STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE IDENTIFICATION NUMBER 1		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL039-039	B. WING		09/2	2/2025
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
ADVANTA	AGE CARE COMMUN	IITY SERVICES	D OXFORD H), NC 27565	IGHWAY 75		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	rs	V 000			
	Deficiencies were of This facility is licens	sed for the following service				
		C 27G .5600C Supervised th Developmental Disability.				
		sed for 6 and has a current urvey sample consisted of clients.				
V 118	27G .0209 (C) Med	lication 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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED	
l		MHL039-039		B. WING		09/	22/2025
	PROVIDER OR SUPPLIER	IITY SERVICES	5079 OLD	DRESS, CITY, S OOXFORD HI , NC 27565	TATE, ZIP CODE GHWAY 75		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCI Y MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 118	(5) Client requests checks shall be rec	nge 1 for medication char corded and kept with appointment or cons	n the MAR	V 118			
	This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to keep a client's MAR current and administer medications on the written order of a physician for 1 of 3 audited clients (#6)'s . The findings are:		ent's MAR the written				
	- September 201 - diagnoses: Bip Hyperlipidemia, Mil Disorder & Epileps - a physician's or 300 milligrams (mg (Bipolar) - physician's ord	olar, Hypertension, d Intellectual Devel	opmental Quetiapine dtime ustedo				
	summary dated 7/2 Health Service Reg	tedo 36mgthis me	ision of				
	September 2025 M - staff initialed th	of client #6's July 2 ARs revealed: e Austedo as admir f July 2025, August	nistered for				

Division of Health Service Regulation

STATE FORM 806411 If continuation sheet 2 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		MHL039-039		B. WING		09/	22/2025
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
ADVANT	AGE CARE COMMUN	ITY SERVICES		OXFORD H NC 27565	IGHWAY 75		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCI MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	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	to 9/19/25 - staff initialed the bedtime as administ July 2025, August 22 Observation on 9/19 revealed: - the Austedo ware - Quetiapine 300 prepackaged pill rown on - when he administ clients, he compared MARs - he then put his electronic system - "did not do that medication label to - the Austedo ware - "just put my init system]" used by the - "at this point I will medications at facil During interview on Director of Operation - the day program medical appointment - the physician expharmacy - he was not aware Quetiapine order ches client #6 needers - staff did not may was not at the facili	e Quetiapine 1 more stered the entire mode 2025 & up to 9/18/25 9/25 of client #6's man as not at the facility man 1 bedtime was listered medications and the medication later facility will look closer to mait in staff took clients that saff took clients that staff took clients that saff took	nths of 5 nedications in a ported: s to the abel to the ication e contact to the ication to the ication to the ication to the ication and contact to the ication to the ica	V 118			
	electronic system	oquel in their medic ouse Manager/Billing					

Division of Health Service Regulation

STATE FORM 806411 If continuation sheet 3 of 7

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		COMPLETED		
		MHL039-039		B. WING		09/	22/2025
	PROVIDER OR SUPPLIER	ITY SERVICES	5079 OLD	DRESS, CITY, S OXFORD H , NC 27565	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC MUST BE PRECEDED E SC IDENTIFYING INFORI	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
V 118	Continued From pa reviewed the MARs changes		edication	V 118			
V 121	27G .0209 (F) Media 10A NCAC 27G .02 REQUIREMENTS (f) Medication revier (1) If the client recession obtaining a revier regimen at least even shall be to be perfor physician. The onsethe client's physician the review when media (2) The findings of the recorded in the corrective action, if	w: ives psychotropic operator shall be reew of each client's ery six months. The rmed by a pharmacite manager shall an is informed of the edical intervention is the drug regimen reclient record along	drugs, the esponsible drug e review cist or assure that e results of is indicated.	V 121			
	Developmental Disc - a physician's or - Aripiprazole 30 - Quetiapine 400	view and interview of 3 audited clients (rug regimen review e findings are: of client #1's record sm & Intellecutual order (IDD) der dated 11/5/24: milligram (mg) mo	the facility (#1, #2 & r at least d revealed:				

