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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		
		MHL080-168	B. WING	<u>-</u>	R 10/19/2021
NAME OF PE	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
CARADDI	IS COUNTY GROUP HO	ME 9 355 HUM	MINGBIRD CIRCL	E	
CABARRO	S COUNTY GROUP HO	SALISBU	JRY, NC 28146		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
V 000	0 INITIAL COMMENTS		V 000		
	An annual survey was deficiency was cited.	s completed on 10/19/21. A			
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disabilities.			
V 118	27G .0209 (C) Medica	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 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 with a physician.				

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:		(X3) DATE SURVEY COMPLETED	
		MHL080-168	B. WING		10	R / <b>19/2021</b>
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	,	
		355 HUN	MINGBIRD CIRCL			
CABARRI	JS COUNTY GROUP HO	ME 9 SALISBU	JRY, NC 28146			
(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	e 1	V 118			
	drugs administered to current and shall be r administration and fa	riew, observation and refailed to ensure MAR of all of each client must be kept recorded immediately after filed to administer ed affecting 1 of 3 clients				
	revealed: - Admission date 9/3/ - Diagnoses- Intellect Generalized Anxiety I Compulsive Disorder Disease, Obesity, Ex Constipation, Overac - A physician's order Polyethylene Glycol 3	ual Disability Mild, Disorder, Obsessive , Gastroesophageal Reflux ternal Hemorrhoids, Chronic tive Bladder; dated 9/3/21 for 3350 17gm (gram) scoop, stool softener. Take 17gm				
	#1's medication reveal - Polyethylene Glycol	9/21 at 11:33am of client aled: 3350 17gm scoop oral y mouth daily as directed				
	September 2021- Oc - Polyethylene Glycol	3350 17gm scoop oral y mouth daily as directed				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R
		MHL080-168	B. WING		10/19/2021
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STA	TE, ZIP CODE	
CABARRI	JS COUNTY GROUP HO	ME 9	IMINGBIRD CIRC JRY, NC 28146	CLE	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETE
V 118	Continued From page	e 2	V 118		
	- Did not receive med September; - Didn't need the med Interview on 10/19/2* - Acknowledged the rethe MAR; - Client #1 received the medication partially described to September.  Interview on 10/19/2* - Client #1 has medicated to him and the management of the medication partially described by the medication of the medication partial pa	dication in September.  I with staff #1 revealed: medication was not listed on the Polyethylene Glycol luring the month of  I with staff #2 revealed: the station but he never takes it; a few times; September; to see if he wants but he says no.  I with Office Assistant: ication was not listed on			

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