STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL0411228	B. WING		05/19/2025	
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
	DGE ROAD AFL	1344 SH	ARP RIDGE ROAD			
		GREENS	SBORO, NC 27406			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENTS		V 000			
	An annual and follow on May 19, 2025. A d	up survey was completed eficiency was cited.				
	This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living.					
	-	d for 3 and has a current rey sample consisted of an nt.				
V 118	27G .0209 (C) Medica	ation Requirements	V 118			
	 only be administered order of a person auti drugs. (2) Medications shall clients only when auti client's physician. (3) Medications, inclu administered only by unlicensed persons tr pharmacist or other le privileged to prepare (4) A Medication Adm all drugs administered current. Medications a recorded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for ac (D) date and time the 	stration: n-prescription drugs shall to a client on the written horized by law to prescribe be self-administered by horized in writing by the ding injections, shall be licensed persons, or by ained by a registered nurse, egally qualified person and and administer medications. inistration Record (MAR) of d to each client must be kept administered shall be after administration. The following: nd quantity of the drug;				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.				
	MHL0411228		B. WING		05	05/19/2025	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
	IDGE ROAD AFL	1344 SH	ARP RIDGE ROAD				
		GREENS	SBORO, NC 27406				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
V 118	Continued From pag	e 1	V 118				
	checks shall be reco	or medication changes or rded and kept with the MAR opointment or consultation					
	failed to ensure clien immediately recorde	iew and interview, the facility					
	-Admission date of 5 -Diagnoses of Disrup Disorder, Anxiety Dis Developmental Disal Hyperactivity Disorde -Physician-order mer -8/1/24-Quetiapine (mg), take 1 tablet (ta -10/8/24-Lubiproste capsule (cap) twice of -11/7/24-Clonidine mg, 2 tablets (tab) at 100 mg, 1 tab twice of -11/25/24-Montelul every day. -2/4/25- Quetiapine	otive Mood Dysregulation sorder, Mild Intellectual bility, and Attention-Deficit er. dications: Fumarate 400 milligrams ab) every evening. one 24 micrograms (mcg), 1 daily. Hydrochloric Acid (HCL) 0.1 t bedtime, and Lamotrigine daily. kast Sodium 10 mg, 1 tab					
	twice daily, and Aton every morning. -2/4/25-Vyvanse 4 -5/6/25-Qelbree Ex	noxetine HCL 80 mg, 1 tab 0 mg, 1 cap every morning. ktended Release (ER) 200 y, and Atomoxetine HCL 18					

Division of Health Service Regulation STATE FORM

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		MHL0411228	B. WING		05	5/19/2025
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
SHARP RI	DGE ROAD AFL		ARP RIDGE ROAD SBORO, NC 27406			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From page 2		V 118			
	mg, 2 caps x 1 week, then 2 caps every morning x 1 week and then 1 cap every morning x 1 week.					
	Review on 5/19/25 of Client #1's MAR for May 2025 revealed:					
	-Montelukast 10 mg, Atomoxetine HCL 80 mg, and Vyvanse 40 mg -no documentation from					
	5/10/25- 5/19/25 of whether these medications					
	were administered at the 8 am dose time and no					
	reason was documented on the MAR which					
	explained the reason for the lack of					
	documentation at the dosage time during this period					
	period. -Clonidine HCL 0.1 mg, Quetiapine Fumarate 400					
	mg, and Trazadone HCL 100 mg- no					
	documentation from 5/9/25- 5/18/25 of whether					
	these medications were administered at the 8 pm					
	dose time and no reason was documented on the					
	MAR which explained the reason for the lack of					
		e dosage time during this				
	period.					
		e 50 mg and Lubiprostone				
		ntation from 5/10/25- 5/19/25				
		dications were administered e and no documentation on				
		om 5/5/25- 5/18/25 of				
		ations were administered at				
	the 4 pm dose time					
		- no documentation from				
		ose time through 5/19/25 at				
	the am dose of whet	her this medication was				
		reason was documented on				
	the MAR which explained the reason for the lack					
		the dosage time during this				
	period.	and Atomovating LICE 49				
	-	and Atomoxetine HCL 18				
	mg were not listed or	5/6/25- 5/19/25 at the 8 am				
		the medications were				
	administered.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	MHL0411228		B. WING		05	05/19/2025	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	• • •		
			ARP RIDGE ROAD				
SHARP RI	DGE ROAD AFL		SBORO, NC 27406				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)	
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE	
V 118	Continued From pag	e 3	V 118				
	-He took medication was frustrated. -Staff gave him his m -He had medication of						
	revealed: -He and AFL Provide the evening of 5/18/2 -Client #1 stayed with AFL Provider #2 wer the guardian gave Cl -Client #1 was return guardian the evening medications, Qelbrea Atomoxetine HCL. -Client #1 received a 5/19/25; he did not re administration on the pm today to record th from this morning's d policy. -He was aware that re	h his guardian while he and e on vacation for 9 days and lient #1 his medications. led to the facility by his g of 5/18/25 with 2 new e ER and a lowered dose of Il his morning medications on					
	morning administered -Administered medic immediately after add -There should have to 5/10/25-5/18/25 which his guardian during to -He would follow up to	d: nich allowed recording of d medications by 1:00 pm. ations were to be recorded ministration. been documentation from ch showed Client #1 was with					

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OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL0411228	B. WING		05	5/19/2025
OVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE		
DGE ROAD AFL					
(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE AC TAG CROSS-REFERENCED TO		(X5) COMPLETI DATE
	F CORRECTION	F CORRECTION IDENTIFICATION NUMBER: MHL0411228 COVIDER OR SUPPLIER STREET OGE ROAD AFL 1344 SF GREEN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL0411228 B. WING COVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, OGE ROAD AFL 1344 SHARP RIDGE ROAD GREENSBORO, NC 27406 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING: MHL0411228 B. WING B. WING B. WING B. WING COVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE DGE ROAD AFL 1344 SHARP RIDGE ROAD SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF GEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF	F CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COM MHL0411228 B. WING Ot Ot ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE Ot OGE ROAD AFL 1344 SHARP RIDGE ROAD GREENSBORO, NC 27406 Ot SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE