Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION    |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |                                    | (X3) DATE SURVEY<br>COMPLETED |          |  |
|--|---|---|--|------------------------------------|-------------------------------|----------|--|
|  |   |   | D 14/11/0                                |                                    | R                             |          |  |
|  |   | MHL011-329  | B. WING                                  |                                    | 08/2                          | 1/2025   |  |
| NAME OF  | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S                           | STATE, ZIP CODE                    |                               |          |  |
| MCPHERSON HOME 16 WALNUT HILL DRIVE FAIRVIEW, NC 28730 |   |   |  |                                    |                               |          |  |
| (X4) ID<br>PREFIX<br>TAG                               | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTION (X5) |                               | COMPLETE |  |
| V 000  | INITIAL COMMENTS  |   | V 000                                    |                                    |                               |          |  |
|  | An annual and follo<br>on 8/21/25. A defic  | w up survey was completed iency was cited.  |  |                                    |                               |          |  |
|  | This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Individuals of all Disability Groups/Alternative Family Living.   |   |  |                                    |                               |          |  |
|  |   | ed for 3 and has a current<br>urvey sample consisted of an<br>ients.  |  |                                    |                               |          |  |
| V 118  | 118 27G .0209 (C) Medication Requirements   |   | V 118                                    |                                    |                               |          |  |
|  | only be administered order of a person and drugs.  (2) Medications shat clients only when and client's physician.  (3) Medications, included administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Administered order administered current. Medication recorded immediated MAR is to include the (A) client's name;  (B) name, strength, (C) instructions for a | 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 sluding injections, shall be y licensed persons, or by trained by a registered nurse, legally qualified person and e and administer medications. Ininistration Record (MAR) of led to each client must be kept administered shall be ely after administration. The |  |                                    |                               |          |  |

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

TITLE (X6) DATE Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL011-329 |  | ( )   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |   |                                   | (X3) DATE SURVEY<br>COMPLETED |  |  |  |
|--|--|---|---|---|-----------------------------------|-------------------------------|--|--|--|
|  |  | B. WING   |   |   | R<br><b>08/21/2025</b>            |                               |  |  |  |
|  | NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  16 WALNUT HILL DRIVE FAIRVIEW, NC 28730   |   |   |   |                                   |                               |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO 1<br>DEFICIENCE | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE      |  |  |  |
| V 118  | drug. (5) Client requests checks shall be rec  | ge 1 for medication changes or orded and kept with the MAR appointment or consultation  | V 118                                   |   |                                   |                               |  |  |  |
|  | facility failed to kee<br>of 3 clients (#2). The<br>Review on 8/20/25<br>-Date of admission:<br>-Diagnoses: Sleep<br>Oppositional Defiar<br>Mild Intellectual Deconduct Disorder, A                  | views and interviews, the p the MAR current affecting 1 ne findings are:  of Client #2's record revealed: 7/2/14. Disorder, Anxiety Disorder, at Disorder, Allergic Rhinitis, velopmental Disability, Other Attention Deficit Hyperactivity Cerebral Palsy, Other |   |   |                                   |                               |  |  |  |
|  | (mg) (ADHD) - 2 tal<br>-Fluticasone Na<br>(mcg) (allergic rhini<br>6/6/24.<br>Review on 8/21/25<br>Client #2 revealed:<br>-Concerta and were both documer<br>6/30/25. (30 doses)<br>-Fluticasone was | hylphenidate) 36 milligrams blets daily ordered on 5/15/25. asal Spray 50 micrograms tis) - 1 spray daily ordered on of MARs 6/1/25-8/20/25 for the generic methylphenidate as administered 6/1/25-   |   |   |                                   |                               |  |  |  |

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  MHL011-329 |  |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   |                        | (X3) DATE SURVEY<br>COMPLETED |  |  |
|---|--|---|--|---|------------------------|-------------------------------|--|--|
|   |  | B. WING   |  | 1   | R<br><b>08/21/2025</b> |                               |  |  |
|   | NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  16 WALNUT HILL DRIVE FAIRVIEW, NC 28730   |   |  |   |                        |                               |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>'MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLICATION DEFICIENCY) | OULD BE                | (X5)<br>COMPLETE<br>DATE      |  |  |
| V 118   | -"take nasal spra other 2I take 5 (tamorning and 1 at ni -"Use the nasal spra have a cold then us Interview on 8/21/25 Living (AFL) provide -"These MARs are at the time." -"He (Client #2) doe -"I always check whathe MARI know handle in the mark i | 5 with Client #2 revealed: y, ConcertaI don't know the ablets/capsules) in the ght." ay in the morning unless I e it at night too." 5 with the Alternative Family er revealed: all jacked upI didn't catch it es his nasal spray every day." at he takesthen I mark it on the gets what he's supposed to If asleep when I marked them concerta/methylphenidate) 5 with the Qualified ed: trustrated with the MARs not k MARs more closely every accurately document tration, it could not be sereceived their medications | V 118                                    |   |                        |                               |  |  |

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