STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
						R	
		MHL098-169		B. WING		07/	19/2022
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WILSON	COUNTY GROUP HO	MF #1		G STREET NC 27893			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	COMPLETE DATE
V 000	INITIAL COMMENT	-S		V 000			
		w up survey was compeficiencies were cited.					
	category: 10A NCA	sed for the following se C 27G .5600C Superv h Developmental Disa	rised				
	This facility is licensed for 5 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.						
V 108	/ 108 27G .0202 (F-I) Personnel Requirements			V 108			
	10A NCAC 27G .0202 PERSONNEL REQUIREMENTS (f) Continuing education shall be documented. (g) Employee training programs shall be provided and, at a minimum, shall consist of the following: (1) general organizational orientation; (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B; (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and (4) training in infectious diseases and bloodborne pathogens. (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction.						

Division of Health Service Regulation
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	
	MHL098-169					R <b>19/2022</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE			
WILSON	COUNTY GROUP HO	MF #1	GG STREET , NC 27893				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
V 108	(i) The governing be implement policies reporting, investigation	ge 1  pody shall develop and and procedures for identifying ting and controlling infectious diseases of personnel and	V 108				
	facility failed to ensin Cardiopulmonary First Aid affecting 1 findings are:	view and interviews, the ure staff were currently trained Resuscitation (CPR) and of 3 audited staff (#3). The	1				
	Review on 7/13/22 for staff #3 revealed -"1-year provisional Aid/CPR/AED (auto The skills portion m	of a Certificate of Completion d: certification for Adult First omated external defibrillator). nust be taken within 1-year of the course to receive a 2-year tion.					
	about a yearHe worked Saturda and every other we -He worked his shif	a caregiver at the facility for ay 6:00am - Monday 6:00am ekend.					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	MHL098-169		B. WING	B. WING		R <b>19/2022</b>	
	PROVIDER OR SUPPLIER  COUNTY GROUP HO	MF #1 308 BF	ADDRESS, CITY, S RAGG STREET N, NC 27893	STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
V 108	Interview on 7/13/2: stated: -1 staff worked per -Staff #3 had a year skills portion of CPI -She understood the not meet the CPR/F	2 the Residential Director shift. r to complete the required R/First Aid. e provisional certification did First Aid requirement.					
V 118	10A NCAC 27G .02 REQUIREMENTS (c) Medication adm (1) Prescription or r only be administere order of a person a drugs. (2) Medications sha clients only when a client's physician. (3) Medications, inc administered only b unlicensed persons pharmacist or other privileged to prepar (4) A Medication Ad all drugs administer current. Medication recorded immediate MAR is to include th (A) client's name; (B) name, strength, (C) instructions for (D) date and time th (E) name or initials drug. (5) Client requests	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 re and administer medication liministration Record (MAR) ared to each client must be ke administered shall be ely after administration. The	e, s. of ept				

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BEAD11 If continuation sheet 3 of 10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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		MHL098-169	B. WING			9/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
WILSON	COUNTY GROUP HO	)MF #1	G STREET			
			NC 27893			
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	ige 3	V 118			
	•	appointment or consultation				
	interview, the facilit medications as ord maintain an accura clients (#1, #2. #3).  Finding #1 Review on 7/12/22 -64 year old maleAdmitted on 3/18/8 -Diagnoses of Mild	view, observation, and y failed to administer ered by the physician, and te MAR affecting 3 of 3 current The findings are:  of client #1's record revealed:				
	physician orders re Order dated 2/15/2. -Docusate 50mg/5 (ear wax) FL2 dated 4/6/22 -Citrucel Powder 1 of water. (constipat -Hydrocortisone Ac (mg) insect 1 per re (constipation) -Sucralfate 1 gram -Fluastor 250 mg coupport) Order dated 4/19/2.	milliliter (ml) in each ear daily.  teaspoon mixed in 12 ounces ion) etate Suppository 25 milligram ectum twice daily as needed.  tablet 4 times a day. (ulcers) apsule twice daily. (digestive				

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STATE FORM BEAD11 If continuation sheet 4 of 10

