STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		MUI 006 000	B. WING		03/14/2019		
		MHL096-099	D. 11110		03/1	4/2019	
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
NORTHV	NORTHWOOD GROUP HOME 2708 NORTHWOOD DRIVE GOLDSBORO, NC 27534						
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	CTION SHOULD BE THE APPROPRIATE		
V 000	INITIAL COMMENT	-S	V 000				
	2019. A deficiency This facility is licens category: 10A NCA	ras completed on March 14, was cited. sed for the following service C 27G .5600C, Supervised h Developmental Disabilities.					
V 118	8 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 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						

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		MHL096-099	B. WING		03/1	14/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE	-	
NORTHV	VOOD GROUP HOME		RTHWOOD D			
			ORO, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 1	V 118			
	failed to ensure merecorded on each cadministration for 3 and #3). The findin Review on 3/14/19 - 44 year old female 9/23/02 Diagnoses of Posi Moderate Intellectual Hypothyroidism, Ga Disease, and Depresentation of the Physician's orders.	view and interviews the facility dications administered were lient's MAR immediately after of 3 audited clients (#1, #2, gs are: of client #1's record revealed: e admitted to the facility t Traumatic Stress Disorder, al Disability, Obesity, estroesophageal Reflux ession. s signed 1/22/19 for Systane for dry eye relief) one drop to				
	Review on 3/14/19 January - March 20 - Transcribed entry drop to each eye th 4:00 pm, and 8:00 p - No staff document administered at 8:00 - No staff document administered at 4:00 2/1/19 - 2/9/19, 2/11 1/31/19 No documented exclient #1's eye drop.	of client #1's MARs for 19 revealed: for Systane Eye Drops, one ree times daily at 8:00 am, om. tation that the eye drops were 0 am 2/14/19 and 1/28/19. tation that the eye drops were 0 pm 3/2/19, 3/3/19, 3/6/19, 1/19 - 2/17/19, and 1/28/19 - explanation for the omission of s.				
		3/14/19 client #1 stated staff medications daily and she medications.				

Division of Health Service Regulation

STATE FORM 25W411 If continuation sheet 2 of 5

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			
AND FLAN OF CONNECTION IDENTIFICATION NOWIBER.		A. BUILDING:		001111			
MHL096-099		B. WING		03/14/2019			
				03/1	7/2013		
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
NORTHV	WOOD GROUP HOME		RTHWOOD D DRO, NC 27				
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
V 118	Continued From pa	ge 2	V 118				
	- 58 year old female 9/12/03 Diagnoses of Seven Psychotic Disorder, (NOS), Mood Disor Dysmenorrhea, and - Physician's orders (a laxative) 5 milligr daily; buspirone (catablet (15 mg) three softener) 100 mg 2 hydroxyzine (antihis anxiety and allergy every morning. Review on 3/14/19 January - March 20 - Transcribed entrie - No staff documen administered 3/5/19 - No staff documen administered at 8:0 3/9/19 No staff documen administered 2/27/1 - No documented ethe medications. Client #2 was not adue to a medical processor of the staff documen administered 2/27/1 - No documented ethe medications. Client #2 was not adue to a medical processor of the staff documen administered 2/27/1 - No documented ethe medications.	es for medications as ordered. Itation that bisacodyl was 2, or 2/14/19. Itation that buspirone was 0 am 3/5/19, or at 2:00 pm Itation that docusate was 2. Itation that hydroxyzine was 19 or 1/9/19. Itation for the omission of Itation that hydroxyzine was 19 or 1/9/19. Itation that hydroxyzine was 19 or 1/9/19.					

Disability, Anxiety Disorder NOS, Depression

Division of Health Service Regulation

STATE FORM 25W411 If continuation sheet 3 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		5 1/1/10			
MHL096-099	B. WING		03/1	4/2019	
	DDRESS, CITY, S				
NORTHWOOD GROUP HOME	ORTHWOOD DE BORO, NC 275				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
NOS, Traumatic Brain Injury (TBI), Trigeminal Neuralgia, Polycystic Ovarian Syndrome, Borderline Diabetes, Hypothyroidism, Asthma, Seasonal Allergies, Hirsutism, Hereditary Motor and Sensory Neuropathy Type IV, Chronic Constipation, Speech Apraxia, and Motor Disorder related to TBI at birth. - Physician's orders signed 2/28/19 for cetirizine (antihistamine used to treat allergy symptoms) 10 mg one tablet daily, and fluticasone nasal spray (a steroid used to prevent asthma attacks) 50 micrograms 2 sprays to each nostril daily. Review on 3/14/19 of client #3's MARs for January - March 2019 revealed: - Transcribed entries for medications as ordered. - No staff documentation that cetirizine was administered 3/5/19. - No staff documentation that fluticasone nasal spray was administered 3/5/19. - No documented explanation for the omission of the medications. During interview on 3/14/19 client #3 stated staff assisted her with her medications daily, "that's why I have them," and she had not missed any medications since her admission. She got nasal spray for allergies. During interview on 3/14/19 staff #1 stated one or her responsibilities was to administer medications. Medications were always available During interview on 3/14/19, the Registered Nurse stated the facility began using online/electronic MARs in mid-November 2018. She did not see staff initials on the January - March 2019 MARs indicating administration of the medications as listed above. She did not have a explanation for the missing documentation.	f				

Division of Health Service Regulation

STATE FORM 25W411 If continuation sheet 4 of 5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
MHL096-099		B. WING		03/14/2019			
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2708 NORTHWOOD DRIVE GOLDSBORO, NC 27534						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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)	ILD BE	(X5) COMPLETE DATE	
V 118	Due to the failure to medication adminis	accurately document tration it could not be s received their medications	V 118				

6899

Division of Health Service Regulation STATE FORM