Division of Health Service Regulation

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
AND PLAN OF CORRECTION IDENTIFICATION I		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	=TED		
	MHL029-148 B. WING			07/0	7/2025			
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
MARAJO	DI ACE	166 MARA	AJO COURT					
WARAJO	PLACE	WINSTON	-SALEM, NC 2	7127				
(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		
				DEFICIENCY				
V 000	V 000 INITIAL COMMENTS  An annual survey was completed on 7/7/25. Deficiencies were cited.  This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living: Alternative Family Living in a Private Residence.		V 000					
This facility is licensed for 3 and has a current census of 2. The survey sample consisted of audits of 2 current clients.								
V 111	27G .0205 (A-B) Assessment/Treatme	nt/Habilitation Plan	V 111					
	10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN  (a) An assessment shall be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to:  (1) the client's presenting problem;  (2) the client's needs and strengths;							
(3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days								
		that a client admitted to a <sup>-</sup> 24-hour medical program shed diagnosis upon						
	admission;	l, family, and medical history;						
	and (5) evaluations or assessments, such as							
	vocational, as approp	e abuse, medical, and riate to the client's needs.						
		e provided prior to the						
	establishment and im							
treatment/habilitation or service plan, hereafter referred to as the "plan," strategies to address 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:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
		MHL029-148	B. WING		07/07/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
MARAJO	PLACE		AJO COURT N-SALEM, NC 2°	7127	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 111	Continued From page 1		V 111		
	client's presenting pro	oblem shall be documented.			
	failed to ensure admis	ew and interview, the facility ssion assessment was livery of services affecting 1			
		Client #2's record revealed:			
	of Conduct, Severe Ir	nt Disorder with Disturbance ntellectual Developmental			
		alsy; f an admission assessment ceiving services at the			
	Interview on 7/7/25 w Professional revealed - Client #2 transferred				
	to a licensed facility u	nder the same provider; dmission assessment			
V 118	27G .0209 (C) Medica	ation Requirements	V 118		
	10A NCAC 27G .0209 REQUIREMENTS	MEDICATION			

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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	
MHL029-148		B. WING		07/07/2025		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 0.110	
MARAJO	PLACE		JO COURT SALEM, NC 2	7127		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	only be administered order of a person autidrugs.  (2) Medications shall clients only when auticlient's physician.  (3) Medications, incluadministered only by unlicensed persons trepharmacist or other leprivileged to prepare (4) A Medication Admall drugs administered current. Medications a recorded immediately MAR is to include the (A) client's name;  (B) name, strength, a (C) instructions for addictions of the control of	istration: 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 rained by a registered nurse, regally qualified person and and administer medications. hinistration Record (MAR) of d to each client must be kept radministered shall be rafter administration. The following:  Ind quantity of the drug; Iministering the drug; drug is administered; and reperson administering the remedication changes or ded and kept with the MAR pointment or consultation	V 118			
	This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure the MAR was kept current affecting 1 of 2 clients (Client #1). The findings are:					

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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	
MHL029-148		B. WING		07/07/2025		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
MARAJO	PLACE		JO COURT SALEM NO 2	7127		
(V4) ID	SLIMMARY ST		<del>, , , , , , , , , , , , , , , , , , , </del>	PROVIDER'S PLAN OF CORRECTION	N.	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	8 Continued From page 3		V 118			
	SUMMARY STATEMENT OF DEFICIENCIES ( (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)					
V 119	27G .0209 (D) Medica	ation Requirements	V 119			
10A NCAC 27G .0209 MEDICATION						

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Division of Health Service Regulation

DIVISION OF RESIDENCE REGulation				CONCEDUCTION	(VO) D 177 7	LIDVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
THE TENTO CONTINUE TO		A. BUILDING: _	A. BUILDING:			
MHL029-148		B. WING		07/07/2025		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE		
TO TWIL OF TH	TO VIDERY OIL OCIT EIER		AJO COURT			
MARAJO	PLACE		N-SALEM, NC 2	7427		
			N-SALEIVI, NC 2			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
V 119	Continued From page	- A	V 119			
* 110		, <del>,</del>	•			
	REQUIREMENTS					
	(d) Medication dispos					
	(1) All prescription an					
		isposed of in a manner that				
		sion or accidental ingestion.				
	` '	bstances shall be disposed				
	•	shing into septic or sewer				
		r to a local pharmacy for				
	destruction. A record of the medication disposal shall be maintained by the program.  Documentation shall specify the client's name, medication name, strength, quantity, disposal date and method, the signature of the person					
	disposing of medication, and the person					
	witnessing destruction.					
	_	nces shall be disposed of in				
	` '	North Carolina Controlled				
		90, Article 5, including any				
	subsequent amendme					
	(4) Upon discharge of	f a patient or resident, the				
	remainder of his or he	er drug supply shall be				
	disposed of promptly	unless it is reasonably				
	expected that the patient or resident shall return					
		uch case, the remaining				
	drug supply shall not	be held for more than 30				
	calendar days after th	ne date of discharge.				
	This Dule is set of	an avidanaad by:				
	This Rule is not met					
		ews, observations and				
	interviews the facility					
		ner that guards against				
diversion accidental ingestion affecting 1 of 2 current clients (Client #1). The findings are:						

Division of Health Service Regulation

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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				
		MHL029-148	B. WING		07/	07/2025		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
MARAJO	PLACE		AJO COURT N-SALEM, NC 2'	7127				
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE		
V 119	Review on 7/3/25 of C - Admission date 9/13 - Diagnoses Cerebral Developmental Disord Peripheral Neuropath  Observation on 7/3/25 of Client #1's PRN (as revealed: - Acetaminophen 325 tablets by mouth ever dispensed on 1/9/24 a  Interview on 7/3/25 w Living (AFL) Provider	Client #1's record revealed: 1/21; Palsy, Severe Intellectual der, Diabetic Type 2 with y.  5 at approximately 1:08pm is needed) medication milligrams (mg), take two y 6 hours as needed was and expired on 1/2025.  1th the Alternative Family revealed: Acetaminophen 325mg was macy to get the	V 119					

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