

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-115	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/17/2025
NAME OF PROVIDER OR SUPPLIER SPURLING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 19 GREASY CREEK ROAD MARION, NC 28752			
(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 5 -Didn't look at the MARs consistently on home visit. -"I should be looking at medications when I go out but I am not always doing that." Due to the failure to accurately document medication administration, it could not be determined if clients received their medications as ordered by the physician.	V 118			

RECEIVED
JUN 27 2025
DHSR-MH Licensure Sect

Division of Health Service Regulation		(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/17/2025
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-115		
NAME OF PROVIDER OR SUPPLIER SPURLING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 19 GREASY CREEK ROAD MARION, NC 28752		
(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	<p>Continued From page 4</p> <p>-Physician's order dated 11-6-24: Buspirone 15mg, Take 1 tablet by mouth three times daily.</p> <p>Review on 6-17-25 at approximately 9:01 am of Client 31's MAR dated 6-1-25 to 6-17-25 revealed:</p> <p>-Buspirone 15mg: Only 8 am and 8 pm time slots for initials.</p> <p>-Had not been initialed as administered three times daily. The 2 pm dosing was not indicated on the MAR.</p> <p>-No comments on the MAR as to why medication was not administered.</p> <p>Review on 6-17-25 at approximately 9:30 am of Client 31's MAR dated 4-1-25 to 4-30-25 revealed:</p> <p>-Buspirone 15mg: dates not initialed as administered; 4-23-25, 4-24-25, 4-25-25, 4-26-25, 4-27-25, 4-28-25, 4-29-25.</p> <p>Interview on 6-17-25 with the AFL Provider #1 revealed:</p> <p>-Had been "...beyond stressed and that is not an excuse."</p> <p>-"I'm not sure what I did there (April MAR missing dates)."</p> <p>-Thought the Buspirone was for heartburn.</p> <p>-The missing initials for the June MAR "...just overlooked. I have been really stressed."</p> <p>-"...don't know why. I have no idea why (the 2 pm dose wasn't marked). I have been stressed out with everything happening."</p> <p>Interview on 6-17-25 with the Qualified Professional revealed:</p> <p>-The Licensee has a nurse for medication oversight.</p> <p>-The AFL Provider didn't turn in MARs in a timely manner.</p>	V 118	<p>V118-</p> <p>While in med training with RN-AFL will bring member's current meds and RN will review bottles and MAR to ensure they are listed correctly and being dosed correctly.</p> <p>QP will follow up with AFL monthly until MAR's are turned in to the office for review as CCHC policy states.</p> <p>If QP can not get AFL to turn in MAR she will let Supervisor or CEO know and they will also reach out to AFL on requirements of an AFL.</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-115	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/17/2025
NAME OF PROVIDER OR SUPPLIER SPURLING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 19 GREASY CREEK ROAD MARION, NC 28752		
(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	<p>Continued From page 3</p> <p>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.</p> <p>(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.</p> <p>(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:</p> <p>(A) client's name;</p> <p>(B) name, strength, and quantity of the drug;</p> <p>(C) instructions for administering the drug;</p> <p>(D) date and time the drug is administered; and</p> <p>(E) name or initials of person administering the drug.</p> <p>(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.</p> <p> </p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to keep the MAR current affecting 1 of 1 clients (Client #1). The findings are:</p> <p> </p> <p>Review on 6-16-25 and 6-17-25 of Client #1's record revealed: -Date of Admission: 6-1-19 -Diagnoses: Moderate Intellectual Developmental Disability and obesity.</p>	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-115	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/17/2025
NAME OF PROVIDER OR SUPPLIER SPURLING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 19 GREASY CREEK ROAD MARION, NC 28752		
(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 116	Continued From page 2 technician revealed: -Client #1 had a current prescription for Escitalopram 10mg; Take 1 tablet by mouth once daily. -Medication was last filled and picked up on 5-7-25. Interview on 6-17-25 with the AFL Provider #1 revealed: -Would combine medication bottles when she had more than one. -"Was doing a purge of medication bottles." -"...just my own fault for not paying attention..." -"I had a habit of putting them (medication) in the older bottles. I know that is not a good thing." -Had been "...beyond stressed and that is not an excuse." -Couldn't remember if she had taken Escitalopram herself. "I suppose I have taken it. Since I have the bottle, I guess I have." Interview on 6-17-25 with the Qualified Professional revealed: -The Licensee has a nurse for medication oversight. -Didn't look at the medications consistently on home visit. -"I should be looking at medications when I go out but I am not always doing that."	V 116		
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.	V 118		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-115	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/17/2025
NAME OF PROVIDER OR SUPPLIER SPURLING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 19 GREASY CREEK ROAD MARION, NC 28752			
(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 116	<p>Continued From page 1</p> <p>not possess a stock of prescription legend drugs for the purpose of dispensing without hiring a pharmacist and obtaining a permit from the NC Board of Pharmacy. Physicians may keep a small locked supply of prescription drug samples. Samples shall be dispensed, packaged, and labeled in accordance with state law and this Rule.</p> <p>This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to ensure dispensing was restricted to pharmacists, or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy affecting 1 of 1 clients (Client #1). The findings are:</p> <p>Review on 6-16-25 and 6-17-25 of Client #1's record revealed: -Date of Admission: 6-1-19 -Diagnoses: Moderate Intellectual Developmental Disability and obesity. -Physician's order dated 11-6-24: Escitalopram (depression) 10mg, Take 1 tablet by mouth once daily.</p> <p>Observation on 6-17-25 at approximately 9:01 am of Client #1's medication revealed: -Escitalopram 10 mg; Take 1 tablet by mouth once daily; dispensed on 2-11-22; with the name of the AFL provider. -Client #1's name was not on the label.</p> <p>Interview on 6-17-25 with the local pharmacy</p>	V 116	See previous page for corrections.		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-115	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/17/2025
NAME OF PROVIDER OR SUPPLIER SPURLING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 19 GREASY CREEK ROAD MARION, NC 28752		
(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 000	INITIAL COMMENTS An annual survey was completed on June 17, 2025. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Alternative Family Living. This facility is licensed for 2 and has a current census of 1. The survey sample consisted of audits of 1 current client.	V 000		
V 116	27G .0209 (A) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (a) Medication dispensing: (1) Medications shall be dispensed only on the written order of a physician or other practitioner licensed to prescribe. (2) Dispensing shall be restricted to registered pharmacists, physicians, or other health care practitioners authorized by law and registered with the North Carolina Board of Pharmacy. If a permit to operate a pharmacy is Not required, a nurse or other designated person may assist a physician or other health care practitioner with dispensing so long as the final label, Container, and its contents are physically checked and approved by the authorized person prior to dispensing. (3) Methadone For take-home purposes may be supplied to a client of a methadone treatment service in a properly labeled container by a registered nurse employed by the service, pursuant to the requirements of 10 NCAC 26E .0306 SUPPLYING OF METHADONE IN TREATMENT PROGRAMS BY RN. Supplying of methadone is not considered dispensing. (4) Other than for emergency use, facilities shall	V 116	V116- AFL in home will go through med training course with nurse to ensure proper med management in the home. Training will cover disposal of medication, med storage, and dosage/ MAR documentation standards. QP will also be monitoring MAR and checking med storage when she goes on home visits.	

Division of Health Service Regulation

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

TITLE

(X6) DATE

Jinger Kiser, CEO

6/24/2025