AND DUAN OF CORRECTION IDENTIFICATION NUMBER				(X3) DATE COMP	SURVEY LETED	
					R	
		MHL098-169	B. WING			9/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
WILSON	COUNTY GROUP HO	OME #1 308 BRAG WILSON,	G STREET			
(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 APPROVIDERICIENCY)	D BE	(X5) COMPLETE DATE
V 118	Continued From pa	nge 4	V 118	`		
	•					
	8 Continued From page 4 supper. (digestive support)  Review on 7/12/22 and 7/13/22 of client #1's MARs from April 2022 to July 12, 2022 revealed: July 2022 Sucralfate 1gram tab, 4 times daily, not documented as administered on 7/13/22 at 6:00pm and 8:00pm; 7/14/22 7/17/22 at 7:00am, 3:00pm, 6:00pm and 8:00pm.  VSL #3, 1 capsule twice daily, documented as unavailable on 7/5/22 at 5:00pm; 7/6/22 at 8:00am and 7/11/22 - 7/12/22 at 8:00am and 5:00pm; 7/13/22 at 8:00am documented as unavailable.  Lactulose 10g/15ml , 30ml everyday, not documented as administered on 7/14/22 -7/17/22 at 7:00am; and 7/19/22 documented as unavailable.  -Hydrocortisone Acetate Suppository 25 milligram (mg) insect 1 per rectum twice daily as needed not listed on April 2022 - July 2022's MARsFluastor 250 mg capsule twice daily not listed on April 2022 - July 2022's MARs.					
	Observation on 7/12/22 at approximately 3:20 pm of client #1's medications revealed: -Docusate 50mg/5ml, Hydrocortisone Acetate Suppository 25mg, Sucralfate 1 gram, Fluastor 250 mg and VSL #3 were not available onsite for reviewCitrucel Powder container was empty.					
	Interview on 7/12/22 client #1 stated: - "Oh yes" he took his medications daily.					
	-59 year old male. -Admitted on 3/1/81	of client #2's record revealed:  I. lectual Disability and Vision				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	MHL098-169				R <b>07/19/2022</b>	
	PROVIDER OR SUPPLIER  COUNTY GROUP HO	MF #1 308 BRA	DRESS, CITY, S GG STREET NC 27893	STATE, ZIP CODE		
(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 118	order dated 1/8/22 and Guaifenesin DM Syneeded. (cough)  Review on 7/12/22 and Guaifenesin DM Syneeded.  Observation on 7/12/22 and Guaifenesin DM Syneeded.  Observation on 7/12/22 and Guaifenesin DM Syneeded.  Interview on 7/12/22 and Guaifenesin DM Syneeded.  Interview on 7/12/22 and Guaifenesin DM Syneeded.  Finding #3  Review on 7/12/22 and Guaifenesin DM Syneeded. (colon clear Guaifenesin DM Syneeded.	of client #2's signed physician revealed: yrup 10ml every 6 hours as on client #2's MARs from April 22 revealed: yrup, 10ml, every 6 hours as 2/22 at approximately 3:40pm ations revealed: yrup was not available onsite 2 client #2 stated: ations in the morning and at iility ran out of his medications. It to bring them medications. It to bring them medications. It to decide the state of client #3's record revealed: In the control of client #3's signed physician revealed: In as directed for bowels as	V 118			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						R	
		MHL098-	169	B. WING		07/	19/2022
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
WILSON	COUNTY GROUP HO	OME #1		GG STREET NC 27893			
(X4) ID PREFIX TAG	_	TEMENT OF DEFICE MUST BE PRECED SC IDENTIFYING IN	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
V 118	Continued From pa	ige 6		V 118			
	Review on 7/12/22 2022 - July 12, 202 -Gavilyte-N- Solution bowel habit. -Guaifenesin DM syneeded. -Metoclopramide 50 bowel habit.	2 revealed: on as directed fo yrup 10ml every	or change in  / 6 hours as				
	Observation on 7/12/22 at approximately 3:55pm of client #3's medications revealed: -Gavilyte-N- Solution, Guaifenesin DM syrup and Metoclopramide 5mg were not available for review.						
	Interview on 7/12/22 client #3 stated: -"Yes" when asked if he had received his medications.						
	Interview on 7/12/22 and 7/13/22 staff #1 stated: -Client #1 last used his Docusate 50mg/5ml yesterday (7/11/22)Client #1 last received his VSL #3 morning capsule 2 days ago. He received his afternoon doseShe ordered the Citrucel Powder today (7/12/22)She was unsure about client #1's Hydrocortisone Acetate Suppository 25mg, Sucralfate 1 gram, Fluastor 250 mgThe client's medications that were taken "as needed" were ordered.						
	Interview on 7/13/2 stated: -All medications we -Some medications pharmacy medicati ordered by staffThe staff were supmedications when the staff were supplied to the staff were supplied	ere ordered duri were not include ons pack and no	ng survey. ded in eeded to be the				

