STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL011-331	B. WING			R 2 5/2025
					1 0172	10/2020
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
PAT BRA	DLEY HOME		.E COVE ROA NOA, NC 28			
(X4) ID				PROVIDER'S PLAN OF CORRI		(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	COMPLETE DATE
V 000	INITIAL COMMENT	-s	V 000			
	An annual and follo on 7/25/25. A defic	w up survey was completed iency was cited.				
		sed for the following service C 27G .5600F Supervised e Family Living.				
		ed for 2 and has a current urvey sample consisted of clients.				
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	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. (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 administering the					

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	MHL011-331 B. WING			1	R 2 5/2025	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	DI EV LIOME	420 LYTL	E COVE ROA	ND .		
PAT BRADLEY HOME SWANNANOA, NC 28778						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 1	V 118			
	(5) Client requests to checks shall be rec	for medication changes or orded and kept with the MAR appointment or consultation				
	facility failed to ensu administered on the	views and interviews, the ure medications were written order of a physician he MAR current affecting 2 of				
	-Date of admission: -Diagnoses: Chrom Osteoporosis, Scoli Gastroesophageal I Spectrum Disorder, Developmental Disa Bipolar Disorder, Vi Degenerative Eye I -Physician's orders -Budesonide 3 capsules (caps) dai daily for 4 weeks, th 3/27/25. A second "after you (Client #1 budesonide x (times mouth) QD (daily) u -Clonidine 0.1m (tab) twice daily ord discontinued on 6/5 -Testosterone 1	osomal Abnormality, osis, Kyphosis, Reflux (GERD), Autism Severe Intellectual ability (IDD), Panic Disorder, tamin D Deficiency, Disease, Crohn's Disease. included: milligrams (mg) (Crohn's) - 3 ly for 6 weeks, then 2 caps nen 1 cap daily ordered order dated 5/6/25 revealed) complete 6mg of s) 2 weeks, continue 1 PO (by intil next office visit." ng (hyperactivity) - 1 tablet ered on 1/23/25 and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		D	
	MHL011-331		B. WING		07/2	₹ 25/2025
NAME OF PROV	IDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PAT BRADI FY HOME			E COVE ROANOA, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
1/1 pre time ord spr 12/ tab app 6/1. Rev 5/1, Ma adr des dos cor the doc adr pos Jur adr dos dos dos (30) (30)	eventative) - apples daily and to rilered 3/7/25Azelastine 0.1'ay to each nostrology to each nostrology to each nostrology and contrology thin layer into 4/24. There was view on 7/22/25 at 4:y: -Budesonide was indistered 3 times spite the order was ested 2 caps daily attinue through 5/2 dose to 1 cap doses in control doses) -Clonidine was ministered on 6/1/2 ses. (7 doses) -Erythromycin was ministered in the doses) -Calcium Citration (30 doses) -Refresh Lacriak. (30 doses)	Eye Ointment 5mg (infection y small amount to left eye 4 ght eye at bedtime daily? % nasal solution (allergies) - 1 il "once or twice daily" ordered e 250mg (supplement) - 2 6/19/24. In the eye ointment (moisture) - both eyes every night ordered is no discontinue order. of Client #1's MARs for 20 pm revealed: as documented as es daily on 5/1/25-5/31/25 ritten on 5/6/25 to reduce the y for 2 weeks which would 20/25 and then further reduce aily. There was no ow many caps were	V 118			

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DIVISION	of Health Service Re	guiation			r	
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R	
		MUI 044 224	B WING		07/25/2025	
		MHL011-331	B: Wiite		0712	5/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		420 I YTI	E COVE ROA	AD.		
PAT BRA	DLEY HOME		NOA, NC 28			
			· ·			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION CONTROL OF THE PROVIDER OF THE P		(X5) COMPLETE
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		DATE
IAG			IAG	DEFICIENCY)	=	
V 118	Continued From pa	ge 3	V 118			
	possible doses)					
	July:					
		vas not listed on the MAR. (21				
	doses)					
		e was not listed on the MAR.				
	(22 doses)					
	-Refresh Lacri-l	lube was not listed on the				
	MAR. (21 doses)					
	Review on 7/23/25 of Client #2's record revealed:					
	-Date of admission: 5/20/17.					
	-Diagnoses: Modera	ate IDD, Generalized Anxiety				
		chotic Disorder, Idiopathic				
		order, Hypertension, Colon				
	Cancer, Thrombosi					
	-Physician's orders					
		or (supplement) - 1 tab daily				
	ordered 5/31/24.	or (cappionioni) I tab daily				
		e 325mg (supplement) - 1 tab				
	every other day ord					
		g (thrombosis) - 1 tab on				
		ridays ordered 3/4/25.				
		(sleep) - 1 tab at bedtime				
	daily ordered 4/8/24	ł.				
	Di 7/00/05	of Olivert HOLV NAAD of the				
		of Client #2's MARs for				
	5/1/25-7/22/25 reve	ealed:				
	May:					
		or was not listed on the MAR.				
	(31 doses)					
		not listed on the MAR. (31				
	doses)					
		e was documented as				
	administered on 5/3	31/25.				
	June:					
	-Certavite Senio	or was not listed on the MAR.				
	(30 doses)					
	` '	not listed on the MAR. (31				
	doses)	(

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-Ferrous Sulfate was documented as

