AND BLAN OF CORRECTION . IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
MHL001-224		B. WING		02/2) 3/2021	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
NEW RE	GINNINGS GROUP H	OME	WIN ROAD			
NEW BE		BURLING	TON, NC 27	217		
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 000 INITIAL COMMENTS		V 000				
	23, 2021. The comp (intake #NC001736 This facility is licens	was completed on February plaint was substantiated 91). Deficiencies were cited.				
	Living for Adults wit	C 27G .5600A Supervised h Mental Illness.				
V 118	27G .0209 (C) Med	ication Requirements	V 118			
	only be administered order of a person and drugs. (2) Medications shat clients only when and client's physician. (3) Medications, included and individual drugs administered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Adall drugs administer current. Medication recorded immediated MAR is to include the (A) client's name; (B) name, strength, (C) instructions for a (D) date and time the (E) name or initials drug.	inistration: non-prescription drugs shall d 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 ly licensed persons, or by trained by a registered nurse, legally qualified person and e and administer medications. Iministration Record (MAR) of red to each client must be kept administered shall be ely after administration. The ne following: and quantity of the drug; administering the drug; he drug is administering the for medication changes or				
		orded and kept with the MAR appointment or consultation				

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

(X6) DATE TITLE

AND BLAN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					С	
		MHL001-224	B. WING		02/2	3/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
NEW BE	GINNINGS GROUP H	OME	WIN ROAD TON, NC 27	217		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 118	Continued From pa	age 1	V 118			
	with a physician.					
	This Rule is not m Based on record reinterview the facility medication adminis current for three of and #3). The findir Review on 2/23/21 - Admission date o - Diagnoses of Sch Unspecified; Histor History of Stimulan	of Client #1's record revealed: f 12/7/20. iizoaffective Disorder, y of Traumatic Brain Injury;				
	Review on 2/23/21 dated the following -Order dated 12/17 -Ingrezza 80 m capsule once dailyOrder dated 12/28 -Meloxican 7.5 morningSertraline 100 dayDivalproex 500 eveningClozapine 100 morning.	7/20 revealed: illigram (mg). Take one				

Division of Health Service Regulation

STATE FORM 6899 GS7F11 If continuation sheet 2 of 7

AND DIAM OF CODDECTION IDENTIFICATION NUMBER					TE SURVEY MPLETED	
		MHL001-224 B. WING 02/23/2				
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
NEW BE	GINNINGS GROUP H	OME	WIN ROAD TON, NC 27	247		
(V4) ID	SHIMMADV STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION)N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 2	V 118			
	medication revealed the form of bubble of the form	J.				
	January and February the following dates: January 2021: -Meloxican 7.5 mg-Sertraline 100 mg-Clozapine 100 mg-Clozapine 100 mg-Clozapine 100 mg-	ary 2021 revealed blanks on 1/7-1/31				
	February 2021: -Meloxican 7.5 mg-Sertraline 100 mg-Divalproex 500 mg-Clozapine 100 mg-Clozapine 100 mg-lngrezza 80 mg-2	2/19-2/23. j- 2/19-2/23. - 2/19-2/23. - 2/19-2/23.				
	- Admission date of	izoaffective Disorder, Bipolar				
	dated the following: -Order dated 6/25/2 -Duloxetine 60 daily.					

Division of Health Service Regulation

STATE FORM 6899 GS7F11 If continuation sheet 3 of 7

AND DIAN OF CORRECTION INDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
	A. BUILDING.				•		
		MH	IL001-224	B. WING			C 23/2021
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
NEW BE	GINNINGS GROUP H	ОМЕ		WIN ROAD TON, NC 27	217		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE	F DEFICIENCIES PRECEDED BY FULL YING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 3		V 118			
	sublingually before each meal and at bedtime.						
	once a week. -Omeprazole 4 a day. -Perphenazine times a day. -Propranolol 20 times a day. -Orders missing da -Farxiga 5 mg. morning. -Victoza 18 mg Subcutaneously on	,000 unit. 0 mg. Ta 4 mg. Ta 1 mg. Tak te: Take one /3I injecti	Take one capsule ke one capsule twice ke one tablet three e one tablet three				
	medication reveale the form of bubble -Duloxetine 60 mgHyoscyamine 0.12 -Vitamin D2 50,000 -Omeprazole 40 mgPerphenazine 4 m -Propranolol 20 mg -Farxiga 5 mgVitamin D3 5,000 u	d the follo backs: 5 mg. unit. g. g. unit. of Client ough Fel ving date	bruary 2021 revealed s: 12/1-12/31.				

