STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL098-167	A. BUILDING: _____ B. WING _____	R 12/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON COUNTY GROUP HOME #4	1502 PINEVIEW AVENUE WILSON, NC 27893

(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
V 000	INITIAL COMMENTS An annual and follow up survey was completed on December 13, 2018. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		
V 118	27G .0209 (C) Medication Requirements 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 administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician.	V 118		

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V 118	Continued From page 1 This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to administer medications as ordered by the physician and maintain a current MAR affecting 2 of 3 clients audited (clients #1, #6). The findings are: Finding #1: Review on 12/13/18 of client #6's record revealed: -37 year old female admitted 7/1/11. -Diagnoses included intellectual developmental disorder, moderate; high blood pressure; diabetes; major depressive disorder; intermittent explosive disorder. -Order dated 9/28/18 to check blood pressure twice daily and administer Valsartan (lowers blood pressure) if the blood pressure is greater than 140/80. -Order dated 1/8/18 with primary care physician's medication list to administer Diovan (same as Valsartan) 40 mg, 1 daily, as needed for blood pressure greater than 140/80. -No documentation of an order to clarify if Valsartan was to be administered if either the systolic or diastolic readings were greater than 140 or 80 respectively, or, if both systolic and diastolic readings had to be higher than 140 or 80 respectively to administer Valsartan. -Order dated 7/13/18 for Hydrocortisone 1% cream, apply twice daily. (Mild corticosteroid that reduces the swelling, itching, and redness that occurs with various skin conditions.) -Orders dated 8/9/18, 9/28/18, and 11/30/18 to discontinue Hydrocortisone 1% cream and	V 118		

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V 118	Continued From page 2 Neutrogena T-Gel shampoo. (Dry, itchy scalp conditions, i.e. psoriasis, seborrhea dermatitis, and dandruff.) Review of client #6's October, November, and December 2018 MARS revealed: -Valsartan (or Diovan) had not been transcribed to the October or November 2018 MARs. -Blood pressures were recorded twice daily at 7 am and 8 pm. -October 2018 MARs documented blood pressures greater than 140/80 on 14 occasions, ranging from 130/82 - 146/93. No documentation Valsartan was administered. -November 2018 MARs documented blood pressures greater than 140/80 on 22 occasion, ranging from 111/81 - 142/97. No documentation Valsartan was administered. -December 2018 MARs: Valsartan 40 mg daily for blood pressure greater than 140/80 was transcribed to the MAR. Eight (8) blood pressures documented greater than 140/80 between 12/1/18 and 12/12/18 ranging from 133/83 - 129/94. No documentation Valsartan had been administered. -Hydrocortisone 1% cream had been documented twice daily at 8 am and 8 pm from 10/1/18 - 11/30/18. -Neutrogena T-Gel shampoo had been documented twice weekly from 10/1/18 11/30/18. Interview on 12/12/18 client #6 stated she always got her medications. Finding #2: Review on 12/13/18 of client #1's record revealed: -26 year old female admitted 8/1/18. -Diagnoses included intellectual developmental disorder, mild.	V 118		

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V 118	Continued From page 3 -Order dated 5/24/18 for vitamin D3 5000 units daily. (Supplement) -Order dated 8/28/18 for vitamin D3 5000 units daily Monday through Friday. Review on 12/13/18 of client #1's October 2018 MAR revealed: -Both orders for vitamin D3 5000 had been printed on the October 2018 MAR. -Vitamin D3 5000 units had been documented as given at 7 am and again at 8 am 10/1/18 - 10/5/18, 10/8/18 - 10/12/18, 10/15/18 - 10/19/18, and 10/22/18. -Vitamin D3 5000 units had been documented on 10/13/18 (Saturday) and 10/14/18 (Sunday) at 7 am. Interview on 12/12/18 client #1 stated she always received her medications. Interview on 12/13/18 the Group Home Manager stated: -The staff had not administered Valsartan to client #6 because the systolic readings had not been greater than 140. They had not considered the diastolic readings being greater than 80. She would contact the physician for clarification of when to administer the blood pressure medication. -The vitamin D3 order dated 8/28/18 replaced the 5/24/18 order. The staff did not administer vitamin D3 twice daily as documented in October 2018. The pharmacy would not have sent enough of the medication for the staff to have given that much vitamin D3. This must have been a documentation error. Due to the failure to accurately document medication administration it could not be determined if clients received their medications	V 118		

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V 118	Continued From page 4 as ordered by the physician. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 118		