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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		MHL081-008	B. WING		10/0	8/2019	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
TRI-CITY GROUP HOME 132 BELLVUE STREET FOREST CITY, NC 28043							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
V 000	INITIAL COMMENTS		V 000				
	2019. Deficiencies	vas completed on October 8, were cited.					
	category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.						
V 118	/ 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 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						

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

(X6) DATE TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED			
		MHL081-008	B. WING		10/0	8/2019			
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE					
TRI-CITY GROUP HOME 132 BELLVUE STREET									
0(0) ID	FOREST CITY, NC 28043								
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE			
V 118	Continued From pa	ge 1	V 118						
	This Rule is not me								
	failed to ensure the	view and interview, the facility MAR's were kept current for 1 (Client #4). The findings are:							
	-Admitted on 10-11- -Diagnoses include	d Major Depressive Disorder							
	Developmental Disc	Severe, Mild Intellectual order, Moderate Mental se Control Disorder, Allergic							
	following medicatio	cen for anxiety) 0.5 mg 1 tablet							
	-oxybutynin (tal mg 1 tablet by mou	ken for overactive bladder) 5							
	-donepezil hydr	outh each night at bedtime; ochloride (taken for cognition) outh each night at bedtime.							
	MAR revealed:	of Client #4's August 2019							
	as given by staff on	ications were not documented 8-31-19: sen for anxiety) 0.5 mg 1 tablet							
	by mouth twice per	day; ken for overactive bladder) 5							
	-montelukast so 10mg 1 tablet by m	odium (taken for asthma) outh each night at bedtime; ochloride (taken for cognition)							
		outh each night at bedtime.							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED			
		MHL081-008	B. WING		10/0	8/2019			
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
TRI-CITY GROUP HOME 132 BELLVUE STREET FOREST CITY, NC 28043									
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE			
V 118	Continued From pa	ge 2	V 118						
	Interview on 10-7-1 Manager revealed: -She reviews the cl -She was unaware were not initialed by -Client #4 was not of 8-31-19 and would -The log of controlle count for Client #4's shift change on 8-3 -She stated the me documentation was staff.  Due to the failure to medication adminis	9 with the Residential ient MAR's monthly; the medications for Client #4 y staff on 8-31-19; on a leave of absence on have been at the facility; ed medications showed the is lorazepam was accurate at 1-19; dications were given and the is an oversight by the nightshift of accurately document iteration it could not be is received their medications							

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