If continuation sheet 1 of 4

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ MHL068-098 B. WING 06/02/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 417 CLAYTON ROAD **RSI-CLAYTON ROAD** CHAPEL HILL, NC 27514 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 REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual survey was completed on June 2. RECEIVED 2025. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised DHSR-MH Licensure Sect Living for Adults with Developmental Disability. This facility is licensed for 6 and has a current census of 6. The survey sample consisted of audits of 3 current clients. V 118 27G .0209 (C) Medication Requirements V 118 All medication certified staff trained at Clayton will receive supplemental training on medication requirements. By 6/16/25. 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 (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 drug. Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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Division of Health Service Regulation

STATE FORM

06/02/2025

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING: ___

(X3) DATE SURVEY COMPLETED

MHL068-098

B. WING ___

STREET ADDRESS, CITY, STATE, ZIP CODE

RSI-CLAYTON ROAD

NAME OF PROVIDER OR SUPPLIER

417 CLAYTON ROAD

NOI-OLA	YTON ROAD CHAPEL F	IILL, NC 275	514	
(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 118	Continued From page 1	V 118		
	(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: Based on record reviews and interviews, the facility failed to keep the MAR current affecting two of three audited clients (#2 and #3). The findings are:			
	Review on 5/29/25 of client #2's record revealed: -Admission date of 2/5/24Diagnoses of Mild Intellectual Disability, Hypopituitarism, Anxiety Disorder, Hypoglycemia, Trichotillomania, Attention Deficit Hyperactivity Disorder (ADHD), Neuromuscular Dysfunction of the bladder, Calculus of kidney and Lobulated fused and horseshoe kidneyPhysician's order dated 4/21/25 for the following			
	medication: Sertraline 100 milligrams (mg) (Anxiety Disorder), one tablet daily Daily-Vite (Vitamin Deficiency), one tablet daily Fish Oil 1000 mg (Heart Health), 3 capsules daily Guanfacine Extended Release (ER) 1 mg (ADHD), one tablet daily			
	-Physician's order dated 3/31/25 for Mupirocin 2% (Skin infections), spread topically to affected toes once dailyPhysician's order dated 9/23/24 for Ketoconazole Shampoo (Fungal infections), use as directed daily; Ketoconazole 2% cream, spread topically to affected area once daily and Hydrocortisone 2.5			

Division of Health Service Regulation

Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) PROV

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED					
	a.	MHL068-098	B. WING		06/	02/2025					
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STATE, ZIP CODE								
RSI-CLAYTON ROAD 417 CLAYTON ROAD											
CHAPEL HILL, NC 27514 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)											
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X: COMP						
V 118	Continued From page 3		V 118								
	tablet once daily Diphenhydramine 2 daily	5 mg (Insomnia), one tablet									
	Review on 5/29/25 of client #3's May 2025 MAR revealed:										
	No staff initials to incadministered for the -Zoloft 100 mg on 5/-Seroquel 100 mg o -Diphenhydramine 2	5, 5/6 and 5/20. n 5/5, 5/6 and 5/20.									
	Interview on 5/29/25 with the Supervisor of Support Services revealed: -The clients got their prescribed medication daily"[Client #2] goes home a lot." -"[Client #3] also goes on home visits." -"Staff possibly forgot to sign off on the MARs because they were both out of the facility." -He confirmed the MARs were not kept current for clients #2 and #3.										
	Services confirmed:	vith the Director of Autism kept current for clients #2									
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Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ B. WING 06/02/2025 MHL068-098 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 417 CLAYTON ROAD **RSI-CLAYTON ROAD** CHAPEL HILL, NC 27514 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) V 118 Continued From page 2 V 118 % ointment (Skin conditions), spread topically to rough raised or red itchy spots twice daily. Review on 5/29/25 of MARs for client #2 revealed: May 2025: No staff initials to indicate the medication was administered for the following: -Sertraline 100 mg on 5/7, 5/12, 5/18 and 5/19. -Daily-Vite on 5/7, 5/12, 5/18 and 5/19. -Fish Oil 1000 mg on 5/7, 5/12, 5/18 and 5/19. -Guanfacine ER 1 mg on 5/7, 5/12, 5/18 and 5/19. -Mupirocin 2% on 5/6 and 5/18. -Ketoconazole 2% cream on 5/4, 5/5 5/6, 5/11, 5/12, 5/13, 5/15, 5/17, 5/18, 5/19, 5/20, 5/24, 5/25 and 5/26. March 2025: No staff initials to indicate the medication was administered for the following: -Sertraline 100 mg on 3/24. -Fish Oil 1000 mg on 3/24. -Ketoconazole Shampoo on 3/1, 3/15 and 3/23. -Ketoconazole 2% cream on 3/24. -Hydrocortisone 2.5 % ointment on 3/15, 3/23 pm dose and 3/24 am dose. Review on 5/29/25 of client 3's record revealed: -Admission date of 4/1/25. -Diagnoses of Asperger's Syndrome and Obsessive Compulsive Disorder (OCD). -Physician's order dated 4/14/25 for the following medication: Zoloft 100 mg (OCD), one and one half tablet

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Division of Health Service Regulation

Seroquel 100 mg (Anxiety), one and one half

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