Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL040-019 | A. BUILDING: _____ B. WING _____ | R 09/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EASTER SEALS UCP-GREENE COUNTY GROUP HOM | 704 SE SECOND STREET SNOW HILL, NC 28580 |

| (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<br><br>An annual and follow up survey was completed on September 3, 2019. A deficiency was cited.<br><br>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<br><br>10A NCAC 27G .0209 MEDICATION REQUIREMENTS<br>(c) Medication administration:<br>(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.<br>(2) Medications shall be self-administered by clients only when authorized in writing by the client's physician.<br>(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.<br>(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:<br>(A) client's name;<br>(B) name, strength, and quantity of the drug;<br>(C) instructions for administering the drug;<br>(D) date and time the drug is administered; and<br>(E) name or initials of person administering the drug.<br>(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 | RECEIVED<br>OCT 01 2019<br>DHSR-MH Licensure Sect | |

Division of Health Service Regulation

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Tomeka Savage Digitally signed by Tomeka Savage DN: dc=LOCAL, dc=WECARE, ou=Easter Seals UCP North Carolina, Date: 2019.09.30 23:36:29 -04'00' | Residential Program Manager | 9-30-19 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL040-019 | A. BUILDING: _____ B. WING _____ | R 09/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EASTER SEALS UCP-GREENE COUNTY GROUP HOM | 704 SE SECOND STREET SNOW HILL, NC 28580 |

| (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 118 | Continued From page 1<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to administer medications on the written order of a physician and failed to keep the MARs current affecting two of three audited clients (#4 and #6). The findings are:<br><br>Finding #1<br>Review on 09/03/19 of client #4's record revealed:<br>-70 year old male.<br>-Admission date of 08/11/88.<br>-Diagnoses of Moderate Mental Retardation, Cerebral Palsy, Learning Disability, Gastroesophageal reflux disease, Hay Fever, Cellulitis, Nausea, Scoliosis, Hypokalemia, Abnormal Prostate, Hypothyroidism, Hypertension, Macular Degeneration and Allergic Rhinitis.<br><br>Review on 09/03/19 of client #4's Physician Orders revealed:<br>02/25/19<br>-Ammonium Lactate 12% Lotion Apply 1 application topically to affected areas twice daily.<br>-Petrolatum Ointment Base Apply topically to base of 2nd toe on right foot for hyperkeratosis as directed.<br>-Tinactin 1% aerosol powder Apply 1 application topically to affected areas every day for one month.<br><br>Review on 09/03/19 of client #4's June-August 2019 MAR's revealed initials on each medication from the first of the month to the end of each | V 118 | Group home manager/QP will monitor the MAR daily to make sure medications are being administered according to physician's orders. Group home manager will also monitor to make sure creams are being applied consistently. Group home manager will monitor MAR to make sure staff are documenting accurately the insulin level. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL040-019 | A. BUILDING: _____ B. WING _____ | R 09/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EASTER SEALS UCP-GREENE COUNTY GROUP HOM | 704 SE SECOND STREET SNOW HILL, NC 28580 |

| (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 118 | Continued From page 2<br>month to indicate the medication had been administered.<br><br>Review on 09/03/19 of the labels of the medication revealed:<br>-Ammonium Lactate 12%- Filled 02/14/18.<br>-Petrolatum Ointment Base- Filled 04/22/18.<br>-Tinactin 1%- Filled 08/27/18.<br><br>Observation on 09/03/19 at approximately 1:00pm of the medications revealed each bottle was almost full and did not appear that the medication had been used or administered to client #4.<br><br>Client #4 was unable to be interviewed due to being out of the facility at the time of the survey.<br><br>Finding #2<br>Review on 09/03/19 of client #6's record revealed<br>-69 year old male.<br>-Admission date of 08/15/88.<br>-Diagnoses of Severe Mental Retardation, Cerebral Palsy, Myopia, Stroke with probable right hemiparesis, Diabetes Mellitus, Hypertension, Sleep Apnea, Seasonal Allergies, Low Potassium, Macrocytic Anemia, Hyperlipidemia, Onychomycosis.<br><br>Review on 09/03/19 of client #6's Physician orders revealed:<br>07/21/19<br>-Novolog Flexpen Inject Sub Q with breakfast and dinner as directed per sliding scale.<br>-Check Blood Sugar twice a day before breakfast and dinner.<br><br>Review on 09/03/19 of client #6's July and August MARs revealed the following blanks:<br>-Novolog/Blood Sugar reading- | V 118 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL040-019 | A. BUILDING: _____ B. WING _____ | R 09/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EASTER SEALS UCP-GREENE COUNTY GROUP HOM | 704 SE SECOND STREET SNOW HILL, NC 28580 |

| (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 118 | Continued From page 3<br><br>07/26/19-07/29/19, 08/04/19-08/06/19. No initials to indicate the blood sugar levels had been checked to determine if sliding scale insulin would be needed.<br><br>During interview on 09/03/19 the Qualified Professional/House Manager revealed:<br>-She contacted the staff to inquire about the MARs and staff informed her the Novolog was not needed to his blood sugar.<br>-She takes responsibility for the errors on the MARs because she should have noticed the errors.<br>-She was having a staff meeting with all staff at the facility to discuss the MAR errors and all the staff would be retrained on Medication Administration.<br><br>This deficiency constitutes a re-cited deficiency and must be corrected within 30 days. | V 118 | | |