AND PLAN OF CORRECTION IDENTIFIC		IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED 02/20/2019		
		MHL018-008					
CATAWBA COUNTY GROUP HOME #1 401 NORTH FOURTH AVENUE							
		MAIDEN	, NC 28650				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
V 000	INITIAL COMMENTS		V 000				
	An annual survey was completed on 2/20/19. A deficiency was cited.						
V 118	27G .0209 (C) Med	lication Requirements	V 118				
	<ul> <li>only be administered order of a person a drugs.</li> <li>(2) Medications shat clients only when a client's physician.</li> <li>(3) Medications, include the distribution of the privileged to prepare of the privileged to prepare of the privileged to prepare (4) A Medication Act all drugs administered only built drugs administered on the privileged to prepare (4) A Medication Act all drugs administered on the privileged to prepare (4) A Medication Act all drugs administered marks is to include the (A) client's name;</li> <li>(B) name, strength, (C) instructions for (D) date and time the the distribution of the privileged of the prepare of the privileged to prepare of the prepare</li></ul>	inistration: non-prescription drugs shall ed to a client on the written uthorized by law to prescribe all be self-administered by uthorized in writing by the cluding injections, shall be by licensed persons, or by a trained by a registered nurse r legally qualified person and re and administer medications liministration Record (MAR) of red to each client must be kep s administered shall be ely after administration. The	t				

P0D011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 02/20/2019	
		MHL018-008				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
		401 NOR	TH FOURTH A	VENUE		
	A COUNTY GROUP I	MAIDEN	, NC 28650			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
V 118	Continued From pa	age 1	V 118			
	with a physician.	-				
	This Rule is not met as evidenced by: Based on observation, record review and					
		ity failed to keep the MAR				
	current and failed to follow the written order of a					
		2 of 3 sampled clients (Client				
	#1 and Client #2).	The findings are:				
	Record review on 2	2/20/19 for Client #1 revealed:				
		8/13/03 with diagnoses of				
		al Disability, Diabetes and				
	Seizure Disorder.	tod 11/20/18 for the following:				
		ated 11/20/18 for the following: 1000mcg (Vitamin B) inject				
		llar) SQ(subcutaneous) once a	1			
	month.	,				
		0mg (diabetes) twice daily.				
		ng (liver support) three times				
	daily.	histic) 4 super container twice				
	daily.	biotic) 4 ounce container twice	;			
		50mg (seizures) 3 tabs in the				
	evening.	3 (11 11)				
		of MARs for December 2018				
	through February 2					
		was not initialed as				
	administered at all	not initialed as administered				
	for 12/20/18 pm do					
		not initialed as administered				
	for 1/8/19 8am dos	e, 1/19/19 3pm dose and				
	1/21/19 10pm dose					
		not initialed as administered				
	for 1/21/19 pm dos					
	ealth Service Regulation	not initialed as administered				

STATE FORM

P0D011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         MHL018-008         NAME OF PROVIDER OR SUPPLIER       STREET A			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING		00/00/0040		
		DDRESS, CITY, STATE, ZIP CODE		02/20/2019		
		401 NOR	TH FOURTH A			
ATAWE	A COUNTY GROUP I	HOME #1	NC 28650			
(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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
V 118	Continued From page 2		V 118			
	for 1/17/19, 1/21/19 or 1/31/19.					
	-Admission date of Intellectual Disabili D Deficiency, Oste Reflux Disease, Bij and Seizure Disord -Physician order da Levetivacetam 7 daily. Exelon 6mg (der Calcium with D 5 times daily Risperdal 0.5mg Carbitrol ER 300 and 3 caps in PM. Metronidazole 0. thin amount to han Systane Ultra Op drop in each eye tw Review on 2/20/19 through February 2 Levetivacetam w administered for 1/ Exelon was not i 1/16/18 am dose. Calcium with D w administered for 12 dose; 1/17/19-8pm 2/19/19 -8pm dose Risperdal was no 12/12/18 am dose; dose or 1/31/19 am Carbitrol ER was for 12/12/18 am do ym dose.	ated 7/26/18 for the following: 50mg (seizures) 2 tabs twice mentia) twice daily. 500mg (supplement) three (antipsychotic) twice daily mg (seizures) 2 caps in AM 75% cream (antibiotic) apply ds twice daily. of MARs for December 2018 2019 revealed: vas not initialed as 24/18 pm dose. nitialed as administered for vas not initialed as 2/12/18-am dose; 1/8/19-5pm dose; 1/25/19-5pm dose or 				
vision of H	Metronidazole w for 12/12/18 am do pm dose. Systane Ultra Op ealth Service Regulation	as not initialed as administered ose; 1/8/19 am dose or 1/31/19 ohthalmic was not initialed as		00011	If continu	ation she

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL018-008	B. WING		02/20/2019	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ATAWB	A COUNTY GROUP I	HOMF #1		VENUE		
(X4) ID	SUMMARY STA		, NC 28650	PROVIDER'S PLAN OF	CORRECTION (X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLE THE APPROPRIATE DATE	
V 118	Continued From pa	age 3	V 118			
	-She can herself sh -She had never mis she could not reme Interview on 2/20/1 -She put the drops day. Staff watched -Staff always reme meds. Interview on 2/20/1 revealed: -The staff that left the were all new staff. -He had reviewed e have missed these -He was almost cent their medications a knew what they too	<ul> <li>9 with Client #1 revealed: nots for diabetes in her belly.</li> <li>ssed any medications although ember what she took.</li> <li>9 with Client #2 revealed: in her eyes herself twice a d her.</li> <li>9 with Group Home Manager</li> <li>9 with Group Home Manager</li> <li>blank spaces on the MARs</li> <li>each of the MARs but must</li> <li>tain the clients had received is ordered because the clients</li> <li>bk. They might not know the dication but they knew the</li> </ul>				
sion of H	ealth Service Regulation		I			