PRINTED: 10/17/2024 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL041-613	B. WING		10/	14/2024
NAME OF PR	OVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, ST	FATE, ZIP CODE		
		7311-A FRIE	NDSHIP CH	IURCH ROAD		
M & S SU	PERVISED LIVING, LLC	BROWNS S	UMMIT, NC	27214		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	An annual survey was 2024. Deficiencies we This facility is licensed category: 10A NCAC 2 Living for Adults with E	for the following service 27G .5600C Supervised Developmental Disability. for 4 and has a current by sample consisted of	V 000	M&S Supervised Living LLC will corre employee file to reflect a correct First certificate. Director /QP will ensure this completed by 12/1/2024. QP will creat certificate for employees who success complete CPR and First Aid training. Of make sure the ability to train the staff is current.	Aid CPR s is e a fully QP will	
V 108	27G .0202 (F-I) Persor 10A NCAC 27G .0202	nnel Requirements	V 108			
	REQUIREMENTS (f) Continuing education (g) Employee training provided and, at a minifollowing: (1) general organic (2) training on clie	on shall be documented.				
	client as specified in the and  (4) training in infect bloodborne pathogens. (h) Except as permitted .5602(b) of this Subchamember shall be availatimes when a client is pmember shall be trained including seizure managet o provide cardiopulmor	pter, at least one staff ble in the facility at all resent. That staff d in basic first aid gement, currently trained hary resuscitation and haneuver or other first aid se provided by Red art Association or their		RECEIVED NOV 7 2024 DHSR-MH Licensure Sect		

Jenil Euro PP 10/30/2024

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Division of Health Service Regulation

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

TITLE

(X6) DATE

STATE FORM

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If continuation sheet 1 of 7

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					FORM APPR	
STATE <b>DINISION OF MEANTH-SERVICE REGULATION</b> PROVIDER/SUPPLIER/CLIAN AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Regulation PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL041-613		B. WING		10/14/2024	
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADD		RESS, CITY, STATI	E. ZIP CODE	10/14/2024	
			NDSHIP CHUR			
VI&SSU	IPERVISED LIVING, LLC	BROWNS S	UMMIT, NC 27	7214		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST OR LSC ID	TEMENT OF DEFICIENCIES BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATI	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE	
V 108	Continued From page	1	V 108			
	policies and procedure investigating and control communicable disease. This Rule is not met a record review and interensure each staff had Cardiopulmonary Rescertificate.	es of personnel and clients as evidenced by:Based on erview, the facility failed to				
	Care Technician (DCT) Red Cross (ARC) train Staff #8's digital code of completed training date -Staff #2 with hire date a 10/6/23 ARC training Staff #8's digital code of completed training date -Staff #4 with a hire date a 7/23/20 and 7/12/24 / with former Staff #8's d certificate and complete Staff #5 with a hire date	e of 9/3/20. e of 10/6/23 as a DCT had certificate with former on the certificate and e of 9/3/20. e of 1/30/20 as a DCT had ARC training certificate				

former Staff #8's digital code on the certificate and completed training date of 9/3/20.

	T	
-Staff #6 with a rehire date in 3/2023 as a DCT had a 3/1/24 ARC training certificate with former Staff #8's digital code on the certificate and		
completed training date of 9/3/20.		

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLI	A (X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	3:	COMP	PLETED
			B. WING			
		MHL041-613			10/	14/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
				HURCH ROAD		
M&SSU	PERVISED LIVING, LLC		ENDONIF C	HORCH ROAD		
		BROWNS	SUMMIT, NC	27214		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
17.0	NEGOLATORT OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE
				,		
V 108	Continued From page	. 2	V 108			
	Continued From page					
	Review on 10/11/24 o					
	Director/Qualified Pro certificate revealed:	fessional (QP)'s ARC				
		fied as an ARC First Aid and				
	CPR instructor.	iled as all AIC Filst Ald alld				
	Review on 10/11/24 or	f the Director/QP's ARC				
	certificate revealed:					
	-9/20/24, she was cert	tified as an ARC First Aid				
	and CPR instructor.					
	Intension on 1077/24	ith Ctaff #4 managed at 11.				
		vith Staff #1 revealed: -He and CPR training from the				
	Former Director/QP.	and CFR training from the				
	Tomor Birodon Qr.					
	Interview on 10/9/24 w	ith Staff #2 revealed: -He				
	received his First Aid a	and CPR training from the				
	Former Director/QP.					
	1-1					
	Interview on 10/11/24	with the Director/QP				
	revealed:	to through ABC aget				
	<ul> <li>Each training certifica money and this was th</li> </ul>					
		ner staff #8's ARC training				
	certificate.	and the state of t				
	-She was sure each of	the current staff (#1- #6)				
	was trained in First Aid	and CPR by the Former				
	Director/QP.					
	-She would ensure the					
	certificates were correc	ctea.				
V 112			V 112			
	27G .0205 (C-D)		A 1.15			
	Assessment/Treatment	/Habilitation Plan				
	104 NOAC 270 2025	ACCECOMENT			1	
	10A NCAC 27G .0205 TREATMENT/HABILITA	ASSESSMENT AND				
	PLAN	ATION OR SERVICE				
1		eveloped based on the				
	(-)	s. spod badod off tile				I

