PRINTED: 03/03/2025 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: MHL063-089 B. WING 02/27/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2251 LINDEN ROAD LINDEN LODGE ABERDEEN, NC 28315 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual and follow up survey was completed on February 27, 2025. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600A Supervised Living for Adults with Mental Illness. DHSR-MH Licensure Sect This facility is licensed for 6 and has a current census of 6. The survey sample consisted of audits of 3 current clients. V 112 27G .0205 (C-D) V 112 V 112 Assessment/Treatment/Habilitation Plan An Assessment and Treatment 10A NCAC 27G .0205 ASSESSMENT AND /Habilitation or Service Plan for TREATMENT/HABILITATION OR SERVICE Client #2 will be completed PLAN before March 24th (c) The plan shall be developed based on the assessment, and in partnership with the client or a certified OP, will legally responsible person or both, within 30 days be preparing, racilitating and of admission for clients who are expected to signing off on the client's personal receive services beyond 30 days. care plan. (d) The plan shall include: (1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement: (2) strategies; (3) staff responsible; (4) a schedule for review of the plan at least annually in consultation with the client or legally responsible person or both; (5) basis for evaluation or assessment of outcome achievement; and (6) written consent or agreement by the client or responsible party, or a written statement by the

Division of Health Service Regulation

obtained.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

provider stating why such consent could not be

TITLE

(X6) DATE

STATE FORM

If continuation sheet 1 of 6

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	
MHL063-08		MHL063-089	B. WING		R 02/27/2025	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	1 02/	
LINDEN LODGE 2251 LINDEN ROAD ABERDEEN, NC 28315						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
V 112	Continued From page 1		V 112			
	facility failed to have treatment plan with	views and interviews, the an annually updated written consent or agreement onsible party affecting one of				
	-Admission dated of -Diagnosis of Schizo Type. -Treatment plan was -There was not an u	paffective Disorder, Bipolar s last signed on 11/9/22. pdated signature or written ardian or responsible party on				
	revealed: -Facility contracted a complete the client's -He was completing and plan was for him Professional once he -He knew that Client Qualified Profession update the treatmen inform on why it was -He acknowledged cont been completed	#2's legal guardian and the al had been discussing to t plan, but was not able to never finalized. lient #2's treatment plan had and updated annually.				
	This deficiency cons and must be corrected to Service Regulation	titutes a re-cited deficiency ed within 30 days.				

FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING MHL063-089 02/27/2025 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2251 LINDEN ROAD LINDEN LODGE ABERDEEN, NC 28315 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 118 V 118 27G .0209 (C) Medication Requirements V 118 10A NCAC 27G .0209 MEDICATION Client #2 script for Mupirocin 2% REQUIREMENTS ointment and Doxycycline have (c) Medication administration: been received and in file. (1) Prescription or non-prescription drugs shall only be administered to a client on the written Staff has prepared a prescription order of a person authorized by law to prescribe checklist to ensure all scripts are druas. current and on file. (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 Medicine administration training privileged to prepare and administer medications. for each staff member will be (4) A Medication Administration Record (MAR) of updated and scheduled for all drugs administered to each client must be kept appropriateness to be compliant current. Medications administered shall be with the State regulations recorded immediately after administration. The applicable for 27G.5600A -MAR is to include the following: (A) client's name: Supervised Living for Adults with (B) name, strength, and quantity of the drug; Mental Illness with a capacity of (C) instructions for administering the drug; 6 Residence. (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.

This Rule is not met as evidenced by:

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ MHL063-089 B. WING 02/27/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2251 LINDEN ROAD LINDEN LODGE ABERDEEN, NC 28315 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) V 118 V 118 Continued From page 3 Based on record reviews, observation and interviews, the facility failed to: A) administer medications on the written order of a physician affecting 1 of 3 audited clients (#2) and B) ensure medications were administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person affecting 3 of 3 audited staff (#4, #5 and #6). The findings are: A. Review on 2/27/25 of Client #2's record revealed. -Admisison date of 5/1/10. -Diagnosis of Schizoaffective Disorder, Bipolar Type. -There were no physician orders for: -Mupirocin 2% ointment- Apply to affected area twice a day until healed. -Doxycycline 50 milligrams (mg)- take one tablet daily. Observation on 2/27/25 of Client #2's medications revealed: -Mupirocin 2% ointment was available. Doxycycline 50 mg was available. Review on 2/27/25 of Client #2's February 2025 MAR revealed: -Mupirocin 2% ointment was marked by staff as -Doxycycline 50 mg was marked by staff as administered. Review on 2/27/25 of www.webmd.com revealed: -Mupirocin 2% ointment was used to treat bacterial skin infections. Doxycycline was used to treat infections.

B. Review on 2/27/25 of Staff #4's personnel

Division of Health Service Regulation

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED			
MHL063-089		B. WING		R 02/27/2025				
		MHL063-089			02/2//2025			
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE				
LINDEN LODGE 2251 LINDEN ROAD ABERDEEN, NC 28315								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE			
V 118	Support Professiona-There was a certific RELIAS- "Managing Self- Administration -Certificated indicate training. Review on 2/27/25 or revealed: -Hire date of 6/17/24-She was hired as a -There was a certific RELIAS- "Managing Self- Administration -Certificated indicate training. Review on 2/27/25 or revealed: -Hire date of 12/6/23-She was hired as a -There was a certific RELIAS- "Managing Self- Administration -Certificated indicate training. Interview on 2/27/25 or she was first completed and she was first completed to work at the she was first completed to work at the she was first training was at Interview on 2/27/25.	5. a Executive Director- Direct al. cate dated 1/29/25 from a Medications in AFLs: Helping a Medications in AFLs: Helping and that it was a 1 hour of Staff #5's personnel record at a Direct Support Professional. Cate dated 2/13/25 from a Medications in AFLs: Helping and that it was a 1 hour of Staff #6's personnel record a Direct Support Professional. Cate dated 2/13/25 from a Medications in AFLs: Helping and that it was a 1 hour and that it was a 1 hour are divided by the medications in AFLs: Helping and that it was a 1 hour and that it was a 1 hour and the medications in AFLs: Helping and that it was a 1 hour and the medications in AFLs: Helping and that it was a 1 hour and the medications in AFLs: Helping and that it was a 1 hour and the medications after being facility. There was not a live also no live observations. Sout one hour long.	V 118					
		"Relias" online training.						

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					l p	
MHL063-089		B. WING		02/27/2025		
		M112003-003			02/21/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LINDEN	LODGE		DEN ROAD			
LINDLIN		ABERDEI	EN, NC 2831	5		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI		
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		
140	NEODENIONI ONE	oo ibertii tiito itti ottiiAttotti	TAG	DEFICIENCY)	TRAIL	
11110	2	_	27.110			
V 118	Continued From pa	ge 5	V 118			
	-She did not comple	ete any medications training				
		interactions with an instructor				
	nor did it include ob	servations.				
	Interview on 2/27/29	5 with the Executive Director				
	revealed:					
		taken to his doctor by his				
		an and the scripts were sent				
	directly to his pharm					
		prought the scripts to the				
	facility.	W - C - W - P - C - C - P - C - C - C - C - C - C				
		re that all clients' medication				
	scripts were placed					
		Client #'2's medication scripts				
	for Mupirocin 2% ointment and the Doxycycline					
	were not in his record.					
	 -Facility staff had always been doing the online Relias training. 					
		hat it was never noted before				
		ot being the correct one that				
	they need to take.	or boiling the control one that				
	-He was not aware	that the medication				
		ng was more complex than				
	the one offered by Relias. -He would let the board know about and contact a					
	trainer to complete	the required training.				