Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
701012701	or domination of	IDENTIFICATION TO MIDEN.	A. BUILDING:			
		MHL097-044	B. WING		01/31/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MULBERF	RY GROUP HOME		Y RIDGE ROA			
	0.11.11.15.4.07		LKESBORO, N			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS	•	V 000			
		up survey was completed Deficiencies were cited.				
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disabilities.				
V 118	V 118 27G .0209 (C) Medication 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 drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation					

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

TITLE (X6) DATE Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
,	o.	15211111101111011110	A. BUILDING: _	A. BUILDING:			
		MHL097-044	B. WING		01/	/31/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
MULBERI	RY GROUP HOME		NDY RIDGE ROA WILKESBORO, N				
0(0) ID	CLIMMADV CT.	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CO	DDECTION .	0/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
V 118	Continued From page	e 1	V 118				
	failed to ensure medical as prescribed on the authorized person and medications were discorder affecting 1 of 3. The findings are:  Review on 1/30/19 of admitted 4/23/07 - diagnoses of Mild Into Disability, Chronic Pateonal Nodular Hypergola Hepatitis, Unspecified Reflux and Hypertens.  Review on 1/30/19 of dated 8/31/18 revealed - "ZENPEP 10000-320 with each meal and 2 - Spironolactone 25 m. Review on 1/30/19 of Administration Record through January 2015	ew and interview, the facility cations were administered written order of an d failed to ensure continued per physician's clients sampled (Client #1).  Client #1's record revealed: ellectual Developmental ncreatitis, Hearing Loss, plasia of Liver, Autoimmune I Depression Disorder, Acid sion.  Client #1's physician orders ed: 000 units CPEP, TK 4 CS CS with snacks" g - 1 tablet daily.  Client #1's Medication ds from November 2018					
	-Spironolactone 25 m any MAR reviewed. Interview on 1/30/19 -ZENPEP was chang	sules with snack "PRN" g - 1 tablet daily was not on with Staff #1 revealed: ed to be given PRN with could not locate the order					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		MUU 007 044	B. WING		04/0	4/0040
NAME OF D	ROVIDER OR SUPPLIER	MHL097-044	RESS, CITY, STA	TE ZIR CODE	01/3	1/2019
			Y RIDGE ROA			
MULBER	RY GROUP HOME	NORTH WII	LKESBORO, N	IC 28659		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Continued From page	2	V 118			
	-Spironolactone was discontinued but she could not find the discontinued order prior to surveyor's exit.					
	This deficiency consti and must be corrected	tutes a re-cited deficiency d within 30 days.				
V 138	V 138 27G .0404 (A-E) Operations During Licensed Period		V 138			
	10A NCAC 27G .0404 OPERATIONS DURING LICENSED PERIOD  (a) An initial license shall be valid for a period not to exceed 15 months from the date on which the license is issued. Each license shall be renewed annually thereafter and shall expire at the end of the calendar year.  (b) For all facilities providing periodic and day/night services, the license shall be posted in a prominent location accessible to public view within the licensed premises.  (c) For 24-hour facilities, the license shall be available for review upon request.  (d) For residential facilities, the DHSR complaint hotline number shall be posted in a public place in each facility.  (e) A facility shall accept no more clients than the number for which it is licensed.					
	This Rule is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure that it would serve no more clients than the number for which it is licensed. The findings are:					