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL011-331	B. WING			R 25/2025
PAT BRADI EY HOME 420 LYTLE			DRESS, CITY, S E COVE ROA NOA, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 118	administered on 6/2 days of administraticular -Warfarin was on 6/2/25, 6/9/25, 6 were Mondays, and 6/21/25 which were July: -Warfarin was on 7/6/25, 7/13/25, Sundays. (3 days) Attempted interview unsuccessful. Client tablet and did not rehim. Interview on 7/22/2-He received medic names or amounts administered. Interview on 7/23/2-pharmacist reveale -"Recently combines systemsthe MAR of issues but hoped worked out." -Budesonide is a st made any difference administered the Bicaps one time daily -Testosterone level work and it "look Client #1)75 grar pumpswould last each refill" -Azelastine bottles spray into both nos days. "If he (Client	I/25, resulting in 2 consecutive ion. documented as administered i/16/25, and 6/23/25 which if on 6/7/25, 6/14/25, and if Saturdays. (7 days) documented as administered and 7/20/25 which were I/ on 7/23/25 with Client #1 was int #1 played with his electronic espond to questions asked of its with Client #2 revealed: sations but did not know the of the medications he was its a new systemhad a lot it to have gotten all the kinks eroid and it would not have e if Client #1 was udesonide 3 times daily or all 3	V 118			

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R	
		MHL011-331	B. WING		07/25/2025	
	1		1		0112	0,2020
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PAT BRA	DLEY HOME		E COVE ROA			
	SWANNAN		NOA, NC 28	778		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
IAG			IAG	DEFICIENCY)		
	O	F	V/ 44.0			
V 118	Continued From pa	ge 5	V 118			
	worse"					
	-If Client #1 was no	t administered his Calcium				
	Citrate "he'd likely h	ave increased gastro				
	(gastrointestinal) iss	sues."				
	-"Ferrous Sulfate w	as usually tolerated well1				
		would not have made any				
	difference."					
		lelatonin "might affect ability to				
	get to sleep or stay	asleep."				
	l-4					
		5 with the Alternative Family				
	Living (AFL) provide					
		nged their internal systems not always accurate.				
		nide "reduced the				
		gutclarified with the doctor				
		give (administer) 3 times a day				
		ce" but did not document on				
		capsules were administered.				
		Client #1's Clonidine due to				
	his blood pressure	because his "doctor told me				
		essure was lowI think I				
	pulled the Clonidine	out of the (dispill) pack in				
	'	se few days and sent it back				
	to the pharmacy to	•				
	-"I know he's (Clien					
		Azelastine) because I put				
		sterone on his back and the				
		very nightI just missed				
	seeing them on the	ent #1's Refresh eye ointment				
	when the Erythromy					
		te Senior was dispensed in the				
		s other medications and was				
		In't notice it was not on the				
	MAR."					
		an said "it was okay to give				
		ous sulfate) starting on the 1st				
		ven if Client #2 had been				
	administered the Fe	errous Sulfate on the last day				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL011-331	B. WING			R 25/2025	
	PROVIDER OR SUPPLIER	420 LYTLE	DRESS, CITY, SECOVE ROANOA, NC 28				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
V 118	of the monthWhen documentin Client #2's MAR for Wednesdays and F administered. "I monthI marked to rememberI'm just just didn't pay atten administered) it on -"I honestly don't re administered Melat -"[Former Qualified together 2-2 ½ hou straightshe left lat Despite requests for documentation that approved administr Sulfate on consecut was provided prior Interview on 7/22/2 Professional (QP) r -Only became resp month when the Fo -She had not had th AFL provider to rev orders.	g medication administration on Warfarin, she put a dot on the ridays it was due to be ust have looked at the wrong he wrong datesI can't to to sureI don't know if I tionI know he got (was Wednesday and Friday" member" if Client #2 was onin in May and June 2025. Professional] and I worked as each month and had all this ast month (June 2025)" The AFL provider to furnish Client #2's physician ation of Client #2's Ferrous tive days, no documentation to the survey exit. We with the Qualified evealed: onsible for the facility last rmer QP left employment. The opportunity to meet with the liew medications, MARs, and	V 118				
	medication adminis	accurately document tration, it could not be s received their medications hysician.					
	7/25/25 and signed the QP revealed: "What immediate a ensure the safety o	of Plan of Protection dated by the Executive Director and ction will the facility take to f the consumers in your care? criptions) and pill package all					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		MHL011-331	B. WING		F 07/2	₹ 5/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	ADLEY HOME	420 LYTL	E COVE ROA	AD		
PAIDRA	ADLEY HOME	SWANNA	NOA, NC 28	778		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 7	V 118			
V 118	reviewed for accura-MAR completed dathat were prescribe -MAR faxed to QP of Describe your plans happensQP will review MAI packages for accuracy (Faxed by This deficiency con Client #1 was diagrabnormality, Osteo GERD, Autism Spe Panic Disorder, Bip Deficiency, Degene Crohn's Disease. Cadministered Budes order decreased further to the was not documer administered for ea 2025 MAR did not in administere	by AFL (AFL provider) and acy by QP 7/25/25 aily to ensure all medications d have been given daily for review over weekend is to make sure the above. R, scripts and medication acy on 7/25/25. R daily for completion and a AFL each night)" stitutes a recited deficiency. Hosed with Chromosomal porosis, Scoliosis, Kyphosis, ctrum Disorder, Vitamin Disor	V 118			
	Generalized Anxiety	y Disorder, Other Psychotic Epilepsy, Sleep Disorder,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		.	
		MHL011-331	B. WING		7 07/2	5/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
PAT BRA	ADLEY HOME		E COVE ROA			
			NOA, NC 28			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 8	V 118			
	Client #2's May and include Certavite Se for each medication doses of medication documented as adr Ferrous Sulfate was every other day; hor administered daily f Warfarin was to be and Fridays; howev documented as adr Wednesdays and F deficiency constitute which is detrimenta	ministered to Client #2. s ordered to be administered wever, was documented as for 2 two consecutive days. administered on Wednesdays				

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