STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					R	
		MHL092-389	B. WING		07/1	4/2022
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WAKE CO	UNTY GROUP HOM	F #2	TEHALL AVE	ENUE		
WAILE GO	- CIVIT CIVOUT TIONS	RALEIGH	NC 27604			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	S	V 000			
	on 7/14/22. Deficier					
	category: 10A NCA0 Living for Adults witl	sed for the following service C 27G .5600C Supervised h Developmental Disability.				
:		urrent census of 5. The survey f audits of 2 current clients ent.				
V 118	27G .0209 (C) Medi	ication Requirements	V 118			
	only be administere order of a person andrugs.  (2) Medications shat clients only when a client's physician.  (3) Medications, incadministered only bunlicensed persons pharmacist or other privileged to prepare (4) A Medication Ad all drugs administer current. Medications recorded immediate MAR is to include the (A) client's name;  (B) name, strength,  (C) instructions for a (D) date and time the	inistration: ion-prescription drugs shall d to a client on the written uthorized by law to prescribe  Il be self-administered by uthorized in writing by the  luding injections, shall be y licensed persons, or by trained by a registered nurse, legally qualified person and e and administer medications. ministration Record (MAR) of ed to each client must be kept s administered shall be ely after administration. The				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		R	
		MHL092-389	B. WING			4/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WAKE C	OUNTY GROUP HOM	IF #7	ITEHALL AVI	ENUE		
(X4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	I, NC 27604	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
V 118	Continued From pa	age 1	V 118			
	checks shall be rec	for medication changes or corded and kept with the MAR appointment or consultation				
	Based on record re failed to ensure one (DC#3) medication	et as evidenced by: eview and interview the facility e of one deceased client s were administered on the hysician. The findings are:				
		of DC#3's record revealed: 99 and passed away on				
	<ul><li>diagnosed with</li><li>Developmental Dis</li><li>no physician's</li></ul>	Mild Intellectual order order for Phenytoin 100mg ning and 2 bedtime (treat &				
	DC#3 revealed: - no MARs for Fe	of the facility's 2022 MAR's for ebruary & March 2022 inistered the entire month of				
	reported: - he thought the facility - will submit the	n 7/14/22 the g Qualified Professional physician's order was at the physician's order if located sizure disorder but no seizures				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					) DATE SURVEY COMPLETED	
		MHL092-389				R 14/2022
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
WAKEC	OUNTY GROUP HOM	E #2 4808 WH	ITEHALL AVE	ENUE		
WARLO		RALEIGH	I, NC 27604			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 118	Continued From pa	ge 2	V 118			
	* the Phenytoin was survey.	s not submitted by exit of the				
V 121	27G .0209 (F) Med	ication Requirements	V 121			
	governing body or of for obtaining a review regimen at least even shall be to be performant of the client's physician. The onest the client's physician the review when medical the findings of the formal of the client's physician the review when medical the findings of the formal of the client's physician the review when medical the findings of the findings of the formal of the client's physician the client's p	w: ives psychotropic drugs, the operator shall be responsible ew of each client's drug ery six months. The review rmed by a pharmacist or site manager shall assure that n is informed of the results of edical intervention is indicated, the drug regimen review shall client record along with				
	failed to ensure psy completed at least	et as evidenced by: view and interview the facility vchotropic drug reviews were every 6 months for 1 of 1 OC#3). The findings are:				
	<ul> <li>admitted 5/10/9</li> <li>4/29/22</li> <li>diagnosed with</li> <li>Developmental Disc</li> <li>physician order</li> <li>100mg daily (depre</li> </ul>	dated 2/10/22: Trazadone				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MHL092-389		B. WING		R <b>07/14/2022</b>		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	<u>  U//1</u>	4/2022
	OUNTY GROUP HOM	4808 WHI	TEHALL AVE			
WAREC	OUNTY GROUP HOM	RALEIGH	NC 27604			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	.D BE	(X5) COMPLETE DATE
V 121	Continued From pa	ge 3	V 121			
	documented in the	record				
	reported: - DC#3 been on - last prescription in the system was f  During interview on Administrator/Acting reported: - a drug review w however, it was door	7/14/22 the g Qualified Professional was completed January 2022, cumented January 2021 the drug review due to the				
	This deficiency con and must be correct	stitutes a re-cited deficiency sted within 30 days.				
V 291	27G .5603 Supervis	sed Living - Operations	V 291			
	six clients when the developmental disa on June 15, 2001, a than six clients at the provide services at licensed capacity. (b) Service Coordinated between qualified profession treatment/habilitation (c) Participation of Responsible Person provided the opport relationship with he means as visits to the control of the six clients of the control of the	cility shall serve no more than e clients have mental illness or abilities. Any facility licensed and providing services to more nat time, may continue to no more than the facility's mation. Coordination shall be not the facility operator and the nals who are responsible for on or case management. The Family or Legally not be called the facility and visits outside a shall be submitted at least				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			E SURVEY MPLETED	
	MHL092-389		B. WING		07/1	R 4/2022	
NAME OF	PROVIDER OR SUPPLIER		<u>l</u>	STATE, ZIP CODE	1 0771	4/2022	
WAKE C	OUNTY GROUP HOM	F #2	TEHALL AVE	ENUE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		, NC 27604 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETE		
V 291	legally responsible Reports may be in conference and sha progress toward may (d) Program Activiti activity opportunitie needs and the treat Activities shall be dinclusion. Choices or legal system is in	ent of a minor resident, or the person of an adult resident. writing or take the form of a all focus on the client's eeting individual goals. ties. Each client shall have as based on her/his choices, tment/habilitation plan. esigned to foster community may be limited when the court involved or when health or me a primary concern.	V 291				
	This Rule is not met as evidenced by: Based on record review and interview the facility failed to coordinate with other professionals who are responsible for the treatment of 1 of 2 current clients (#4). The findings are:  Based on record review on 7/13/22 & 7/14/22 of client #4's record revealed: - admitted 11/5/05 - diagnoses of Moderate Intellectual Disorder - a physician's order dated 3/28/22 for Aristada injection 1064 every 2 months - no documentation of the injections  During interview on 7/14/22 the						
	Administrator/Actin reported: - the nurse docu injection but not the will submit doc 2022 injection	g Qualified Professional mented the January 2022 April 2022 injection umentation of the January					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		7. Boileante.		R		
		MHL092-389	B. WING		07/1	4/2022
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
WAKE C	OUNTY GROUP HOM	E #2	TEHALL AVE , NC 27604	ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 736	Continued From page 5		V 736			
V 736	27G .0303(c) Facili	ty and Grounds Maintenance	V 736			
	EXTERIOR REQUI (c) Each facility and maintained in a safe	03 LOCATION AND REMENTS I its grounds shall be e, clean, attractive and orderly e kept free from offensive				
	failed to maintain th The findings are:	et as evidenced by: view and interview the facility le grounds in a safe manner. 1/22 between 3:42pm -				
		de of the men's bathroom nd warped				
	revealed: - "the shower tha againcan't locate the first time"	of an email dated 6/27/22  It was repaired is leaking your contractor whom fixed it r Qualified Professional (QP)				
	reported: - maintence was the leak in the bath - the leak was fix started back 2 weel - staff unsure wh	ed 2 - 3 months ago but				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
		MHL092-389	B. WING			R 14/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	<u>.</u>	
WAKE 0	COUNTY GROUP HOM	F #7	TEHALL AVE	ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
V 736	reported: - he was not sure with the organizatio 6/27/22 - they could not h without approval fro	7/14/22 the g Qualified Professional e if anyone had followed up n that owned the facility since hire their own maintence	V 736			

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