

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL007-026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R 07/29/2022</b>
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**BEAUFORT COUNTY GROUP HOME #1**

**405 EAST 6TH STREET  
WASHINGTON, NC 27889**

(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 000	<p><b>INITIAL COMMENTS</b></p> <p>An annual and follow up survey was completed on July 29, 2022. A deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>This facility is licensed for 5 and currently has a census of 4. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 291	<p><b>27G .5603 Supervised Living - Operations</b></p> <p><b>10A NCAC 27G .5603 OPERATIONS</b></p> <p>(a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity.</p> <p>(b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management.</p> <p>(c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals.</p> <p>(d) Program Activities. Each client shall have activity opportunities based on her/his choices, needs and the treatment/habilitation plan.</p>	V 291		

Division of Health Service Regulation

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

TITLE

(X6) DATE

STATE FORM

6899

5QE011

DHSR - Mental Health

continuation sheet 1 of 4

AUG 17 2022

Lic. & Cert. Section

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL007-026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/29/2022</b>
---	--	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

**BEAUFORT COUNTY GROUP HOME #1****405 EAST 6TH STREET  
WASHINGTON, NC 27889**

(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 291	<p>Continued From page 1</p> <p>Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.</p> <p>This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to maintain coordination between the facility operator and the professionals who are responsible for the client's treatment, affecting one of three audited clients (#1). The findings are:</p> <p>Review on 07/28/22 of client #1's record revealed:</p> <ul style="list-style-type: none"> <li>- 64 year old male.</li> <li>- Admission date of 09/24/81.</li> <li>- Diagnoses of Autism Spectrum Disorder with Intellectual Impairment, Severe Intellectual Developmental Disability and Seizure Disorder.</li> </ul> <p>A. Review on 07/28/22 of a signed physician order sheet for client #1 and dated 06/30/22 revealed:</p> <ul style="list-style-type: none"> <li>- Proair Inhaler (treats Asthma symptoms) - inhale 2 puffs every 4 hours as needed for shortness of breath/wheezing.</li> <li>- No order for self administration of the Proair inhaler.</li> </ul> <p>Observation on 07/28/22 at approximately 2:45pm of client #1's medications revealed a Proair inhaler for client #1 dispensed on 08/18/21.</p> <p>B. Review on 07/28/22 of a signed prescription for client #1 dated 02/20/20 revealed:</p> <ul style="list-style-type: none"> <li>- "Check BS (blood sugar) twice weekly. Call if [greater than or equal to] 140 5 consecutive</li> </ul>	V 291	<p>-</p> <p>A. Does Not Have a Self Administration order of His Proair Inhaler Due to him not being competent enough to self-admin this PRN. Client #1 has never registered the use of this medication for shortness of breath or wheezing at any time. Client #1</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL007-026</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R 07/29/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>BEAUFORT COUNTY GROUP HOME #1</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>405 EAST 6TH STREET WASHINGTON, NC 27889</b>	

(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 291	<p>Continued From page 2</p> <p>checks."</p> <p>Review on 07/28/22 and 07/29/22 of client #1's blood glucose log from February 2022 thru July 2022 revealed:</p> <ul style="list-style-type: none"> <li>- 02/04/22 - 171.</li> <li>- 02/08/22 - 156.</li> <li>- 02/11/22 - 155.</li> <li>- 02/14/22 - 158.</li> <li>- 02/18/22 - 156.</li> <li>- 02/21/22 - 154.</li> <li>- 02/25/22 - 162.</li> <li>- 02/28/22 - 153.</li> <li>- 03/04/22 - 179.</li> <li>- 03/07/22 - 162.</li> <li>- 03/11/22 - 156.</li> <li>- 03/14/22 - 164.</li> <li>- 03/18/22 - 150.</li> <li>- 03/21/22 - 152.</li> <li>- 03/25/22 - 169.</li> <li>- 03/28/22 - 166.</li> <li>- 04/01/22 - 156.</li> <li>- 04/04/22 - 149.</li> <li>- 04/08/22 - 160.</li> <li>- 04/11/22 - 147.</li> <li>- 04/15/22 - 175.</li> <li>- 04/18/22 - 163.</li> <li>- 04/22/22 - 159.</li> <li>- 04/25/22 - 142.</li> </ul> <p>- No documentation the physician was notified for blood sugar values above 140 for 5 consecutive checks.</p> <p>Interview on 07/29/22 the Qualified Professional stated:</p> <ul style="list-style-type: none"> <li>- She understood staff had not documented contact with client #1's doctor per written order when blood sugar values were above 140.</li> <li>- She would follow up with staff about ensuring blood sugar value parameters were followed.</li> </ul>	V 291	<p>HAVE NOT DEMONSTRATED OR SHOWN SYMPTOMS AT ANY TIME TO USE THIS INHALER. Client #1 Does HAVE AN Appointment with His Physician on 8/2/22. This writer will Accompany and Did accompany client #1 to His Physician and Discussed this matter with Physician. It was revealed that #1 Physician changed this year 2022. But new Physician that's treating #1 currently suggested that she discontinue the pro-Air yet continue to evaluate him. Client #1's PRO-AIR Inhaler was discontinued, as <del>an</del> discontinued order was written, dated and signed on 8/2/22. Discontinue order was placed in client's chart. This writer assured this action was completed on this date, Gale Purris, BA/RP- 8/2/22.</p>	8/2/22