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STATE FORM BEAD11 If continuation sheet 7 of 10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED				
	MHL098-169		B. WING		R <b>07/19/2022</b>				
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 0	<u> </u>			
WILSON	WILSON COUNTY GROUP HOME #1 308 BRAGG STREET								
		WILSON,	NC 27893						
(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 APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE			
V 118	Continued From pa	ge 7	V 118						
	(QP)The QP was respo	ired a Qualified Professional nsible for ensuring MARs edications were available.							
	medication adminis	accurately document tration it could not be s received their medications hysician.							
	This deficiency cons and must be correc	stitutes a re-cited deficiency ted within 30 days.							
V 290	27G .5602 Supervis	sed Living - Staff	V 290						
	numbers specified in of this Rule shall be enable staff to responeeds.  (b) A minimum of compresent at all times premises, except whabilitation plan doccapable of remaining without supervision as needed but not let the client continues the home or commuspecified periods of (c) Staff shall be prefollowing client-staff child or adolescent (1) children of abuse disorders shall of one staff present.	is above the minimum in Paragraphs (b), (c) and (d) is determined by the facility to cond to individualized client  one staff member shall be when any adult client is on the hen the client's treatment or cuments that the client is ing in the home or community.  The plan shall be reviewed ess than annually to ensure to be capable of remaining in unity without supervision for time. The sesent in a facility in the fortal ratios when more than one							

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Division of Health Service Regulation		
	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: CO	COMPLETED	
	R	
MHL098-169 B. WING 07	/19/2022	
IIII E GOO TOO	113/2022	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
WILSON COUNTY GROUP HOME #1 308 BRAGG STREET		
WILSON COUNTY GROUP HOME #1 WILSON, NC 27893		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	COMPLETE	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE	
V 290 Continued From page 8 V 290		
emergency back-up procedures determined by		
the governing body; or		
(2) children or adolescents with		
developmental disabilities shall be served with		
one staff present for every one to three clients		
present and two staff present for every four or		
more clients present. However, only one staff		
need be present during sleeping hours if		
specified by the emergency back-up procedures		
determined by the governing body.		
(d) In facilities which serve clients whose primary		
diagnosis is substance abuse dependency: (1) at least one staff member who is on		
(1) at least one staff member who is on duty shall be trained in alcohol and other drug		
withdrawal symptoms and symptoms of		
secondary complications to alcohol and other		
drug addiction; and		
(2) the services of a certified substance		
abuse counselor shall be available on an		
as-needed basis for each client.		
This Rule is not met as evidenced by:		
Based on record review and interviews, the		
facility failed to assess the client's capability of		
having unsupervised time in the home or		
community without staff supervision for 1 of 3		
current clients (#3). The findings are:		
Review on 7/12/22 of client #2's record revealed:		
-59 year old male.		
-Admitted on 3/1/81.		
-Diagnoses of Intellectual Disability and Vision		
Loss.		
-No evidence of a current assessment for client		
#2's capability of having unsupervised timeNo evidence of a sign in and out record for		

unsupervised time for client #2.

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER.			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	MHL098-169		B. WING		R <b>07/19/2022</b>	
NAME OF F	PROVIDER OR SUPPLIER		<u>I</u>	STATE, ZIP CODE	1 0771	<u> </u>
WILSON	COUNTY GROUP HO	MF #1	G STREET NC 27893			
(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 APPROPRIED TO THE APPROPRIED TO THE APPROPRESS OF THE APPROPRIED TO THE	.D BE	(X5) COMPLETE DATE
V 290		of client #2's treatment plan	V 290			
	maintain his safety supervised time. [C instruction when it i community due to ir -"How (Support/Interparticipate with [Lic skills required for u community. Staff will also remin the community. Staff will also remin the community. Staff recommunity. Staff will also remin the community. Staff will also remin the community. Staff recommunity.	ge Goal) [Client #2] will in the community during lient #2] requires verbal in the solution of				
	Interview on 7/12/22 client #2 stated: -He went out into the community without staffHe went around and cut grass.  Interview on 7/13/22 the Residential Director stated: -Client #2 had 4 hours of unsupervised time in the communityClient #2 typically left around 1:30pm and returned about 5:30pmClient #2 was not required to sign out for unsupervised timeThere was not a current assessment for client #2's unsupervised time.					

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