Division of Health Service Regulation

STATE FORM 6899 GS7F11 If continuation sheet 4 of 7

DIVISION	Division of Health Service Regulation						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED			
					С		
		MHL001-224	B. WING			3/2021	
NAME OF I	PROVIDER OR SUPPLIER	STDEET AF	INDESS CITY	STATE, ZIP CODE			
IVAIVIL OI I	TROVIDER OR GOLT EIER		DWIN ROAD	STATE, ZII GODE			
NEW BE	GINNINGS GROUP H	OMF	STON, NC 27	7217			
(V4) ID	STIMMADV STA	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTI	ON	(VE)	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE	
				BEI IOIEIVOT)			
V 118	Continued From pa	ige 4	V 118				
	-Pernhenazine 4 m	g- 1/6 @ 2pm, 1/22 @ 2pm,					
	1/25 @ 2pm.	g 170 @ 2pm, 1722 @ 2pm,					
	February 2021:						
	-Victoza 18 mg/31 i						
	-Duloxetine 60 mg-						
		5 mg- 2/1 @ 12pm, 2/2					
		m, 2/5 @12pm, 2/19-2/23. unit- Last given was 2/6.					
	-Omeprazole 40 mg	· ·					
		g- 2/1 @2pm, 2/4 @2pm, 2/5					
	@2pm, 2/19-2/23.						
		- 2/1 @2pm, 2/4 @2pm, 2/5					
	@2pm, 2/19-2/23.						
	-Farxiga 5 mg- 2/19						
	-Vitamin D3 5,000 t	unit- 2/19-2/23.					
	Poviow on 2/23/21	of Client #3's record revealed:					
	- Admission date of						
		derate Intellectual Dysfunction;					
		eizure Disorder; Asthma;					
	Nicotine Dependen	t.					
		of Client #3's physician's order					
	dated 12/1/20 revea	aled: g- Take one tablet twice a day.					
		g- Take one tablet twice a day. g- Take one tablet twice a day.					
		ng- Take one tablet at night.					
		.g .s.to one tablet at mg.ft.					
	Observation on 2/2	3/20 at 12:00 PM of Client #3's					
		d the following was available in					
	the form of bubble						
	-Aripiprazole 15 mg						
	-Divalproex 500 mg	•					
	-Escitalopram 20 m	ıy.					
	Review on 2/23/21	of Client #1's MAR's for					
		ary 2021 revealed blanks on					
	the following dates:						

Division of Health Service Regulation

STATE FORM 6899 GS7F11 If continuation sheet 5 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
			A. BUILDING.			С	
		MHL001-224	B. WING 02			3/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
NEW DE	GINNINGS GROUP H	OME 326 BALD	WIN ROAD				
NEW DE	GINNINGS GROUP II	BURLING	TON, NC 27	217			
(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 5	V 118				
	February 2021: -Aripiprazole 15 mg -Divalproex 500 mg -Escitalopram 20 m	g 2/19-2/23. g2/19-2/23.					
	Interviews on 2/23/2 revealed:	21 with Clients #1, #2 and #3					
	-They received thei	em their medications and					
	-She had been wor -She was the Owne -She did not know s shifts after her. -She reported that s job." -She gave clients the	staff's name that worked other she "only came I and did her neir medications.					
	-She reported that of his sugars checked -She was not award to be in place regar sugars checkedShe was to talk to	e that documentation needed ding his denying on having his physician to had it she wanted him to have labs					
	discontinued. She washowed on the MAI -She reported having dealing with COVID normally worked at home doing contract.	ng had a tough few months In general at the hospital she She worked for the group					

Division of Health Service Regulation

STATE FORM 6899 GS7F11 If continuation sheet 6 of 7

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		A. BUILDING:				
	MHL001-224	B. WING			C 23/2021	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
NEW BEGINNINGS GROUP H	IOME	OWIN ROAD STON, NC 27	217			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
and needed labs of on Clozaril. -She reported that did more harm that staff at the home completing the Manda in the same of t	ew weeks. at Client #1 was on Clozaril ften. She disliked that he was it was a bad medications that n good on the person. were responsible for AR. ved the MAR for clients as she any medications to them. ponsibility for oversight on not rs check up discontinued for naving the orders at the house of the Victoza for Client #2. 21 with the Owner revealed: all staff had been trained in ications and completing the to do a refresher training on If a nurse to help her do clients. onal and the Nurse were riewing the MAR monthly. clients did receive their nat staff did not marked the e facility failed to ensure the estration record (MAR) was	V 118				

6899

Division of Health Service Regulation STATE FORM