Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | 3) DATE SURVEY COMPLETED | |
|---|--|---|---------------------|--|-------|-----------------------------|--|
| | | | 71. 501251110. | | | | |
| | | MHL073-057 | B. WING | | 03/0 | 7/2025 | |
| NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | | |
| SOUTH | SOUTH MOORE DRIVE 109 SOUTH MOORE DRIVE ROXBORO, NC 27573 | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | _D BE | (X5) COMPLETE DATE | |
| V 000 | INITIAL COMMENTS | | V 000 | | | | |
| | An annual survey w 2025. A deficiency | vas completed on March 7, was cited. | | | | | |
| | This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living. | | | | | | |
| | | sed for 3 and has a current urvey sample consisted of clients. | | | | | |
| V 118 | V 118 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; | | V 118 | | | | |
| | | | | | | | |
| | (C) instructions for (D) date and time the | and quantity of the drug; administering the drug; ne drug is administered; and 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 IDENTIFICATION NUMBER: MHL073-057 | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED 03/07/2025 | |
|--|---|---|---|---|--------------------------------|---------------------------------------|--|
| | | B. WING | | 03/ | | | |
| | PROVIDER OR SUPPLIER | 109 SOU | DDRESS, CITY, S' TH MOORE DI RO, NC 27573 | RIVE | | | |
| (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 ACTI CROSS-REFERENCED TO TI DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE | |
| V 118 | (5) Client requests checks shall be rec | ge 1 for medication changes or orded and kept with the MAR appointment or consultation | V 118 | | | | |
| | to ensure 1 of 1 clie immediately after a are: | view and interview the facility ents (#1) MARs current record dministration. The findings | | | | | |
| | admission date diagnoses: Inte Disorder & Depress physician order following medicatio Losartan Potas (blood pressure) Omeprazole 20 Sertraline 50mg | llectual Developmental sion dated 2/13/23 with the | | | | | |
| | Division of Health S - December 202 the December 3 1/17/25 with a strike 12/31/25 - an initial was w | 2024 MARs had 12/1/24 - e thru 1/17/25 and had written ritten beside the strike thru | | | | | |
| | Living (AFL) provide | 3/6/25 the Alternative Family er reported: gement office had January | | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (2) MULTIPLE CONSTRUCTION (X3) DATE COMP | | SURVEY PLETED | | |
|---|---|--|---------------------|--|------------------------------|--------------------------|--|--|
| | | MHL073-057 | B. WING | | 03/0 | 07/2025 | | |
| | NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 109 SOUTH MOORE DRIVE ROXBORO, NC 27573 | | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE | | |
| V 118 | 2025 and February During interview on - was not able to MAR - thought the nur - she wrote incor 2024 MAR, suppos - sent the Decen - was not sure w the December 2024 - contacted the r responded Due to the failure to medication adminis | 2025 MARs 3/7/25 the Licensee reported: locate the February 2025 see sent the January 2025 rect dates on the December e to be January 2025 dates aber 2024 MAR hy their were blank spaces on 4 MAR hurse and she had not accurately document stration, it could not be sereceived their medications | V 118 | | | | | |

Division of Health Service Regulation STATE FORM

R41O11 If continuation sheet 3 of 3