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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		BERTH TO ATTOM TO MISER.	A. BUILDING:		00		
MHL084-029		MHL084-029	B. WING		10/02/2025		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
DURRET	DURRETT HOME 824 BLAKE ROAD ALBEMARLE, NC 28001						
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENTS		V 000				
	An annual survey w 2025. A deficiency	vas completed on October 2, was cited.					
	This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.						
		sed for 5 and has a current urvey sample consisted of clients.					
V 119	119 27G .0209 (D) Medication Requirements		V 119				
	medication shall be guards against dive (2) Non-controlled so of by incineration, fl system, or by trans destruction. A record shall be maintained Documentation shamedication name, so date and method, the disposing of medication medication of medication	osal: and non-prescription disposed of in a manner that ersion or accidental ingestion. Substances shall be disposed ushing into septic or sewer fer to a local pharmacy for d of the medication disposal by the program. Ill specify the client's name, strength, quantity, disposal ne signature of the person ation, and the person ion. tances shall be disposed of in e North Carolina Controlled S. 90, Article 5, including any					

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

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED		
MHL084-029		B. WING		10/0	2/2025			
		WII 12004-023			10/0	2/2025		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
DUDDET	TUOME	824 BLAP	(E ROAD					
DURRET	I HOME	ALBEMA	RLE, NC 280	001				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)		
PRÉFIX			PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE		
TAG			TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE		
				22.10.2.10				
V 119	Continued From page 1		V 119					
	colondar daya aftar	the date of discharge						
	calendar days after	the date of discharge.						
	This Rule is not met as evidenced by: Based on record review, observation and interview the facility failed to ensure medications were disposed of in a manner that guarded							
		r accidental ingestion for 1 of 3						
	audited clients (#3). The findings are:							
	Review on 10/2/25 of Client #3's record revealed: -Admission date of 3/1/14.							
		sm Spectrum Disorder, Severe						
		y Disorder, Seizure Disorder,						
	Hydrocephalus, Gastroesophageal Reflux Disease (GERD), Scoliosis, Seizure Disorder, Bilateral Optic Nerve Hypoplasia -Physician order dated 6/3/25 for Lorazepam 0.5 milligrams (mg), take 1 tablet every 6 hours as needed for seizure activity or agitation.							
	needed for seizure	activity of agitation.						
	Observation on 10/	2/25 at 2:55 PM of Client #3's						
	medications reveale							
		y was packaged in 3 bubble						
	packs.	, , , , , , , , , , , , , , , , , , , ,						
	•	packs was labeled as filled on						
	10/3/23 and expired							
	-There were no tab	lets missing from the bubble						
	pack dated 10/3/23							
		5 with Qualified Professional						
	revealed:							
		that one of the Lorazepam						
		s was dated 10/3/23, and						
	expired 10/3/24.							

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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		
					12/2		
NAME OF		MHL084-029			10/0	2/2025	
	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
DURRETT HOME 824 BLAKE ROAD ALBEMARLE, NC 28001							
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 119	-"I don't know" why cabinet this longShe reported that the responsible for che sure they are not exampleThe nurse comes this checkShe acknowledged ensure medications.	it was left in the medication the agency nurse is cking on medications to make cpired. In once a month to complete that the facility failed to see were disposed of in a ed against diversion or	V 119				

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XQHG11 If continuation sheet 3 of 3