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

MHL007-026

(X2) MULTIPLE CONSTRUCTION

A. BUILDING: \_\_\_\_\_

B. WING: \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

R

07/29/2022

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BEAUFORT COUNTY GROUP HOME #1

405 EAST 6TH STREET  
WASHINGTON, NC 27889(X4) ID  
PREFIX  
TAGSUMMARY STATEMENT OF DEFICIENCIES  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL  
REGULATORY OR LSC IDENTIFYING INFORMATION)ID  
PREFIX  
TAGPROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE  
CROSS-REFERENCED TO THE APPROPRIATE  
DEFICIENCY)(X5)  
COMPLETE  
DATE

V 291

Continued From page 2  
checks."Review on 07/28/22 and 07/29/22 of client #1's  
blood glucose log from February 2022 thru July  
2022 revealed:

- 02/04/22 - 171.
- 02/08/22 - 156.
- 02/11/22 - 155.
- 02/14/22 - 158.
- 02/18/22 - 156.
- 02/21/22 - 154.
- 02/25/22 - 162.
- 02/28/22 - 153.
- 03/04/22 - 179.
- 03/07/22 - 162.
- 03/11/22 - 156.
- 03/14/22 - 164.
- 03/18/22 - 150.
- 03/21/22 - 152.
- 03/25/22 - 169.
- 03/28/22 - 166.
- 04/01/22 - 156.
- 04/04/22 - 149.
- 04/08/22 - 160.
- 04/11/22 - 147.
- 04/15/22 - 175.
- 04/18/22 - 163.
- 04/22/22 - 159.
- 04/25/22 - 142.

- No documentation the physician was notified for  
blood sugar values above 140 for 5 consecutive  
checks.Interview on 07/29/22 the Qualified Professional  
stated:

- She understood staff had not documented  
contact with client #1's doctor per written order  
when blood sugar values were above 140.
- She would follow up with staff about ensuring  
blood sugar value parameters were followed.

V 291

Continued—  
This wr. the HAS  
Followed-up with staff  
regarding following the  
Parameter trends for  
B/sugar checks values  
above 140 for 5 consecutive  
checks will be done, and if  
every 30 minutes.  
If Blood sugar remains  
over 140 at the end of  
the 5th check or higher  
STAFF WILL IMMEDIATELY  
CONTACT this wr. the who  
will contact the physician  
for further guidance.  
QP will document what  
in order to document  
what was reported by  
the physician, and  
File Document Sheet  
in client #1's chart  
to show follow up.  
— gals. Purvis, QP 8/12/22



STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

MHL007-026

(X2) MULTIPLE CONSTRUCTION

A. BUILDING: \_\_\_\_\_

B. WING: \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

R

07/29/2022

NAME OF PROVIDER OR SUPPLIER

BEAUFORT COUNTY GROUP HOME #1

STREET ADDRESS, CITY, STATE, ZIP CODE

405 EAST 6TH STREET  
WASHINGTON, NC 27889

(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 291	<p>Continued From page 3</p> <p>- She will follow up with client #1's doctor on the need for a self administration order for his Proair or possibly have it discontinued.</p> <p>Interview on 07/28/22 the Chief Executive Officer stated client #1 did not take his Proair inhaler to the day program.</p> <p>[This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.]</p>	V 291		