		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		MHL007-049	B. WING		R 06/06/2025		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
COUNTR	Y LIVING ESTATES		ARTON STATIC	ON ROAD			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET	
V 000	INITIAL COMMENT	ſS	V 000				
	An annual and follow up survey was completed on June 6, 2025. A deficiency was cited.						
		sed for the following service C 27G .5600A Supervised h Mental Illness.					
	This facility is licensed for 6 and has a current census of 4. The survey sample consisted of audits of 3 current clients.						
V 118	27G .0209 (C) Med	ication Requirements	V 118				
	 only be administered order of a person a drugs. (2) Medications shat clients only when all client's physician. (3) Medications, inclusion administered only builticensed persons pharmacist or other privileged to prepare (4) A Medication Ad all drugs administered current. Medication recorded immediate MAR is to include th (A) client's name; (B) name, strength, (C) instructions for (D) date and time the data and the dat	inistration: non-prescription drugs shall d to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by trained by a registered nurse legally qualified person and e and administer medications iministration Record (MAR) of red to each client must be kep s administered shall be ely after administration. The					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL007-049		B. WING			R 06/06/2025	
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
OUNTR	Y LIVING ESTATES	424 WHA WASH, N	RTON STATIO C 27889	N ROAD			
(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 ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
V 118	Continued From pa	ge 1	V 118				
	checks shall be rec	for medication changes or orded and kept with the MAR appointment or consultation					
	interviews, the facili medications were a MARs were kept cu and #4). The finding Review on 6/5/25 or	views, observation and ity failed to ensure dministered as ordered and irrent for 3 of 3 clients (#1, #2 gs are: f client #1's record revealed:					
	Depressive Disorde Hyperactivity Disord - Physician orders of Divalproex (depress times daily; Fluticas micrograms (mcg) Melatonin (insomnia	1 n Spectrum Disorder; Major er-Recurrent, Attention Deficit der (ADHD)-Combined dated 7/1/24 revealed: sion) 250 milligrams (mg) 1- 2 sone Propionate (allergies) 50 1 spray each nostril daily; a) 3 milligrams- 2 at bedtime; ychotic) 10mg 1 at bedtime.					
	2025 revealed the f - Divalproex SOD D 8am; 3/1/25-3/6/25 - Fluticasone Propio 3/2/25-3/3/25 at 8ar - Melatonin 3mg, 3/	DR 250mg- 3/2/25-3/3/25 at at 8pm. onate 50mcg Spray, m					
	- Olarizapine Turng,	, 5/1/25-5/0/25 at opin.					

STATE FORM

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If continuation sheet 2 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		MHL007-049				R 06/06/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
COUNTR	Y LIVING ESTATES	424 WHA WASH, N	RTON STATIC	ON ROAD		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
V 118	Continued From page	ge 2	V 118			
	- He received his m	edications daily.				
	 Admitted 12/4/23 Diagnoses include Schizoaffective Disc ADHD-Combined P Physician orders of Buspirone HCL (and Cetirizine (allergies) HCL (depression) 2 40mg (resentation. Jated 11/1/24 revealed xiety) 10mg 1 twice daily;) 10mg 1 daily; Fluoxetine 20mg 1 daily; Fluoxetine HCL 1 daily; Paliperidone Extended d) 1 daily; Rosuvastatin erlipidemia) 1 daily; ia) 100mg- 1 bedtime. f client #2's MAR for March ollowing blanks: Jmg 3/2/25-3/3/25 at 8am; m. mg 3/2/25-3/3/25 at 8am. Jmg 3/2/25-3/3/25 at 8am. Jmg 3/2/25-3/3/25 at 8am. ium 10mg 3/2/25-3/3/25 at 8am. Jmg 3/2/25-3/3/25 at 8am.	1			
	Interview on 6/5/25	3/1/25-3/6/25 at 8pm. client #2 stated he had not tions and staff administered ly.				
	 Admitted 4/23/19. Diagnoses include Hyperactivity Disorc Disorder; Bipolar II Episodes and Anxie Physician orders of 	ler; Autism Spectrum Disorder w/ Hypomanic				

STATE FORM

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If continuation sheet 3 of 5

Division of Health Servi			CONCEDUCTION			
STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	S (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
	MHL007-049 B. WIN		B. WING		R 06/06/2025	
NAME OF PROVIDER OR SUP	PLIER STREET A	ADDRESS, CITY, S	TATE, ZIP CODE			
COUNTRY LIVING ESTA	424 WH	ARTON STATIC	ON ROAD			
	WASH,	NC 27889				
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 118 Continued Fro	m page 3	V 118				
Clonazepam (Esomeprazola (DR) (Gastroe breakfast; Flu Compulsive D daily; Levocet Risperidone (Topiramate (s Review on 6/5 2025 revealed - Atomoxetine - Clonazepam - Clonazepam - Esomeprazo 3/3/25. - Fluvoxamine 8am; 3/1/25-3 - Levocetirizin - Risperidone 3/6/25 at 8pm - Topiramate 2 3/1/25-3/6/25 Interview on 6 medications d always availab Interview on 6 supervisor sta - Medications - Staff probab Interview on 6 Professional/F - Staff adminis - When the da documented a	e 5mg 3/1/25- 3/6/25 at 8pm. 1mg 3/2/25- 3/3/25 at 8am; 3/1/25- 200mg 3/2/25- 3/3/25 at 8am; at 8pm. /5/25 client #4 stated he took his aily and his medications were ole. /5/25 the Quality Assurance	<i>I</i> .				

Division of Health Service Regulation STATE FORM

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If continuation sheet 4 of 5

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		R	
		MHL007-049	B. WING			R 06/2025
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
OUNTR	RY LIVING ESTATES		ARTON STATIC	ON ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From page 4 - Clients had not refused medications. - He understood the MAR had to be kept current.		V 118			
	This deficiency con and must be correc	stitutes a re-cited deficiency ted within 30 days.				