Division of Health Service Regulation

STATE FORM 806411 If continuation sheet 4 of 7

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL039-039	B. WING		09/2	2/2025
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ADVANT	AGE CARE COMMUN	IITY SERVICES	OXFORD HI NC 27565	IGHWAY /5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
V 121	Continued From pa	ge 4	V 121			
	Review on 9/19/25 - admitted 6/24/1 - diagnoses: Aut - a physician ord - Clonazepam .5 - Divalproex 500 - Divalproex 250 - no documentat Review on 9/19/25 - admitted in Sep - diagnoses: Bip Hyperlipidemia, Mil - physician order 1mg twice day - a physician's or .5mg daily - a physician's or	of client #2's record revealed: 14 ism, IDD & Seizure Disorder er dated 7/31/24: img morning mg everyday mg 1 morning & 3 bedtime ion of a drug regimen review of client #6's record revealed: otember 2017 olar, Hypertension,				
	During interview on Operations reported had not contact the 6 month drug re	ted the pharmacist to complete				
V 291	10A NCAC 27G .56 (a) Capacity. A factorized from the developmental disacon June 15, 2001, a than six clients at the six clients at the six clients.	sed Living - Operations OPERATIONS cility shall serve no more than e clients have mental illness or abilities. Any facility licensed and providing services to more nat time, may continue to no more than the facility's	V 291			

Division of Health Service Regulation

STATE FORM 806411 If continuation sheet 5 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	MHL039-039		B. WING		09/22/2025	
	PROVIDER OR SUPPLIER	UITY SERVICES 5079 OLD	DRESS, CITY, S OXFORD HI NC 27565	GHWAY 75		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 291	maintained betwee qualified profession treatment/habilitation (c) Participation of Responsible Persoprovided the opportelationship with hemeans as visits to the facility. Reports annually to the pare legally responsible Reports may be in conference and shaprogress toward modificativity opportunities needs and the treat Activities shall be dinclusion. Choices or legal system is in	nation. Coordination shall be nother facility operator and the nals who are responsible for on or case management. It the Family or Legally note and client shall be tunity to maintain an ongoing or or his family through such the facility and visits outside as shall be submitted at least ent of a minor resident, or the person of an adult resident. Writing or take the form of a call focus on the client's eeting individual goals. The based on her/his choices, the through such the same and the transfer of the person of an adult resident. Writing or take the form of a call focus on the client's eeting individual goals. The based on her/his choices, the through the foster community may be limited when the court involved or when health or me a primary concern.	V 291			
	This Rule is not met as evidenced by: Based on record review and interview the facility failed to coordinate with other qualified professionals who are responsible for the treatment/habilitation for 1 of 3 audited clients (#6). The findings are: Review on 9/19/25 of client #6's record revealed: - September 2017 - diagnoses: Bipolar, Hypertension, Hyperlipidemia, Mild Intellectual Developmental Disorder & Epilepsy - physician's order dated 7/15/25: Austedo 18					

Division of Health Service Regulation

milligrams (mg) daily (involuntary movement)

STATE FORM 806411 If continuation sheet 6 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL039-039	B. WING		09/2	22/2025
	PROVIDER OR SUPPLIER	ITY SERVICES 5079 OL	DDRESS, CITY, S D OXFORD H D, NC 27565	STATE, ZIP CODE IGHWAY 75		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
V 291	Review on 9/22/25 summary dated 7/2 Health Service Reg - "rejected:Aus requires prior author During interview on Director of Operatio - client #6 neede - was not aware facility - he reached out (9/20/25) & the insu Austedo	of a physician's claim /5/25 sent to the Division of riulation revealed: tedo 36mgthis medication rization"	V 291			

6899

Division of Health Service Regulation STATE FORM