Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | COMPLETED | | |
|---|---|--|--|---|--|--|--|
| | | MHL094-006 | B. WING | | 01/06/2023 | | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AL | DDRESS, CITY, S | STATE, ZIP CODE | • | | |
| WASHINGTON COUNTY GROUP HOME #3 108 HAMPTON DRIVE PLYMOUTH, NC 27962 | | | | | | | |
| (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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | E ACTION SHOULD BE O TO THE APPROPRIATE | | |
| V 000 | V 000 INITIAL COMMENTS | | V 000 | | | | |
| | deficiency was cited | | | | | | |
| | This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability. | | | | | | |
| | | sed for 6 and currently has a urvey sample consisted of clients. | | | | | |
| V 118 | V 118 27G .0209 (C) Medication Requirements | | V 118 | | | | |
| | only be administered order of a person and drugs. (2) Medications shat clients only when an client's physician. (3) Medications, included administered only bunlicensed persons pharmacist or other privileged to prepar (4) A Medication Adall drugs administer current. Medication recorded immediate MAR is to include the (A) client's name; (B) name, strength, | 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 all licensed persons, or by trained by a registered nurse, legally qualified person and e and administer medications. Iministration Record (MAR) of red to each client must be kept administered shall be ely after administration. The | | | | | |
| | (D) date and time the | ne drug is administered; 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

| · · · · · · · · · · · · · · · · · · · | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---|---|-----------|-------------------------------|--|
| | | MHL094-006 | B. WING | | 01/ | 06/2023 | |
| NAME OF PROVIDER OR SUPPLIER WASHINGTON COUNTY GROUP HOME #3 STREET ADDRESS, CITY, STATE, ZIP CODE 108 HAMPTON DRIVE PLYMOUTH, NC 27962 | | | | | | | |
| (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 | (5) Client requests to checks shall be rec | ge 1 for medication changes or orded and kept with the MAR appointment or consultation | V 118 | | | | |
| | did not ensure that on the written order audited clients (#3). Review on 1/5/23 o Admitted: 7/31/ Diagnoses: Sev Developmental Dist Low Vitamin D, and No current phys (Docusate Sodium) (colace), 1 capsule Review on 1/5/23 o MAR revealed: DOK 100mg so staff initialed Jabeing administered Review on 1/5/23 o dated 9/24/21 revealed: "Please stop Co | view and interview, the facility medication was administered of a physician affecting 1 of 3 of 3. The findings are: If Client #3's record revealed: 95 overe Intellectual ability, High Blood Pressure, I High Cholesterol sician's order for DOK of 100 milligram (mg) softgel 2 times a day (constipation) If Client #3's January 2023 oftgel, 1 cap 2 times a day anuary 1st - 5th as medication to client #3 If Client #3's Physician order aled: | | | | | |

6899

Division of Health Service Regulation STATE FORM

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 | | |
|---|--|--|---|--|-------------------------------|--------------------------|--|
| | | MHL094-006 | B. WING | | 01/0 | 6/2023 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, | STATE, ZIP CODE | - | | |
| WASHINGTON COUNTY GROUP HOME #3 108 HAMPTON DRIVE PLYMOUTH, NC 27962 | | | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | 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) | ILD BE | (X5) COMPLETE DATE | |
| V 118 | Interview on 1/5/23 (QP) reported: - Been the QP for the Checking the MARS - The medication 2021 - Staff did not draw 2023 MAR to show - She didn't know the Colace on the Staff should hamedication like shewn - She would make medication on the Staff should specific shewould specific specific shewould specific specific shewould specific specific specific shewould specific specific specific shewould specific | the Qualified Professional or about 20 years reordering medications and of for errors or, colace, was discontinued in aw a line through the January it was discontinued or that staff did not discontinue lanuary 2023 MAR ove discontinued the did on the previous MARs ove sure she discontinued the | V 118 | | | | |

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