STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: MHL097-044		(X2) MULTIPLE CON		(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		MHL097-044	B. WING		R 09/11/2020	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, Z	IP CODE		
		1904 WI	NDY RIDGE ROAD			
IULBERF	RY GROUP HOME	NORTH	WILKESBORO, NC 2	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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
V 000	INITIAL COMMENTS		V 000			
	violation was complet This was a limited foll NCAC 27G .0209 Me (V118) was reviewed. Medication Requirem back into compliance This facility is license category: 10A NCAC	rvey for the Type B rule ed on September 11, 2020. ow up survey, only 10A dication Requirements . 10A NCAC 27G .0209 ents (V118) was brought . A deficiency was cited. d for the following service 27G .5600C Supervised Developmental Disabilities.				
V 118	27G .0209 (C) Medica	ation Requirements	V 118			
	 only be administered order of a person auti drugs. (2) Medications shall clients only when auti client's physician. (3) Medications, inclu administered only by unlicensed persons tr pharmacist or other le privileged to prepare (4) A Medication Adm all drugs administered current. Medications a recorded immediately MAR is to include the (A) client's name; (B) name, strength, a (C) instructions for ac (D) date and time the 	stration: n-prescription drugs shall to a client on the written horized by law to prescribe be self-administered by horized in writing by the ding injections, shall be licensed persons, or by ained by a registered nurse, egally qualified person and and administer medications. inistration Record (MAR) of d to each client must be kept administered shall be after administration. The following: nd quantity of the drug;				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL097-044		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		B. WING		09	R / 11/2020		
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
MULBERF	RY GROUP HOME			00050			
			WILKESBORO, NC				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORR		R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)		
V 118	Continued From page	e 1	V 118				
	checks shall be recor	r medication changes or ded and kept with the MAR pointment or consultation					
	failed to keep all drug after administration o audited clients (Client	ew and interview, the facility is recorded immediately n a client's MAR for 1 of 1 t #2) and failed to keep a for 1 of 1 audited clients					
	-a date of admission -diagnoses which incl Depressive Disorder, Developmental Disord	luded Unspecified Mild Intellectual					
	-physician-prescribed which included: -Vitamin E 400 Unit twice daily for antioxid -ZenPep10000-320	l medications dated 6/9/20 : soft gel, 1 capsule (cap) dant; 00 Units, 4 caps 3 times 2 caps with snacks as					
	needed to treat pance -Montelukast Sodiu tablet at bedtime to tr	m 10 milligrams (mg), 1					
		nd 9/10/20 of Client #2's April e 2020, July 2020 and evealed:					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R 09/11/2020	
		MHL097-044				
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	• • •	
		1904 WI	NDY RIDGE ROAD			
MULBERF	RY GROUP HOME	NORTH	WILKESBORO, NC	28659		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	(EACH CORRECTIVE AC	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIEN		DATE
V 118	Continued From pag	e 2	V 118			
	-the Vitamin E 400 Unit soft gel had:					
		I 2020 MAR at the 8:00 PM				
	dosage times on 4/25/20, 4/26/20, 4/27/20,					
	4/28/20, 4/29/20 and 4/30/20 (the 45th day for the					
	correction period ended for the $3/10/20$ survey for					
	V118 on 4/24/20); -blanks on the June 2020 MAR at the 8:00 AM					
	dosage time on 6/26/20, 6/27/20 and 6/28/20;					
	-blanks on the July 2020 MAR at the 8:00 AM					
	dosage time on 7/1/20, 7/2/20, 7/3/20, 7/4/20,					
	7/5/20, 7/6/20, 7/7/20, 7/8/20, 7/9/20, 7/10/20,					
	7/11/20, 7/12/20, 7/13/20, 7/14/20, 7/15/20,					
	7/16/20, 7/17/20, 7/18/20, 7/19/20, 7/20/20,					
	7/21/20, 7/22/20, 7/23/20, 7/24/20, 7/25/20,					
	7/26/20, 7/27/20, 7/28/20, 7/29/20, 7/30/20 and					
	7/31/20; ZanBan 10000, 22000 Linita had:					
	-ZenPep10000-32000 Units had: -a blank on the May 2020 MAR at the 12:00					
	-a blank on the May 2020 MAR at the 12:00 Noon dosage time on 5/25/20 and had a blank on					
	the July MAR at the 12:00 Noon dosage time on					
	7/30/20;					
	-the Montelukast Sodium 10 mg had:					
	-blanks on the Aug	ust 2020 MAR at the 8:00				
	AM dosage times on	8/26/20, 8/27/20, 8/28/20				
	and 8/29/20.					
	Interview on 9/2/20 w	vith Client #2 revealed:				
	-no problems or issue					
	medication administr	ation by staff.				
	Interview on 9/10/20	with Staff #1 revealed:				
	-The staff was on du	ty the last day of the month				
	was responsible for updating the clients' MARs					
	for the following month;					
	-She missed recording Client #2's Vitamin E					
	administration on the June MARs;					
		nome visit the first part of the				
	-	nd her MAR should have 'H" to indicate she was at				
	home;	IT TO INCIDATE SHE WAS AL				
	alth Service Regulation					

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AND PLAN OF CORRECTION		CIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			
			A. BUILDING:			COMPLETED	
		MHL097-044	B. WING		09/11/2020		
IAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE			
IULBERF	RY GROUP HOME		NDY RIDGE ROAD WILKESBORO, NC	28659			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
V 118	Continued From page	e 3	V 118				
	 -There were pill count sheets that could be provided that showed Client #2 was given her medication. Interviews on 9/10/20 and 9/11/20 with the Executive Director revealed: -There were 2 staff (Staff #1 and Staff #2) who administered the client medications; -She would be notified by either staff if there were problems with client medication administration; -She would review and send Client #2's pill count sheets on the three medications which had MAR blanks; Both staff were trained in medication administration by a registered nurse; -She used to have someone meet Staff #2 in the office and check the MARs quarterly; -There was no one who currently monitored the MARs for completeness and accuracy; -She planned to change client MAR process to correct this situation. 						