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	
					F		
		MHL082-041	B. WING		04/2	0/2022	
NAME OF PROVIDER OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
GARLAND GROUP	GARLAND GROUP HOME 168 HERRING AVENUE GARLAND, NC 28441						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECT	ON	(X5)	
PRÉFIX (EACH		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE	
V 000 INITIAL C	V 000 INITIAL COMMENTS		V 000				
		w up survey was completed A deficiency was cited.					
category:	10A NCA	sed for the following service AC 27G .5600C Supervised th Developmental Disabilities.					
census o		sed for 5 and currently has a urvey sample consisted of clients.					
V 118 27G .0209 (C) Medication Requirements		V 118					
REQUIRI (c) Medici (1) Prescionly be an order of a drugs. (2) Medici clients on client's ph (3) Medici administe unlicense pharmaci privileged (4) A Medici all drugs current. Mine recorded MAR is to (A) client' (B) name (C) instru (D) date a	EMENTS ation admiription or individual ations shall be an anysician. ations, incompleted at the prepartication and include the include the include the same; strength ations for and time the same to the same;	inistration: non-prescription drugs shall ad 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 by licensed persons, or by a trained by a registered nurse, ar legally qualified person and administer medications. Iministration Record (MAR) of a and administered shall be all y after administration. The and quantity of the drug; administering the drug; administering the drug; and of person administering the					

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

(X6) DATE TITLE

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	
			71. BOILDING.		F	₹	
		MHL082-041	B. WING			20/2022	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GARLAN	GARLAND GROUP HOME 168 HERRING AVENUE GARLAND, NC 28441						
(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)	JLD BE	(X5) COMPLETE DATE	
V 118	(5) Client requests checks shall be red file followed up by a with a physician. This Rule is not m Based on record reinterview the facility	for medication changes or corded and kept with the MAR appointment or consultation et as evidenced by: eview, observation and y failed to administer	V 118				
	to keep the MAR colients (#2). The fill Review on 4/20/22 - 33 year old female - Diagnoses include Disability, severe; A Persistent Mood (A Disorder, and encologister of the color - Signed Physician's glycol (PEG) 3350 grams) in 8 ounces 3/01/22 take once Primary Care Proving 2/21/22 and 1/24/ client #2's Psychiat 12/02/21 take twice Gastroenterologist Review on 4/19/22 MARs for February - March 2022: Print daily marked throughtranscription for PE	of client #2's record revealed: e admitted 11/12/11. ed Intellectual/Developmental Autism Spectrum Disorder; Affective) Disorder; Anxiety presis without constipation. 's orders for polyethylene (laxative) mix 1 capful (17 s of water and drink as follows: e daily signed by client #2's ider 22 take at bedtime signed by trist be daily, signed by client #2's					

Division of Health Service Regulation

STATE FORM 6899 F6UV11 If continuation sheet 2 of 4

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 A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		F	,
		MHL082-041	B. WING			0/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GARLAND GROUP HOME 168 HERRII GARLAND,						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 118	8:00 am and 8:00 p - February 2022: Fonce daily marked transcription for PE documentation it was 8:00 am and 8:00 p During interview on took her medication assistance. During interview on - One of her job duadministration Medication chang verbally and in writi - Either the Resider the Qualified Profest made sure the charstaff and the change During interview on - One of her job duadministration Staff were notified verbally and in writi - Medication change During interview on Services Coordinat - Her job responsibility clients to the medication than the MARs and make stock If a provider made would ensure the control of the provider made would ensure	om). Printed transcription for PEG through and a handwritten G twice daily with as administered twice daily (at om). 4/20/22 client #2 stated she as everyday with staff 4/20/22 staff #1 stated: ties was medication es were communicated to staff and. Services Coordinator or asional/Executive Director ange was communicated to be made to the MAR. 4/20/22 staff #2 stated: ties was medication for medication changes ang. es were written on the MAR.	V 118			

Division of Health Service Regulation

STATE FORM 6899 F6UV11 If continuation sheet 3 of 4

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	
		MHL082-041	B. WING			R 20/2022	
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
GARLAND GROUP HOME 168 HERRING AVENUE GARLAND, NC 28441							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
V 118	end of the month at the beginning of the - If a Physician charwere printed and be the facility, the new on the MAR The "Manager" wathe new orders onto - Client #2 went to the December 2021 and aily They did not realize changed the PEG of and continued it on - The pharmacy printer administered twice accordance with the 12/02/21 order Client #2 received and March despite administered once - The change in clied communicated with administer it twice of - Client #2's Medical communicate with a and the Residential ensure each Medicothers had prescrib	and sent to the facility before enew month. Inged an order after the MARs efore they were received by order would not be reflected as responsible for transcribing to the MAR. The Gastroenterologist in the Gastroenterologist in the prescribed PEG twice are client #2's Psychiatrist order to bedtime on 1/24/22 2/21/22. The transcriptions on the home MARs were marked out by a transcription for PEG to be daily was handwritten in the Gastroenterologist's are perfectly	V 118				

6899

Division of Health Service Regulation STATE FORM