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	( -,			(3) DATE SURVEY COMPLETED				
MHI 041-613		MHL041-613	B. WING		10	0/14/2024				
NAME OF F	PROVIDER OR SUPPLIER		RESS CITY S	TATE, ZIP CODE		7/14/2024				
	7311-A FRIENDSHIP CHURCH ROAD									
M & S SU	JPERVISED LIVING, LLC	BROWNS S								
(X4) ID PREFIX TAG				(EACH CORRECTIVE ACTION SHOUL	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					
V 112	assessment, and in palegally responsible per of admission for client receive services beyon (d) The plan shall incl (1) client outcome achieved by provision date of achievement; (2) strategies; (3) staff responsible annually in consultation responsible person or (5) basis for evaluation outcome achievement; (6) written conserves ponsible party, or a	artnership with the client or reson or both, within 30 days is who are expected to and 30 days.  ude: e(s) that are anticipated to be of the service and a projected in with the client or legally both; uation or assessment of	V 112							
	failed to develop and in for 1 of 3 clients (Client Review on 10/8/24 of C -Admission date of 6/30	w and interview, the facility inplement a treatment plan #2). The findings are: lient #2's record revealed: 1/22. Epilepsy, Mood Disorder,	2							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL041-613	B. WING		10/	14/2024	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE	101	17/2027	
				HURCH ROAD			
M & S SU	JPERVISED LIVING, LLC	BROWNS	SUMMIT, NC	27214			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
V12	"I don't have any (goa goals at the day program Interview with the Dire (QP) revealed: -She provided a treath Client #2 which had: -the first goal was to habits such as teeth be showeringthe second goal was community based or factivitiesno staff strategies for the helped by staff to an endient, guardian or person who signed the review or consultation treatment plan.	with Client #2 revealed: - ls) here (facility). I have am I go to."  actor/Qualified Professional ment plan dated 6/30/22 for maintain healthy hygiene rushing, hand washing, and as to participate in acility based social or how Client #2 would chieve the stated goals. legally responsible a plan which indicated a of the plan for a current utes a re-cited deficiency within 30 days.	V 112	QP will develop strategies in the planted help staff achieve his goals. QP has with the guardian and went over the and goals, and had plan signed. QF complete this by 11/10124  M&S Supervised Living LLC, will loc RN or a person licensed to administration.	s met e plan P will cate a		
	10A NCAC 27G .0209 REQUIREMENTS (c) Medication administ (1) Prescription or shall only be administe order of a person authodrugs. (2) Medications sholients only when authoclient's physician. (3) Medications, in administered only by lice	MEDICATION  tration: non-prescription drugs red to a client on the written prized by law to prescribe  nall be self-administered by prized in writing by the acluding injections, shall be		RN or a person licensed to administed medication to teach the initial medical class to all employees. Each employ be made aware and will be mandate attend this training in person. All staff requiring this training will be informed attend. All medication concerns will be completed by 12/1/24	ation ee will d to f d to		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
MHL041-613		B. WING		10/14/2024		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DESC CITY S	TATE, ZIP CODE		
	THE					
M & S SU	PERVISED LIVING, LLC	BROWNS S		1URCH ROAD 27214		
(X4) ID	SUMMARY STA		ID			0/5)
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETE DATE
V 118			V 118			
	Continued From page	5				
	pharmacist or other le	gally qualified person and				
		and administer medications.				
		nistration Record (MAR) of				
		to each client must be kept				
	current. Medications a	after administration. The				
	MAR is to include the					
	(A) client's name:					
		th, and quantity of the drug;				
		or administering the drug;				
		the drug is administered; and				
		person administering the drug. medication changes or				
		led and kept with the MAR				
		ointment or consultation				
	with a physician.					
1	This Rule is not met a				-	
		w and interview, the facility				
	failed to ensure staff w	ho administered client ed by a legally qualified				
	and privileged person v					
	administer medications					
1	Reviews on 10/8/24 an personnel record revea	d 10/11/24 of each staff's				1
		te of 7/31/23 as a Direct				
		had 7/31/23 and 7/10/24				
	Medication Administrati					
		and training completed				
	through an online progr	ram.				
1		e of 10/6/23 as a DCT had Medication Administration				

CTATEMEN	T.OF DESIGNATION	T	I		Г	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
			A. BUILDING:		COMPLETED	
		MHL041-613	B. WING		10	14.41000.4
		WINE041-013	1		10/	14/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
M 0 0 011	DED\(() CED         (1)	7311-A FRIE	ENDSHIP CI	HURCH ROAD		
IVI & S SU	PERVISED LIVING, LLC	BROWNS S	HIMMIT NO	27214		
(V4) ID	CUMMADVOTA					
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I	l DE	(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
V 118	Continued From page	6	V 118			
		th a 1.0 training hour and				
	training completed thr	ough an online program.				
	Interview on 10/7/24 v	with Staff #1 revealed: -				
		dication Administration				
	training on computer.					
		vith Staff #2 revealed: -				
	He completed his Med	and took a test on paper				
	at the end of the training					
	at the one of the training	ng.				
	Interviews on 10/8/24 a	and 10/10/24 with the Director/QP				
	revealed:					
		nitial training through a				
	pharmacy service which	ch was conducted in				
	personShe did not know how	v to get in contact with the		· ·		
	registered nurse identi					
	Medication training cer					
	-"Its just a program tha	at's been downloaded on				
	computer."					
		1				
						1