Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _	A. BUILDING:		
MHL096-197		B. WING		08/27/2021		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
UNIVERS	AL		OOD AVENUE	ı		
GOLDSBORO, NC 27534 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)						
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	An annual survey was 2021. Deficiencies w	s completed on August 27, ere cited.				
		d for the following service 27G .5600A Supervised Mental Illness.				
V 118	27G .0209 (C) Medic	ation 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

TITLE (X6) DATE

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		MHL096-197	B. WING		08	3/27/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	. ZIP CODE	•	
			WOOD AVENUE	, =:: • • - =		
UNIVERS	AL	GOLDS	BORO, NC 27534			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5)		
V 118	Continued From page	e 1	V 118			
	facility failed to keep one of three clients (and Review on 08/27/21 or revealed: -34 year old maleAdmission date of 10-Diagnoses of Bipola Hyperactivity Disorder Allergies and High Clien Review on 08/27/21 04/15/21 and Physicial revealed: -Metformin HCL 1000 times daily with morning the series of the seri	ews and interviews the the MARs current affecting #3). The findings are: of client #3's record 1/2012. r Disorder, Attention Deficit er, Diabetes, Asthma,				
	MAR revealed: -Metformin HCL 1000 the MAR and no initial had been self admini Client #3 was not abl client being on a hom were with client #3 at	of client #3's August 2021 Omg was not transcribed on als to indicate the medication stered. e to be interviewed due to be visit and the medications the time of the survey. 8/27/21 the Licensee				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		MHL096-197	B. WING		08	3/27/2021	
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	ZIP CODE			
UNIVERSA	AL		BORO, NC 27534				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
V 118	Continued From page	ued From page 2 V 118					
	-She did not know wh the MAR because cli- taking the medication	ne pharmacy to inform them					
V 736	V 736 27G .0303(c) Facility and Grounds Maintenance		V 736				
		EMENTS					
		n and interview, the facility n a safe, clean, attractive					
	12:05pm revealed: -The bathroom in the bulb that was not wor -The blinds in the din	7/21 at approximately living room area had 1 light rking. ing room were dirty and prown substance on the					
	broken drawers and vroomClient #3's bedroom over the floor and wa -The hall bathroom h	edroom had a dresser with was being used as a storage had clothes and shoes all as very unkept. ad a towel covering the spill in the bathtub had an					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPLI			
			A. BUILDING					
MHL096-197		B. WING		08/27/2021				
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
UNIVERSA	UNIVERSAL 104 VINWOOD AVENUE							
GOLDSBORO, NC 27534 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)								
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETE DATE		
V 736	Continued From page 3		V 736					
	exposed hole and wa	s not covered.						
		#2's bedroom the carpet was						
	bubbled at the entrance created a trip hazard and the carpet was stained throughout the room.							
	During interview on 08/27/21 the Licensee revealed:							
	-She rented the home							
		ry responsive to any issues would let the landlord know						
	of the issues.	would let the landiold know						
ı								

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