/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE			
COUNTR	Y LIVING GUEST HO	MF #6	TAYLOR RO				
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
V 118	thru October 16, 20 August 2024 thru C - Benzoyl peroxide daily. Staff docume area on the MARs administration at 8 the medication was ordered. October 2024 - No staff initials to medications were a 8pm - Clonidine, Di Lorazepam, and Ri Interview on 10/17/ his acne medication Finding #2: Review on 10/17/2 revealed: - Admission date or - Diagnoses Gastro (GERD), History of Hypertension and H Review on 10/17/2 medication orders or - Atorvastatin (treat at bedtime Benztropine (treat disease) 1mg - take - Carbamazepine (sone tablet twice da - Denta 5000 plus (sone)	4 of client #1's August 2024 224 MARs revealed: October 16, 2024 - transcribed as apply twice ented once daily at 8am. No for staff to document om. No staff initials to indicate administered twice daily as indicate the following administered on 10/05/24 at invalproex, Lacosamide, isperidone. 224 client #1 stated he received in once daily in the morning. 4 of client #4's record f 08/22/24. Desophageal Reflux Disease Seizures, Diabetes, Hyperlipidemia. 4 of client #4's signed dated 08/14/24 revealed: its cholesterol) 20mg - take one at bedtime. anticonvulsant) 400mg - take illy. (fluoride) - apply twice daily.					
	Review on 10/17/24	4 of client #4's October 2024					

Division of Health Service Regulation

STATE FORM 6899 72HO11 If continuation sheet 3 of 5

Division of Health Service Regulation

DIVIDION	or riealth Service IN	syulation	1			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER.		A. BUILDING:		COMPLETED		
					F	₹
		MHL007-076	B. WING		10/1	7/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STATE, ZIP CODE			
10 10 1	TO VIDER OR GOLF EIER		TAYLOR RO			
COUNTR	RY LIVING GUEST HO	MF #6	STON, NC 27			
240.15	CUMMA DV CTA		-		DNI .	0.45)
(X4) ID PREFIX	_	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEFICIENCY)		
V 118	Continued From pa	ge 3	V 118			
	MAR revealed:					
		the following medications on				
		Atorvastatin, Benztropine,				
	Carbamazepine an					
		24 client #4 stated he received				
	his medications dai	ly as ordered.				
	Finding #3:					
		4 of client #6's record				
	revealed:					
	- Admission date of 10/01/24.					
- Diagnoses of Traumatic Brain Injury, GERD,						
	Vascular Dementia, Hyperthyroidism,					
		od Disorder and Overactive				
	Bladder.					
	Review on 10/17/24 of client #6's medication					
	orders dated 10/02/					
		g - take 1/2 tablet at bedtime.				
	- Carvedilol (treats high blood pressure) 6.25mg -					
	take twice daily.					
		s symptoms of overactive				
	bladder) 5mg - take	e twice dally. epressant) 100mg - take two				
	tablets at bedtime.	pressant) roomy - take two				
	tablets at bedtime.					
	Review on 10/17/2	4 of client #6's October 2024				
	MAR revealed:					
		the following medications on				
		Atorvastatin, Carvedilol,				
	Oxybutynin and Tra	zodone.				
	Interview on 10/17/	24 client #6 stated he received				
	his medications dai					
	5 11154154110110 441	.,.				
	Interview on 10/17/	24 the Qualified Professional				
	stated:					
		k the MARs to ensure accurate				
	information was tra	nscribed.				

Division of Health Service Regulation

STATE FORM 6899 72HO11 If continuation sheet 4 of 5

Division of Health Service Regulation

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.			E CONSTRUCTION	(X3) DATE	SURVEY LETED	
		7. BOILDING.		F		
		MHL007-076	B. WING			7/2024
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
COUNTR	Y LIVING GUEST HO	ME #6	TAYLOR RO STON, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 4	V 118			
	- He would provide medication issues a	a plan of correction to address at the facility.				
	medication adminis	o accurately document stration it could not be s received their medications shysician.				
	This deficiency con and must be correct	stitutes a re-cited deficiency cted within 30 days.				
l						

6899

Division of Health Service Regulation STATE FORM

72HO11 If continuation sheet 5 of 5