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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	
		MHL097-044	B. WING		01	/31/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
MIII BERE	RY GROUP HOME	1904 WIN	IDY RIDGE ROAD			
WOLDEKI	CT GROOF HOME	NORTH V	VILKESBORO, NC	28659		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 138	Continued From page	e 3	V 138			
		of the facility's license issued alth Service Regulation valid evealed:				
	-there were six currer	with Staff #1 revealed: nt clients at the facility Sunday 9:00 a.m. through				
	Observation and interview on 1/30/19 at approximately 4:30 p.m. revealed: -a seventh individual interacting with the client's in their bedrooms and living room -when asked, she stated she lived at Staff #1's house, but came to the facility and lived there when Staff #1 was working -she showed the surveyor a cot, in the back hallway, in front of the washer and dryer area where she slept -there were a few clothing items stacked on top of the cot as well.					
	-the seventh client liv home and had a diag Developmental Disab -the client was not rel -the previous Director	•				
	facility, but thought it in a while visit -she did not realize th facility the entire time -she was not aware h					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	=1=0
		MHL097-044	B. WING		01/3	1/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
			DY RIDGE ROA	•		
MULBERF	RY GROUP HOME		/ILKESBORO, N			
			TILKESBUKU, N			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
V 290	27G .5602 Supervise	d Living - Staff	V 290			
V 200	27 O .5002 Supervise	d Living - Stan	1200			
	10A NCAC 27G .5602	2 STAFF				
	(a) Staff-client ratios					
	` '	Paragraphs (b), (c) and (d)				
		letermined by the facility to				
		nd to individualized client				
	needs.					
	(b) A minimum of one	e staff member shall be				
	present at all times w	hen any adult client is on the				
	premises, except whe	en the client's treatment or				
	habilitation plan docu	ments that the client is				
	capable of remaining	in the home or community				
		The plan shall be reviewed				
		s than annually to ensure				
		be capable of remaining in				
		ity without supervision for				
	specified periods of ti					
	(c) Staff shall be pres					
		atios when more than one				
	child or adolescent cli					
	` '	adolescents with substance				
		be served with a minimum or every five or fewer minor				
	•	rever, only one staff need be				
		ng hours if specified by the				
		procedures determined by				
	the governing body; of					
		adolescents with				
	` '	lities shall be served with				
	-	every one to three clients				
		present for every four or				
		However, only one staff				
	need be present durir					
		gency back-up procedures				
	determined by the go					
	, ,	serve clients whose primary				
		e abuse dependency:				
		staff member who is on				
duty shall be trained in alcohol and other drug						

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		MHL097-044	B. WING		01	//31/2019	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
MULBERF	RY GROUP HOME		WILKESBORO, NC	28659			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLETE DATE	
V 290	drug addiction; and (2) the services abuse counselor shal as-needed basis for e	and symptoms of ons to alcohol and other of a certified substance be available on an each client.	V 290				
	failed to assess and of having unsupervise affecting three of thre #2 and #3). The finding Review on 1/30/19 of an admission date of diagnoses of Mild Into Disability, Chronic Paragnoses of Mild Into Paragnoses of Mild	Client #1's record revealed: 24/23/07 ellectual Developmental noreatitis, Hearing Loss, plasia of Liver, Autoimmune I Depression Disorder, Acidicion transport of the plan was dated ment/goal that addressed of having unsupervised time with Client #1 revealed: rself at the facility ne store by herself, but felt anymore.  Client #2's record revealed:					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		MHL097-044	B. WING		01/31/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MULBERRY GROUP HOME			Y RIDGE ROA			
	OUR MARK OT		LKESBORO, N			
(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)	D BE COMPL	ETE
V 290	Continued From page	e 6	V 290			
	2/5/18 -there was no assess					
	Interview on 1/30/19 with Client #2 revealed: -she was not left alone at the facility, however she did go into the store by herself -she just went into a local store yesterday and purchased a pink cup for herself that she had been wanting -Staff #1 stayed in the van with the other clients and told her to just go in there and come right back out.					
	-an admission date of -diagnoses of Modera Developmental Disab Hypertriglyceridemia, Rhinitis, Adjustment I and Depressed Mood -the most recent Trea 3/18/18 -there was no assess	ate Intellectual ility, Seizure Disorder, Exophthalmos, Allergic Disorder with mixed Anxiety				
	-she was not left alon could go into the store Interview on 1/30/19 - she would park in fro Client #1 and Client # needed	with Client #3 revealed: e at the facility, however she e, sometimes, by herself. with Staff #1 revealed: ont of the local store and let f2 run in and get what they ery close to the door of the				

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•		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				B) DATE SURVEY COMPLETED	
	MHL097-044		B. WING		01/31	1/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE			
MULBERF	RY GROUP HOME		Y RIDGE ROA				
	CLIMMADY CT	NORTH W  ATEMENT OF DEFICIENCIES	ILKESBORO, N		.,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
V 290	Continued From page	÷ 7	V 290				
V 290	store -she did not think this the clients' treatment Interview on 1/30/19 v -she allowed Client # store by themselves -she always made su amount of money to p wanted -she parked the van in waited with the other Interview on 1/31/19 v Professional revealed -she was aware that 0 the store by themselv capable of doing so -the staff sat in the va she felt this was enou- the unsupervised tim in the Treatment Plan -she was not aware the	unsupervised time was in plans.  with Staff #2 revealed: 1 and Client #2 to go into the  re they had an adequate purchase the items they in front of the store and clients in the van.  with the Qualified b: Client's #1 and #2 went into es and felt they were fully in in front of the store and igh supervision e in the community was not	V 290				

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